afhto association of family health teams of ontario

Guide for Interprofessional Primary Care Teams

INTERPROFESSIONAL HEALTH CARE PROVIDERS ROLES, RESPONSIBILITIES AND SCOPES OF PRACTICE 2023

Contents

Acknowledgements

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Reviewers

We would like to acknowledge the many members who provided input on this guidance, and for their contributions to the review process.

- Canadian Association of Physician Assistants. Website.
- AFHTO IHP Advisory Council. About.
- Nurse Practitioners' Association of Ontario. Website.
- Ontario Association of Social Workers. Website.
- Ontario Physiotherapy Association. Website.
- Ontario Primary Care Team Pharmacists Network.
- Ontario Psychology Association. Website.
- Ontario Society of Occupational Therapists. Website.
- Primary Care Dietitians' Association. Website.

Purpose & Context

Healthcare is undergoing significant transformation in Ontario. We are working simultaneously to reduce cost while improving quality, patient experience, work life of the work force and health equity. The collaborative nature of Interprofessional Health Teams is a positive path forward to achieving these health system transformation goals while meeting the complex needs of today's patients. Collaboration occurs when multiple health care workers from different professions work across disciplines, and together with patients, their families, caregivers, and other social networks to deliver the highest quality of care (World Health Organization, 2010). To achieve this outcome, the traditional approach to care must be set aside, and we must instead leverage the diverse skillsets and expertise of Interprofessional Health Care Providers (IHP) and focus on putting patients at the centre of care planning with a holistic view of healthcare treatment.

This document serves as a guide to provide basic information to aid in the design, coordination, and scope of work of an Interprofessional Primary Health Care Team. Within an Interprofessional team, a group of professionals that cross the healthcare spectrum will work collaboratively to provide the best course of care and results for patients. In this model of care, through strong communication, cooperation, and teamwork, the IHP Team will deliver on the quintuple aim: (1) improved patient, family, and caregiver experience; (2) greater system efficiencies; (3) better work life of the work force; (4) improved population health; and (5) greater health equity.

Though extensive, this document does not serve as an exhaustive review of health care practitioners and their potential roles in a primary care team, or a replacement of the current roles and responsibilities you may have identified within your IHP team. No two teams will function exactly alike. Each, over time, will develop its own character, working relationships, leadership, vision, culture, diversity disclosure practices, and other structures required to deliver on your Interprofessional Primary Health Care Team.

While each provider is regulated within their scope of practice, it is recognized that the working relationship among the members of the team will also consider the expertise, preferences, and skill set of individual providers. While some Teams may wish to provide all services to their patients included in this document, others may work with their community agencies to provide specific services to patients as required.

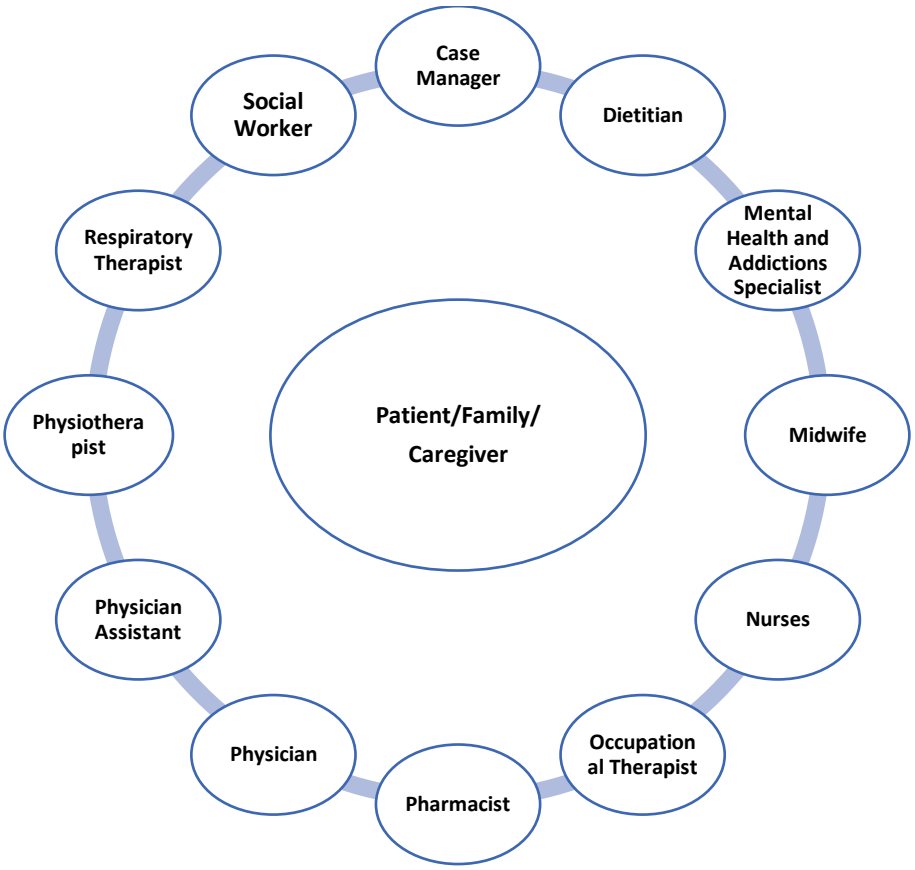
Guidance has been developed under the leadership of the Association of Family Health Teams of Ontario (AFHTO), with the support of the Interprofessional Health Care Providers Advisory Council and other health-care partners (see "acknowledgements"). For comprehensiveness, additional resources on best-practices and evidence-based care are provided within the document.

Leadership Structure

Interprofessional Primary Health Care Teams are often characterized by a non-hierarchical organization in which responsibility for the effective functioning of the team is shared by all team members. IHPs will offer a wide range of services and programs including, but not limited to, home based care programs, social prescribing programs, health promotion programs, chronic disease management programs and obstetrical care services. IHPs will work with members within their team and/or partner with community

organizations to assist with the planning and delivery of services to meet the needs of their population groups. It is recommended that the IHP staff match the needs of the patient population that it serves. For example, ensuring there are translation services available where there is a significant need; cultural training; supports for older adults and the elderly, etc.

Not all teams are made the same. IHP staff maintain flexibility to define leadership structures in a manner that best suits the structure of the team. The goal of an IHP should be outcome focused: promoting better health outcomes for patients; providing informal education across disciplines; enhancing skills and knowledge of other professions, and providing appropriate, culturally safe care where needed.



The composition of the collaborative team depends on the team's goals and values, and the social and financial resources available in each community. Throughout this document, 'IHP' is used to describe the various professions that form a team.

Successful IHPs work in an integrated manner, complementing one another's expertise and skills to achieve a shared vision and to ensure patients' goals are met. In successful teams, each member acknowledges and respects the abilities of their colleagues and is willing to take on responsibilities to help or contribute to others' roles. This requires that everyone understand the extent of their knowledge and areas of overlap with others' disciplines, respect others' perspectives and acknowledge they can learn from others' disciplines and expertise.

The effectiveness of the IHP team model is dependent on cross-training of staff and enabling members of the team to perform additional duties that may typically be performed by others. This ensures that patients receive appropriate treatment regardless of who provides the care. From the time of admission to discharge and/or ongoing management, the patient and IHP team work together to establish, evaluate, and accomplish mutually determined goals. The result is a holistic, collaborative, and patient-focused approach to care. Teams that share a common purpose, communicate clearly, and are composed of professionals from across the care continuum are vital to providing exceptional patient care.

Evaluating Team Effectiveness

A. Performance Improvement and Monitoring

General guidelines for evaluation team effectiveness:

- Establish a process for collection of data and information on outcomes.
- Create standardized clinical practice guidelines.
- Establish interprofessional continuing education to manage risks, to improve patient safety and to facilitate a collaborative patient-centred practice.

B. Expected Impact on Health Outcomes and Service Attributes

The team-based model of interprofessional teams will support the goals of the Quadruple Aim. Measurable impacts may include, but will not be limited to:

I. **Accessibility:** The served should have timely access to care. Services provided should be reflective of the patient population served, with considerations given to culturally safe care, reducing barriers to care that may have been previously experienced.
II. **Appropriateness:** Care delivery is personalized and specific to the person being cared for.
III. **Respect:** Patients/families/caregivers are at the centre of care planning and are engaged in their care journey using share decision making approached to achieve their health goals.
IV. **Safety:** Care provided is physically, culturally, and psychologically safe, fostering security for those receiving care.
V. **Effectiveness:** Providers realize enhanced professional satisfaction through collaborative practice environment that enables use of their expertise within an optimized scope of practice.
VI. **Efficiency:** Increased efficiencies in care delivery by primary care providers working to their optimized scope of practice to respond to the health care needs of patients and populations including all areas of care.
VII. **Equity:** Fair distribution of services and benefit according to population needs.

Common Barriers and Factors for Success

Well-functioning IHP teams are critical for service integration and successful outcomes. Ample evidence in literature supports collaborative practices as a strategy to produce optimal patient outcomes, and IHPs are the vehicle to implement that strategy. To support effective collaboration, the team must be built on mutual respect and trust (O'Daniel & Rosenstein, 2008).

There is no single approach to success – each team will decide what approach to communication, patient care and other such structures work best.

A. Potential Challenges

Some aspects of working within an IHP may be difficult to transition to at the start, but long-term benefits (such as achieving the quadruple aim) are expected to outweigh short-term difficulties.

Some potential challenges of working within an IHP discipline can arise from:

- Lack of knowledge and appreciation of the roles of other health professionals.
- Lack of outcomes research on collaboration.
- Legal issues of scope of practice.
- Hierarchical administrative and educational structures that discourage interprofessional collaboration.
- Poor communication if not on a shared EMR or co-located.
- Different goals of individual team members.
- Inadequate decision making; and conflict regarding individual relationships to the patient.

B. Critical Success Factors

- **Role Clarity**:
    - Understand your discipline and the scope of practice, along with the contributions you can bring to a team.
    - Individual contributions should be valued, yet the focus must be on team success.
- **Willingness to work continuously on overcoming barriers**:
    - Members should have the ability to overcome adversity. Challenges require every member to remain committed to the collective goal despite setbacks.
    - Be comfortable in situations of ambiguity, and areas that may require you to stretch beyond your discipline and comfort zone.
- **Ability to overcome personal differences**:
    - Members must be able to overcome personal differences even if they do not always get along.
- **Collective leadership, a philosophy that takes pressure off any one individual and disperses it throughout the group**:
    - Establish a meeting discussion tool/planning guide to support team meetings.
    - Establish a plan to huddle daily to discuss immediate priorities or issues. Meet at least monthly to proactively manage ongoing work.
    - Agree on a unifying philosophy centred around primary care of the patient and the community. Develop a commitment to the common goal of collaboration, revisiting these goals and updating over time as the practice evolves.
- **Trust and confidence in team members:**
    - Establish positive attitudes about own profession, be willing to share responsibility for patient care.

- **Contribute to and be part of a broader community of practice**:
    - Form a community with colleagues across other teams, participate in a community of practice to share best practices, challenges, seek advice and share resources.

Determining if an Intervention Falls within Scope

The complexity of today's health care environment, and the collaborative nature of the IHP requires that all health care professionals within the team work to their optimized scope of practice. This means that each care professional is utilized to the full range of their role, responsibility, and functions for which they are educated, competent and authorised to perform. The IHP team and scope of practice should be reflective of the patient population, ensuring that people can receive the right care, at the right time, tailored to their care needs.

As the IHP team works together to optimize scope, the following questions may assist individual professions in understanding whether an intervention falls within their scope of practice.

I. Is the proposed intervention consistent with the legislated scope of practice of the profession of that designation?
II. Is the proposed intervention prohibited or protected by other legislation?
III. Will the care professional be able to attain and maintain their competence in its performance?
IV. Will performance of the intervention improve health outcomes of the population? Is there evidence that the skill or service is effective, safe and a benefit to the patient population served?
V. How does the skill or service fit within or enhance a current area of practice?
VI. Does the delivery of this service support the evolution of the profession without compromising safety or quality of practice?
VII. Is the provision of this service being driven by pressure to respond to a trend in demand rather than evidence-based evolving practice?

Team members should work together to ensure the appropriate supports and resources are in place to enable individuals to gain practical experience needed to work within a collaborative setting and build their capacity to perform required interventions safely and competently.

Contrasts Between Traditional Care and Collaborative Care

The traditional approach to care requires that each team member is responsible only for their discipline, creating individual goals for their patients. In contrast, the interprofessional approach to care coalesces a joint effort, where all disciples form a common goal for their patient, keeping the patient/family/caregiver at the center of care planning. The care plan will take into consideration a number of assessments and treatment options to ensure an optimal plan is created for the patient. In turn, the patient/family/caregiver experiences better communication with a cohesive team, rather than numerous health professionals who do not know what others are doing to manage the patient. (O'Daniel & Rosenstein, 2008).

A compilation of the contrast between the tradtional care model and interdisciplinary team is depicted in the table below. (Johnson, 2017).

Traditional Care	Collaborative Care
All team members are not present.	All team members are present.
Located in conference room or hallway ("meat" of discussion and plan here).	The "meat" of team conversation and plan formulation includes the client.
A select few do most of the talking.	A team member (often not the physician) facilitates the conversation.
When the client is in the room, the pace is brisk and does not include all voices. Medical jargon is used.	Everyone on the team has a role, voice, and space to contribute to the conversation. Everyone understands the language used.
Hierarchical undertones are present. Physicians direct, disciplines report, clients and family are informed.	Physicians participate, professionals confer, clients and families are engaged in conversation.
Focus is on disease, treatment, and tasks.	Focus is on people, needs, and goals.
Whispered side conversations occur. The client is "talked about" in third person.	Few side conversations occur, resulting in transparency. Care progress is discussed.
Uniprofessional notes are taken. Parallel interventions occur.	Care plan is jointly developed with the client. Professionals collaborate on interventions.
Who will do what is assumed. Task delegation by team members is not reviewed or summarized.	Safety checklists are often used. The plan is summarized for the team, including the client.

Scope of Practice – Guide to Interprofessional Health Teams

Context

It is a given that all health care professions evolve as policies, evidence, demographic, technology, and other factors expand and change. During these changes, the public's safety must be protected, and health professions should use new information, regulation, and scope of practice to support, not hinder these goals.

This guideline identifies best practices to enable, enhance and sustain teamwork and interprofessional collaboration, and to enhance positive outcomes for patients/clients, systems, and organizations. It is based on the best available evidence (see "citations"); and recommendations from health professionals within IHPs and expert opinion (see "acknowledgements").

Overview and Legal Scope of Practice – Case Manager

The Case Manager is the primary care coordinator within an IHP team. They are aware of the patient-centric care plans developed, and work with other members of the team to keep to the care plan. As the central point of coordination, the Case Manager is the chief communicator to the other team members. Case Managers should be outcome-focused, using the established case management plan designed for each patient to track and achieve short-and long-term goal achievements.

Case Managers help patients achieve wellness and autonomy through advocacy, comprehensive assessment, planning, communication, health education and engagement, resource management, service facilitation, and use of evidence-based guidelines or standards. Their first duty is to the patient/caregiver/family – coordinating care that is safe, timely, effective.

Case Managers must possess the education, skills, knowledge, competencies, and experiences needed to effectively render appropriate, safe, and quality services to their patient/support systems. Additionally, they must demonstrate a sense of commitment and obligation to maintain current knowledge, skills, and competencies. They also must disseminate their practice innovations and findings from research activities to the case management community for the benefit of advancing the field of case management.

Some IHP teams may not have a Case Manager, and instead utilize review nurses, care coordinators, system navigators, and other specialists within the team. Case management is not a profession unto itself. Rather, it is a cross-disciplinary and interdependent specialty practice.

Impact/Outcome of Intervention – Case Manager

- Case Managers support the IHP team in improving patients' health and promoting wellness and autonomy through advocacy, communication, education, identification of service resources, and facilitation of service.
- Case Management has proven effective in the treatment of many chronic diseases due to early interventions and increased presence, support and coordination with the patient/caregiver/family including home visits, telephone/virtual care, adherence to care plan, and structuring of a follow-up protocol for complications or updates to care plan where appropriate.
- Case Managers promote integrated, coordinated, and continuous care, establishing a link between providers across the care continuum. They promote better system navigation and support to the patient. Interventions of Case Managers include the provision of comprehensive care, referral services, patient support and establishment of common and agreed upon goals.
- In observing the effectiveness of Nurse Case Managers evidence shows a reduced use of the emergency department, hospital admissions, and readmissions. Given the less frequent use of hospital emergency department visits, fewer diagnostic tests and accessibility of a case manager, there was a reduction in direct and indirect costs for the health care system. (Doménech-Briz, et al., 2020).

I. Roles and Responsibilities

Primary care team Case Managers work with individuals and groups to:

- Facilitate coordination, communication and involvement with patient, family and/or caregiver; involves members of the IHP and other key partners to achieve target goals and maximize positive outcomes and patient experience.
- Coordinate implementation of treatment plan and communicates insurance benefit information to patient/family/caregiver and members of the team. Coordinates optimal use of available benefits.

- Conduct patient assessment that takes into consideration the patient's cultural, linguistic, and health literacy. It is inclusive of the patient's medical and behavioural needs.
- Identify needs, barriers, and gaps in care. Advocates for additional services where appropriate.
- Assist patients to stabilize medical, behavioural, and cognitive health through his/her/their understanding of disease management and the social barriers that may deter the achievement of healthcare goals.
- Act as the liaison between patient, hospital, and other partners to support patient needs.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values and ways of knowing.

II. Collaboration with Team Members

Primary care team Case Managers work collaboratively to:

- Develop a documented plan of action for the patient, written collaboratively with the patient/family/caregiver. The Case Manager monitors the plan evolution and determines whether the goals are met. The Case Manager revaluates and adjusts the plan as needed (e.g., if goals cannot be met, or plans change).
- Keep team members apprised of patient's progress and potential changes that could impact the patient plan, outcomes or other previously outlined.
- Facilitate team discussion and evaluation of patient days, status of insurance to assist in planning for discharge.
- In developing and maintaining collaborative relationships with other members of the care team, the Case Manager must be flexible in dealing with potential role blending that may take place.
- Treat patients/caregiver/family, health care team members, and other stakeholders with dignity and respect at all times.

III. Additional Resources

- Canadian Standards of Practice for Case Management
- Canadian Core Competency Profile for Case Management Providers

Overview and Legal Scope of Practice - Dietitian

The Dietitian's scope of practice is defined in the Dietetics Act, 1991 and is regulated by the College of Dietitians of Ontario. Registered Dietitians possess 4-year Bachelor of Science or Applied Science degree, majoring in Nutritional Sciences or Human Nutrition (or equivalent); completion of Dietitians of Canada accredited Dietetic Internship program or combined master's and Dietetic Internship program. They must be in good standing with the College of Dietitians of Ontario and possess professional liability insurance.

Dietitians provide patient-centered, evidence-based medical nutrition therapy to improve the physical and mental health of patients and health outcomes in chronic disease management, disease prevention and health promotion. The RD acts as a resource to team members, providing educational updates and championing collaborative care pathways to improve team-based care and patient access to evidence-based best practices (Royall & Brauer, 2009)[26].

Impact/Outcomes of Intervention – Dietitian

- Dietitians can help reduce malnutrition levels in seniors, leading to fewer hospitalizations. (Baldwin & Weekes, 2011).
- Structured and intensive lifestyle interventions delivered by dietitians can reduce the risk of developing type 2 diabetes by up to 60% in clients at risk (Royall & Brauer, 2009).
- Diabetic patients can see a 1-2% reduction in HbA1C (also known as the hemoglobin A1C or HbA1c test). For perspective, to achieve a similar glycemic reduction would take 1-2 hypoglycemic agents. A 1% lowering in A1c results in 21% reduction in deaths from DM, 14% less MI, and 13% fewer deaths (from all causes) (Royall & Brauer, 2009).
- A hyperlipidemia patient can expect to see a 30% lowering of their LDL values via MNT. This equates to one statin medication (Royall & Brauer, 2009).
- For every $1 spent on nutrition intervention saves the health care system $5 to $99 reducing hospitalizations, medication cost and freeing up physician time (Baldwin & Weekes, 2011).

I. Roles and Responsibilities

Primary care team Dietitians work with individuals and groups to:

- Provide medical nutrition therapy for chronic disease management and prevention, identifying nutrition problems, assessing nutritional status of patients, developing nutrition care plans, and evaluating and monitoring effectiveness of nutrition interventions.
- Conduct comprehensive nutrition assessments identifying stages of change, socio-economic and cultural factors impacting health behaviours.
- Utilize appropriate counselling techniques including motivational interviewing and cognitive behavior strategies.
- Communicate nutrition care plans and debrief with primary care team members as needed.
- Ensure ongoing nutritional care by maintaining complete and accurate client records, assessment notes and required correspondence, and by monitoring client progress on a regular basis.
- Safeguard client records and assures confidentiality of client information.
- Identify opportunities for quality improvement for nutrition services and interdisciplinary work.
- Work together within interprofessional team to create resources to enhance patient access to timely, evidence-based primary care nutrition.
- Facilitate/co-facilitate groups with other staff of the primary care health team.
- Assist in the education of staff, students, volunteers and peer support workers and supervision of internship placements.
- Maintain professional competence through participation in professional development activities and maintaining license to practice.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values and ways of knowing.

II. Collaboration with Team Members

Primary care team Dietitians work collaboratively to:

- Provide recommendations on available community resources as appropriate (e.g., food banks, community meal programs).
- Work with team members and with community agencies to build care plans/coordinate referrals and seek feedback from the patient/family/caregiver.
- Collaborate with team to adapt medical nutrition therapy according to patient's needs. Regularly updates team on patients' nutritional status.

- Monitor and evaluate the medical nutrition therapy and patient self-identified outcomes and modify care map accordingly.
- Collaborate with team to implement medical nutrition therapy and to improve nutritional status of the patient.
- Treat patients/caregiver/family, health care team members, and other stakeholders with dignity and respect at all times.

III. Additional Resources

- College of Dietitians of Ontario: Collaborative Care Professional Practice Guidelines for Registered Dietitians in Ontario
- Dietitians of Canada: Learn about Dietitians
- Additional Articles and Resources

Overview – Midwife

Midwifery is regulated in Ontario under the *Regulated Health Professions Act, 1991* and the *Midwifery Act, 1991, S.O.1991, c.31* as well as by the College of Midwifes Ontario (CMO) Bylaws. All midwives must be registered with the College of Midwives of Ontario to be permitted to practice. There are exceptions for Aboriginal midwives and healers in the *Midwifery Act, 1991* and the *Regulated Health Professions Act, 1991*, respectively. These exceptions allow Aboriginal midwives to provide traditional midwifery services to Aboriginal persons or members of an Aboriginal community and to use the title Aboriginal Midwife. The CMO is responsible for registering midwives, ensuring the quality of midwifery care, setting standards, and investigating and responding to any issues related to midwifery care. Midwives who are registered with the CMO are permitted to use the protected title of registered midwife, or RM.

A midwife completes a four-year university program that covers health, social and biological sciences in the classroom, completing clinical placements under the supervision of experienced midwives, attending births as secondary and primary care providers, and providing prenatal and postpartum care in midwifery clinics and clients' homes.

Midwives offer complete care during pregnancy, including regular appointments, physical examinations ultrasounds, routine blood work, the assessment of risk and abnormal conditions and emotional support. With access to laboratories and diagnostic services, a Midwife can order prenatal lab work and screenings and can prescribe certain pregnancy-related medications. The midwifery model of care promotes normal birth, enables clients to make informed choices, offers families the choice of birthplace (in home or in hospital), and provides continuity of care and support throughout the childbearing experience. Midwives provide low-risk prenatal, intrapartum, and postnatal care. Midwives work in collaboration with other health professionals on the team and consult with or refer to medical specialists as appropriate (Association of Ontario Midwives, 2022).

Impact/Outcomes of Intervention – Midwife

- Midwives can help to substantially reduce maternal and neonatal mortality and stillbirths.
- Provide patient emotional support, advocate for patients, provide counselling and establish trust. They empower and recognize patients as the main decision-maker.

I. Roles and Responsibilities

Primary care team Midwife's work with individuals and groups to:

- Support health, wellbeing, and a positive experience of care around pregnancy, birth, and the early weeks of life.
- Consider long term as well as short term effects to care.
- Contribute to the growth of secure attachments between parents (s) and baby.
- Advocate for patients so that their voices are heard; promote self-care and the health of mother, infants, and families, prioritize equitable, culturally appropriate care:
    - Facilitate the process of informed choice, ensuring that the pregnant woman is recognized and supported as the ultimate decision maker.
    - Establish choice of birthplace in attempts to create equitable access to those choices, particularly in rural and remote communities.
    - The Midwife will make every effort to ensure the birth mother is the primary decision maker about their care when appropriate. When this cannot be achieved, the Midwife should keep the patient as informed and involved as possible.
- After birth, the Midwife will monitor and assess the mother and newborn to ensure that both are healthy and revering well by undertaking:
    - A complete physical exam of the newborn
    - Routine newborn screening tests
    - Physical and mental health assessments
    - Parenting support and teaching
    - Chest/breastfeeding support
- Conduct postpartum home visits and provide postpartum care.
- Builds a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values.

II. Collaboration with Team Members

Primary care team Midwives work collaboratively to:

- Enables access to secondary or specialist care as necessary. Midwives can, and should, consult with the Physician, if a woman's care demands knowledge or speciality that is beyond the midwife's scope.
- The Midwife may work collaboratively with Nurses as a second attendant and other members of the team to provide additional support where appropriate.
- Treat patients/caregiver/family, health care team members, and other stakeholders with dignity and respect at all times.

III. Additional Resources

- College of Midwifes Ontario: Standards of Practice and Midwifery Scope of Practice
- National Aboriginal Council of Midwives: What is an Indigenous Midwife?

Overview and Legal Scope of Practice - Nurses

The practice of nursing is the promotion of health and the assessment of the provision of care for, and the treatment of health conditions by supportive, preventative, therapeutic, palliative, and rehabilitative means to attain or maintain optimal function (Nursing Act 1991 c. 32. S3.). The Nursing Act establishes the mandate of the College of Nurses of Ontario and defines the scope of practice for the nursing profession.

This section contains information about Nurse Practitioners, Registered Nurses in the Extended Class (commonly referred to as Primary Health Care Nurse Practitioners), Registered Nurses, and Registered Practical Nurses. Only members of the College of Nurses of Ontario can practice nursing in Ontario and use the titles "nurse", "Registered Nurse (RN)", "Registered Practical Nurse (RPN)", or "Nurse Practitioner" (NP). Regardless of education, experience and competencies, RNs, RPNs, and NPs are different designations of nurses with different scopes of practice, professional authorizations around practice and differing capacities to make autonomous nursing decisions.

Nursing roles are continually evolving to meet the ever-changing needs of the patient population, the health care system, and to reflect changes in legislation, regulation, and educational advancements. The scope of practice of the profession is impacted by:

- The Nursing Act, other relevant federal and provincial legislation,
- Standards of Practice and Entry Level Competencies, relevant College documents and ethical code, and;
- Other standards (e.g., specialty standards).

Further, individual scope of practice is influenced by:

- Individual competency shaped by continuing education and experience,
- Specific competencies required of the NP/RN/RPN,
- Employer authorization to perform specific nursing competencies provided through employer policies, role/job descriptions, and/or care directives, etc.,
- Practice setting, and;
- Needs and health goals of each patient.

Depending on the population health needs and the mix of other providers, the primary care team may choose to integrate an RN, RPN, NP or some combination of nursing professional to the interprofessional team.

Resources:

- Registered Nurses' Association of Ontario: Best Practice Guidelines Program Published Resource List (2022)
- College of Nurses of Ontario: Practice Standards and Guidelines to Support Nurses in Providing Safe and Ethical Care
- College of Nurses of Ontario: Understanding your Scope of Practice

Impact/Outcomes of Interventions – Nursing

- Improved continuity of care.
- Decreased wait times in primary care.
- Increased patient capacity and volume.
- Increased primary care system capacity.
- Decreased strain on physicians (and NPs if other nurse professionals are included on the team).
- Increased retention of nurses through improved role satisfaction.

A. Nurse Practitioner (NP)

Nurse Practitioners are registered nurses with advanced university education and training, regulated by The College of Nurses of Ontario (CNO). NPs independently and collaboratively provide a range of health care services to patients of all ages across the care continuum to manage illnesses and provide preventative care and education to support healthy living (Mian, Koren, & Rukholm, 2012); (College of Nurses of Ontario, 2019).

Nurse Practitioners have the capability to take on a roster of patients independently within the team-based care environment. This is within their scope of practice and consistent with their training and education.

I. Roles and Responsibilities

Primary care team NPs work with individuals and groups to:

- Create care pathways within the IHP to ensure the right provider is seeing patients at the right time.
- Complete a comprehensive health history and assessment; formulate and communicate a diagnosis – identifying a disease, disorder, or condition, taking differential diagnosis into consideration; treat injuries; provide prenatal care; perform physicals.
- Engage the patient/family/caregiver as full participants and partners in their care plan with attention to self-care to the extent that the patient is willing and able to participate.
- Write prescriptions and renew medications.
- Order and interpret diagnostic test.
- Prescribe medications (including controlled drugs and substances) and renew medications. When dispensing controlled substances, education strategies and other risk mitigation factors should be made for potential addiction, misuse, or other risks to a patient.
- Provide counseling and education.
- Provide supportive care through illness.
- Order and interpret diagnostic tests.
- Initiate, order, or prescribe consultations, referrals, and other acts.
- Identify care gaps in care of specific populations and conditions.
- Teaching/mentoring and contribution to research/literature.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values.

II. Collaboration With Team Members

Primary care team NPs work collaboratively to:

- Consult and collaborate with members of the team on the development of a patient's care plan.
- Consult and collaborate with physicians and other members of the team, and partners across the care continuum to monitor patients' response to medication therapy; adjusting, discontinuing as needed.
- Refer patients to other care professionals within the team, or partners across the care continuum where care needs are beyond the NP's scope of practice or additional supports are required.
- Treat patients/caregiver/family, health care team members, and other stakeholders with dignity and respect at all times.

III. Additional Resource(s)

- College of Nurses Ontario: Practice Standard – Nurse Practitioner
- College of Nurses Ontario: Overview of Nurse Practitioners
- Nurse Practitioners' Association of Ontario (NPAO): NP FAQ
- Canadian Nurses Association: Role of Nurse Practitioners Across Canada

B. Registered Nurse (RN)

Registered Nurses have a baccalaureate degree and can either take a collaborative college-university nursing program or a university nursing program and practice across five domains: administration, clinical care, education, policy, and research (Canadian Nurses Association, 2015). RNs achieve, maintain, or recover optimal health and functioning for their patients. They assess, monitor and document patient symptoms, reactions, and progress. RNs have expertise and knowledge to improve patient health and promote health to the patient/family/caregiver. The RN serves as an advocate for the patient by recommending changes to their care plan aligned with best practices and evidence-based strategies (Registered Nurses' Association of Ontario).

I. Roles and Responsibilities

Primary care team RNs work with individuals and groups to:

- Assess and analyze a person's health care needs, and determine the appropriate service or treatment, the appropriate care provider, or the appropriate equipment to provide care.
- Provide nursing care and treatment (e.g., administering medications, providing wound care, informing, and educating patients, providing self-care options, managing medication, and promoting disease prevention). RNs take a holistic approach to care – they involve and encourage individuals to feel empowered regarding their own health and provide preventative health and health promotion information. Screening, early detection, chronic disease management and enhanced access are included in the scope of work for RNs.
- Maintain contact with the patient/family/caregivers and other healthcare providers across the continuum of care should the patient require additional services.
- Collect patient and family data through assessment of the patient's physical, emotional, social, psychological, and cultural status.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values.

II. Collaboration With Team Members

Primary care team RNs work collaboratively to:

- Discuss patients' coping strategies, support system, learning and other health needs in collaboration with other members of the IHP.
- Perform physical and/or mental health evaluations. Identify potential issues with plan of care, provide feedback to therapists regarding a patient's ability to follow through with a skill if there are cognitive, behavioural, or physical changes during the day that are impacting patient's ability to consistently perform.
- Act as a resource to the team by providing information and nursing support based on nursing theory and practice.
- Treat patients/caregiver/family, health care team members, and other stakeholders with dignity and respect at all times.

III. Additional Resource(s)

- Canadian Nurses Association: Framework for the Practice of Registered Nurses in Canada

C. Registered Practical Nurse (RPN)

Registered Practical Nurses have a college diploma and are qualified to work as an RPN upon completion of the Canadian Practical Nurse Registration Exam. RPNs assist patients with general health conditions particularly in areas where their conditions are relatively straight forward. RPNs establish professional, therapeutic relationship, using a patient-centred approach, and advocate for patients in their relationship with the health system.

I. Roles and Responsibilities

Primary care team RPNs work with individuals and groups to:

- Perform nursing interventions such as taking vital signs, applying aseptic techniques including sterile dressing, ensuring infection control, monitoring nutritional intake, and conducting specimen collection.
- Complete comprehensive client assessment, take and record vital signs, collect various samples, dress wounds.
- Administer medication and observe and document therapeutic effects.
- Provide pre-operative and post-operative personal and comfort care.
- Monitor established respiratory therapy and intravenous therapy.
- Monitor patients' progress, evaluate, and document effectiveness of nursing interventions and collaborate with appropriate members of health care team.
- Provide safety and health education to individuals and their families.
- Engage patients as active partners for mutual planning of, and decisions about their care, including overall goal achievement and potential modifications to the patient care plan.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values.

II. Collaboration With Team Members

Primary care team RPNs work collaboratively to:

- Recognize changes/ deviations from predicted patient response(s); probe further and manage or consult appropriately. With RN or other health care team member.
- Provide holistic evidence-informed practice that support the concepts of health promotion, illness prevention, health maintenance and restorative care.
- Support NP/RN when making decisions about a change in care plan or when a change in health status is identified.
- Advocate for the protection and promotion of clients' right to autonomy, respect, privacy, confidentiality, dignity, and access to information.
- Treat patients/caregiver/family, health care team members, and other stakeholders with dignity and respect at all times.

III. Additional Resource(s)

- College of Nurses of Ontario: Requisite Skills and Abilities for Nursing Practice in Ontario
- Canadian Council for Practical Nurse Regulators: Standards of Practice for Licensed Practical Nurses in Canada

Overview and Legal Scope of Work - Occupational Therapist

The profession of Occupational Therapy is regulated in the province under the *Regulated Health Professions Act, 1991* and the *Occupational Therapy Act, 1991*. Individuals who practice in Ontario as an Occupational Therapist must be registered with the regulatory body, the College of Occupational Therapists of Ontario (COTO). Unless registered, the title of Occupational Therapist cannot be used. Before registering to practice, the individual will graduate from an accredited Canadian University Program or obtain the recognition of the equivalence of the diploma or training obtained outside Canada. In all provinces except Quebec, they must also pass the National Occupational Therapy Certification Exam.

The Occupational Therapist (OT) is focused on adapting, modifying, or changing daily activities that the patient is required to do, or wants to do. OTs are problem solvers, and work to ensure patients have a better quality of life by supporting patients to regain independence after an injury, helping those with intellectual or developmental delays adapt to daily life or working to improve skills, provide coping strategies for patients with mental health challenges, prevent injuries and falls, work with those with chronic diseases, and other such barriers to participating in the occupations of everyday living. OTs use a variety of approaches to care such as health promotion, injury prevention, chronic disease management, direct services, and community development.

Impact/Outcomes of Intervention – Occupational Therapist

- Intervention can prevent hospitalizations, shorten hospital stays, and provide additional support to the community or caregiver. This also decreases overall system costs.
- Can enhance patient outcomes from an occupational performance perspective rather than a disease-specific approach. Deliver cost-effective, evidence-based solutions to improve health and

wellness outcomes applying a mix of skills that address the whole person (i.e., cognitive, physical, emotional, spiritual, cultural abilities and environment).

- Contribute to the coordination of care and provide patient-centred care in a direct way by applying their unique skillset and attituded to supplement the contributions of other IHP team members. In discussing this unique role of OTs, The Manitoba Society of Occupational Therapists (2005) note that it is the only profession whose education is entirely devoted to the study of occupational performance and its impact on people's health and wellness. As such, OTs can reduce health care costs and complexities in care.
- Help improve outcomes for those with chronic diseases and leads to a deceased rate of functional decline (Foster, Hartvigsen, & Croft, 2012); (Bornhöft, Larsson, Nordeman, Eggertsen, & Thorn, 2019).

I. Roles and Responsibilities

Primary care team Occupational Therapists work with individuals and groups to:

- Help patients gain maximal function in areas of Activities of Daily Living (ADL).
- Analyse patients' capabilities and expectations related to life activities through observation, interviews, and formal assessments. Incorporate cultural, social, physical, and institutional options to increase inclusion.
- Assess a patient's home and/or work environment and recommending adaptations to fit the patient's needs and improve independence.
- Evaluate patient's limitations that require interventions.
- Train patients and their caregivers/family to use special equipment.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values and ways of knowing.

II. Collaboration with Team Members

Primary care team Occupational Therapists work collaboratively to:

- Seek out and synthesize relevant information about a patient from other sources, such as family, caregivers, and professionals with the care team.
- OTs and PTs collaborate to assist patient to become functional with all components of skills/ADLs.
- Establish personalized care plans working as a member of an interprofessional team.
- Consult and advise on health promotion programs to prevent disabilities and to maximize independent function in all activities of life.
- Collaborate with team members and key community service providers to promote comprehensive and coordinated care. Facilitate referrals to other services as appropriate.
- Treat patients/caregiver/family, health care team members, and other stakeholders with dignity and respect at all times.

III. Additional Resources

- Competencies for Occupational Therapists in Canada
- Ontario Society of Occupational Therapists – Regulation of Occupational Therapy Practice
- College of Occupational Therapists of Ontario – Standards and Resources

- Canadian Association of Occupational Therapists - Occupational Therapy and Primary Care: A Vision for the Path Forward

Overview and Legal Scope of Practice– Pharmacist

The scope of practice and authorized acts for pharmacists is established in the *Pharmacy Act S.O. 1991, c. 36*. In addition to dispensing and compounding, pharmacists may adapt and renew existing prescriptions, and initiate certain medications (I.e., smoking cessation, minor ailments, and Paxlovid™ (nirmatrelvir/ritonavir). Pharmacists may also administer vaccines, administer substances by injection or inhalation (for the purposes of education or demonstration), and perform point-of-care tests. These professional activities and services should be provided only when it is in the best interest of the patient, in accordance with the regulations, Code of Ethics, policies and guidelines of the Ontario College of Pharmacists, and the Standards of Practice developed by the National Association of Pharmacy Regulatory Authorities (NAPRA) (Ontario College of Pharmacists, 2022).

The pharmacist is responsible for identifying, resolving, and preventing actual and potential drug therapy problems, such as untreated indications or medication use without indications, ineffective drug therapies, dosages too high or too low, adverse drug reactions, drug interactions, and patient adherence. They collaborate with patients and the healthcare team to identify and resolve actual and potential drug therapy problems through the provision of comprehensive medication management.

Within an IHP team, pharmacists will make drug therapy recommendations in many areas, including dosage and administration, drug selection using current treatment guidelines, approved and off-label indications, adverse drug reactions, drug interactions, drug monitoring and duplications. Pharmacists support other members of the team on medication management and develop care plans for patients, in order to optimize drug therapy outcomes.

Impact/Outcomes of Intervention – Pharmacist

- The Pharmacist has a direct impact on patient care – including patient counselling, recommending safe and effective therapy, and monitoring medication therapy. This in turn, often identifies, resolves, and prevents medication errors.
- By being a member of a multidisciplinary team, pharmacists can significantly improve appropriate prescribing and expand patient care. They can provide services themselves, liaise with other prescribers and specialists, and bridge the gap between institutions, primary care providers, and community pharmacies to ensure safe and effective transitions of care.
- The Pharmacist plays a critical role in building relationships and collaborating with pharmacists across the health care continuum (e.g., community, hospital) to provide coordinated patient care, including medication reconciliation and monitoring of new medications (Ontario College of Pharmacists, 2022).

I. Roles and Responsibilities

Primary care team Pharmacists work with individuals and groups to:

- Conduct patient counselling and education regarding medical conditions, drug therapies, and medical devices.
- Provide drug therapy-related in-service education to the team.
- Advocate for the most appropriate drug therapy for patients based on current evidence and incorporating patients' preferences through shared decision-making.
- Assist patients in staying healthy and manage acute chronic conditions by identifying and resolving actual and potential drug therapy problems; developing patient-specific care plans based on patient information and assessment, chart review, and assessment of clinical response through monitoring and follow up.
- Provide comprehensive medication reviews using a systematic approach to assess:
    - Previously diagnosed health conditions that may benefit from additional drug therapy.
    - The continued therapeutic appropriateness and optimization of each medication a patient is taking.
    - The effectiveness of drugs used for their stated indication/patient goal.
    - The safety of all drugs taken together, with the aim to minimize adverse effects and complexity wherever possible.
    - Patients with complex co-morbidities and older adults who are more likely to suffer the consequences of drug therapy problems and polypharmacy.
    - Identification of patient adherence barriers (e.g., financial, cognitive, dexterity, literacy, agreement, and consent of drug therapy).
- Build a safe and inclusive environment that recognizes each patient's history, honours diversity, as well as different values.

II. Collaboration with Team Members

Primary care team Pharmacists work collaboratively to:

- Coordinate with physicians and other health professionals within and across the team to coordinate patient care.
- Provide medication reconciliation as patients transition through the healthcare system.
- Assist case managers and social workers with systems navigation, including completing financial assistance applications, advising on formulary or lower cost alternatives, and obtaining compassionate supply medications for patients in need.
- Provide drug information support to physicians, other IHP team members as required, and patients.
- Implement care plans for-patients with complex co-morbidities and optimize health outcomes by ensuring safe and effective use of medications.
- Liaise with community, hospital, and other institutional-based pharmacists for coordinated care plan implementation and support through transitions of care.
- Treat patients/caregivers/family members, health care team members, and other stakeholders with dignity and respect at all times.

III. Additional Resources

- Ontario College of Pharmacists: Legal Authority for Scope of Practice
- Ontario College of Pharmacists: Interprofessional Collaboration
- NAPRA: Standards of Practice

Overview and Legal Scope of Practice – Physician Assistant

A Physician Assistant (PA) is an advanced practice clinician who is educated in the medical school model. PA education programs are accredited to meet national standards of education, including a defined set of competencies that are outlined in the profession's National Competency Profile (EPA-PA). Graduates of accredited Canadian PA programs are eligible to write the Physician Assistant Certification Council of Canada (PACCC) PA Certification entry to practice exam. Individuals who successfully pass the exam are awarded the Canadian Certified Physician Assistant (CCPA) designation.

In order to maintain their certification, PAs are mandated to continue professional development and track their ongoing education opportunities through the Royal College. PAs are committed to lifelong learning and their scope of practice may become broader or more specialized depending on their practice setting.

PAs practice medicine under the supervision of a licensed physician with negotiated autonomy, often within a multidisciplinary health team. A PA's scope of practice is physician-delegated, and the medical services assigned to the PA must be within the scope of the supervising physician. Each PA and their supervising physician(s) will establish a practice agreement that documents the types of clinical work the PA will perform in that practice setting, how that work will be assigned and the type of supervision they will receive when performing that work.

PAs possess a defined body of knowledge and a professional philosophy for effective patient care. They apply these clinical competencies to collect data and interpret information, develop, and investigate differential diagnoses, make appropriate clinical decisions, and carry out required diagnostic, procedural and therapeutic interventions. These highly skilled health professionals can work in any clinical setting to extend a doctor's reach, complement existing services, and help improve patient access to care.

Currently, all activities conducted by PAs are carried out as delegated acts under the authority of the Regulated Health Professions Act 1991 (RHPA). On June 3rd, 2021, *Bill 283, Advancing Oversight and Planning in Ontario's Health System Act* was passed and received Royal Assent, amending the Medicine Act, 1991 to allow PAs to be regulated under the CPSO. Regulation of PAs in Ontario is forthcoming in 2023.

Impact/Outcomes of Intervention – Physician Assistant

- Help to decrease wait times and improve patient access in primary care.
- Provide assessment and management of most common primary care needs, allowing physicians to have more time to utilize their expertise in managing more complex patient needs.
- Create greater capacity for supporting patients with chronic disease.

I. Roles and Responsibilities

Primary care team Physician Assistants work with individuals and groups to:

- Conduct patient interviews, histories, and physical examinations.
- Formulate and communicate a diagnosis – identifying a disease, disorder, or condition, taking differential diagnosis into consideration.

- Formulate and communicate a management plan which may include providing a prescription under medical directive.
- Prescribe medications, nutraceuticals, and medical devices.
- Perform diagnostic and therapeutic procedures (e.g., lumber punctures, reducing casting and splinting factures, injections, biopsies, etc.).
- Ordering and interpreting investigations including blood work and imaging.
- Order consultations with specialists and community care providers.
- Educate and council patient/caregivers on preventative health and chronic disease management.
- Complete preventative care screening such as PAP, ordering colon cancer screening, mammography, etc.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values.

II. Collaboration with Team Members

Primary care team Physician Assistants work collaboratively to:

- Perform focused and comprehensive patient assessments (histories and physicals) and initiate orders as an extension of the physician. This may require consultation with the nursing staff and other members of the team.
- Consult and collaborate with physicians and other members of the team, across the care continuum.
- Work with the IHP team and support staff in optimizing a patient's access to assessment and implementation of care for both acute and chronic needs.
- Lead and/or collaborate with IHP team members in supporting patients/groups for various Chronic Diseases such as: COPD/Respiratory Disease, Heart Disease, Diabetes, Dementia/Cognitive Impairment, Frailty.
- Treat patients/caregiver/family, health care team members, and other stakeholders with dignity and respect at all times (Canadian Association of Physician Assistants, 2009).

III. Additional Resources

- Health Force Ontario: Guides and Toolkits
- CAPA PA Compensation Report
- Bill 283 Advancing Oversight and Planning in Ontario's Health System Act, 2021

Overview and Legal Scope of Work – Physiotherapist

The College of Physiotherapists of Ontario is responsible for governing the self-regulating profession of physiotherapy in Ontario in accordance with the Regulated Health Professions Act, 1991 (RHPA), the *Health Professions Procedural Code and the Physiotherapy Act, 1991*. The profession has seven controlled acts assigned through legislation including communicating a diagnosis, spinal manipulation, procedures below the dermis (including acupuncture/dry needling), tracheal suctioning, procedures for the assessment and treatment of pelvic disorders, ordering forms of energy and administrating a substance by inhalation.

Physiotherapists are focused on improving the patient's function and mobility, preventing and rehabilitating disorders, injury, and disability, managing and improving acute and chronic conditions, and optimizing quality of life through interventions, prescribed exercise, and patient education. PTs analyze the impact of injury, disease, disorders, or lifestyle on movement and function, and develop and implement care plans to improve gross motor skills, while reducing pain, promoting function, and independence. Physiotherapy involves a detailed assessment, diagnosis, and planned intervention or approach to improve functional performance. They treat the underlying physical dysfunction with the goal of maintaining or improving function and overall health and wellness. Physiotherapists work with people in one-on-one or group-based settings and provide care in-person and/or virtually depending on clinical appropriateness and patient preferences.

Physiotherapists in primary care provide care to people with a wide variety of conditions (e.g., acute to chronic; musculoskeletal, neurological, cardiorespiratory, pelvic dysfunction and incontinence, cancer related sequalae, multi-system health conditions, pre-operative preparation, and post-survey recovery). The care physiotherapists provide includes assessment, triage, and treatment or management (Vader, et al., 2022).

Impact/Outcomes of Intervention – Physiotherapist

- The integration of physiotherapist into primary care teams and making them available at the first point of contact is likely to result in improved functional outcomes and reduced cost of care and leads to positive experiences by better supporting patients and other primary care team members (Demont, Bourmaud, Kechichian, & Desmeules, 2021).
- Since the expansion of physiotherapy in primary health care teams in Ontario in 2015, patients have experienced improved pain management, improved function and mobility, and high satisfaction with care (Vader, et al., 2022). Patients with musculoskeletal conditions managed by a physiotherapist show significant improvements in quality of life, less pain and less sick time and disability (Morris, Moule, Pearson, D, & Walsh, 2021).
- Evidence demonstrates that adults (>44) with chronic illness use fewer health services, including planned hospital days after receiving care provided by a rehabilitation professional (PT) in primary care (Vader, et al., 2022).
- Increasing pressures in the health system, including limited staffing, long wait times at hospitals, and staff burnout, has highlighted the importance of timely access to care in the community. Some primary care health teams have adopted new measures to help promote efficient and timely care such as direct access to physiotherapy services (i.e., no physician referral required), reserving time for same day/urgent appointments, and establishing medical directives for physiotherapists to order musculoskeletal diagnostic imaging. The combined effect of these initiatives allows physiotherapists to operate at their full scope of practice while freeing up capacity for primary care physicians and nurse practitioners to see other patients (Vader, et al., 2022).
- Access to physiotherapy for pain management has played an important role in improving pain management. Patients who accessed physiotherapy in primary care have reported less pain, taking less pain medication and/or other substances (including alcohol, cannabis, or street drugs) to manage pain (Morris, Moule, Pearson, D, & Walsh, 2021).

I. Roles and Responsibilities

Primary care team physiotherapists work with individuals and groups to:

- Order diagnostic imaging including ultrasound imaging, radiographs, and bone scans.
- Develop a care plan that empowers a patient to participate and monitor their own recovery, health, and overall wellness.
- Maximize patient function by working with patients to improve gross motor skills. Focuses treatment plan on mobility, including ambulation and balance.
- Educate patient/family/caregiver about exercise, activity, and movement for the prevention of disease and dysfunction and maintain overall health and quality of life. Provides pain management modalities.
- Develop a realistic intervention plans to address patients' needs and goals and works collaboratively with the patient/caregiver/family. Applies intervention procedures safely and effectively.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values and ways of knowing.

II. Collaboration with Team Members

Primary care team Physiotherapists collaboratively to:

- Prescribe and apply braces, prostheses, and advanced mobility aids in consultation with an orthotist and/or prosthetist.
- Work with Occupational Therapist to develop strength, balance, and teaching skills needed for activities of daily living/self-care activities.
- Provide guidance to the team, emphasizing prevention and wellness as alternative cost-effective alternatives to surgery and ongoing prescription drugs.
- Responds to treatment requests prior to and after medical intervention(s) and surgery, and other disease management where movement system disorders occur.
- Participate in concurrent treatment of the same condition when approaches are complementary, of benefit to the patient, and an appropriate use of human/financial resources. Discontinues concurrent services where there is inefficient use of resources, and/or the risks outweigh the benefits to patients.
- Consult with/refer to the appropriate team member when aspects of clients' goals are best addressed by another provider.
- Promote continuity in service by collaborating and facilitating patients' transition from one health-care sector or provider to another.
- Actively engage all members of the care team by listening and valuing their contributions, respecting what other health professionals provide for the comprehensive and coordinated care of patients and sharing responsibility for the care of patients as a collaborative team member.
- Treat patients/caregiver/family, health care team members, and other stakeholders with dignity and respect at all times.

III. Additional Resources

- Ontario Physiotherapy Association: Physiotherapists in Primary Health Care

- Integrating Physiotherapists into Primary Health Care Organizations: The Physiotherapists' Perspective

Overview and Legal Scope of Practice– Psychologist/Mental Health and Addictions Specialist

Mental Health Counsellors provide counselling to patients, caregivers and their families through individual/group sessions and group workshops, to help optimized their psycho-social functioning and mental health. Mental health counsellors have a range of specialties including counselling for depression, anxiety, and trauma.

IHPs may have one or more Mental Health and Addictions specialist within a team. The below provide some context to some of the roles included within an IHP.

Impact/Outcomes of Intervention – Mental Health and Addictions Specialist

- Reduce time needed for emergency room assessment of risks of harm to self or other (certification assessment).
- Reduce decision time in determining need for admission to inpatient mental health services.
- Remove bottlenecks where patients wait for mental health and behavioural health assessment and diagnosis (triage).
- Facilitate quicker access to needed service because more people can be triaged more quickly.
- Ensure availability of care at critical points in illness affecting health outcomes that serve to reduce the negative impact on productivity, inflation of third-party insurance costs, and negative impact on the economy.
- Reduce burden of care on family physicians in the provision of community-based health services
- Facilitate the delivery of seamless interprofessional health care within public health care institutions.
- Enhance greater equity in access to mental health care for the community served (College of Psychologists of Ontario, 2021) (McGinty & Daumit, 2020).

Psychologist

Psychologists provide science-based behavioural interventions (e.g., psychotherapy, cognitive-behavioural therapy, behavioural therapy, interpersonal therapy, family, or couples therapy as well as cognitive rehabilitation) for the treatment and rehabilitation of mental and physical health conditions, behaviour change, health promotion and illness prevention. Clinical Psychologists also conduct assessments of academic, cognitive, and intellectual functions, memory, personality, and for diagnosis of mental disorders such as ADHD, learning and developmental disabilities, brain injury, personality disorders and more. They routinely support persons with disabilities and complete various disability-related applications (Ontario Disability Support Program (ODSP), Disability Tax Credit (DTC), Canada Pension Plan-Disability (CPP-D), Developmental Service Ontario (DSO). Psychologists have research and data analytic backgrounds and may also engage in clinical research, program evaluation, and quality

improvement initiatives. Clinical Psychologists provide comprehensive care by collaborating with other disciplines to meet the behavioral, physical, and psychosocial needs for patient well-being (McGinty & Daumit, 2020).

The College of Psychologists of Ontario is the governing body for Psychologists and Psychological Associates in Ontario. To qualify for professional registration to practise psychology requires successful completion of clinical graduate education (e.g., PhD in Clinical Psychology), training in professional psychology, supervised professional experience, and examinations. Only members of the College of Psychologists of Ontario may use the title 'Psychologist' or 'Psychological Associate'; use the terms 'psychology' or 'psychological' in any description of services offered or provided or hold themselves out to be a psychologist or Psychological Associate (College of Psychologists of Ontario, 2021); (Safieh, et al., 2022).

I. Roles and Responsibilities

Depending on their training and background, Psychologists working as part of interprofessional team will work with individuals and groups to:

- Provide individual and group treatment of mental and physical health conditions (e.g., pain, sleep disorders, PTSD, emotion regulation, anxiety, depression, brain injury, autism spectrum disorder).
- Assess and intervene with patients and families struggling with behavior problems, difficult relationships and other struggles that interfere with overall health and functioning.
- Diagnose, treat, and consult around neurodevelopmental, acquired, and neurodegenerative disorders.
- Support eligibility requirements and navigation support for programs and services supporting persons with disabilities (Developmental Service Ontario, Autism and neurodevelopmental Disorders, Special Education Requirements, brain injury supports, ODSP, CPP-D, DTC).
- Provide the emotional support patients need to be successful in managing their health.
- Use screening tools and primary prevention programs to detect mental health conditions early.
- Present educational sessions for both patients and staff on topics such as disease management.
- Design and use evaluation methods, such as continuous quality improvement measures and patient satisfaction surveys.
- Help address challenges in patient adherence to treatment plans.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values.

Overview and Legal Scope of Practice – Respiratory Therapist

The College of Respiratory Therapists of Ontario (CRTO) is authorized by the *Regulated Health Professionals Act* to regulate the practice of Respiratory Therapy and govern the Members of the CRTO in the public interest. Registered Therapists (RTs) graduate from a three-or four-year education program. Graduates of accredited respiratory therapy programs are eligible to write the CBRC National Certification Examination and successful candidates earn the Registered Respiratory Therapist (RRT) credential (College of Respiratory Therapists of Ontario, n.d.).

RTs are health professionals responsible for the diagnostic evaluation, rehabilitation, education, management, and care of patients at all stages of life who require respiratory support for various reasons (e.g., severe illness, long-term respiratory care for disease or disability).

The RRT works as part of an interdisciplinary team to provide direct client, team, and community support, respiratory care, and education programs, and performs necessary clinical functions, to facilitate the delivery of comprehensive primary health care to achieve best health outcomes for clients with or at risk of developing respiratory disease. (College of Respiratory Therapists of Ontario, n.d.); (Dubois, Sorensen, Buell, Telenko, & & West, 2021).

Impact/Outcomes of Intervention – Respiratory Therapist

- RRTs make unique contributions to integrated patient care across the health care system by providing specialized cardiorespiratory expertise in the context of evidence-based care plans from emergency visits to admission and discharge including all transitions in care to the community and primary care settings.
- Reduce "hallway medicine" in acute care facilities.
- Empower patients and families by promoting knowledge and understanding of the disease process, medical therapy, and self help. (Dubois, Sorensen, Buell, Telenko, & & West, 2021); (Respiratory Therapy Society of Ontario, 2020); (The Canadian Society of Respiratory Therapists).

I. Roles and Responsibilities

- Leads and facilitates the development of relevant population health cardiorespiratory-related programs and services needed in the community through local partnerships with a range of community stakeholders.
- Provides health education and disease prevention services both on an individual and group basis in response to the specific needs of patients, their caregivers, interprofessional team members, and/or community groups.
- Assess and perform medical tests including:
    - Obtaining and analyzing physiological specimens, interpreting physiological data, performing tests and studies of the cardiopulmonary system, performing neurophysiological studies, Performing sleep disorder studies.
- Assesses and addresses potential barriers to respiratory management, including the social determinants of health.
- Performs home oxygen assessment, including walk test, and blood gas procurement, and completes the Application for Funding Home Oxygen and other relevant documentation in accordance with provincial policies and legislation.
- Leads the development of an evidence-based coordinated care plan for a specified group of clients relative to needs of the client and their caregivers, including those with complex needs and multi-morbid conditions, to maximize health outcomes, and facilitate navigation of the healthcare system.
- Participate in research initiatives that help improved healthcare and quality of life.

II. Collaboration with Team Members

- Collaborates with clients/families, primary care providers, and other team members in the circle of care to develop, implement and revise customized self-management plans (Action Plans).
- Leads and/or participates in relevant quality improvement and/or research initiatives within the primary care setting, as well as external partnerships and collaborations, assessing process and outcome measures that impact the providers' and patients' experiences and outcomes.
- Collaborates with community support organizations to meet the unique health and social needs of patients, e.g., home health needs, such as ventilatory support, oxygen therapy, pharmacotherapy, home safety audit, social needs, such as transportation, food security, and social prescribing (Canadian Society of Respiratory Therapists., 2019).

III. Additional Resources

- College of Respiratory Therapists of Ontario: Optimizing Respiratory Therapy Services. A continuum of Care from Hospital to Home.
- Primary Care Registered Respiratory Therapist Job Description.

Overview and Legal Scope of Practice – Registered Social Worker

The practice of social work in Ontario is regulated under the *Social Work and Social Service Work Act, 1998* and through the bylaws of the Ontario College of Social Workers and Social Service Workers (OCSWSSW). To use the title "social worker" in Ontario, one must be registered with the OCSWSSW as a Registered Social Worker (RSW). RSWs adhere to the Code of Ethics and Standards of Practice established by the OCSWSSW. RSWs have at least one or more university degrees in social work; Bachelor of Social Work, Masters in Social Work, or a Doctorate in Social Work (Ontario Association of Social Workers, 2022). RSWs are authorized under the *Regulated Health Professions Act, 1991* to perform the controlled act of psychotherapy and to use the title "Psychotherapist" (Ontario College of Social Workers and Social Service Workers, 2019).

RSWs play an integral role within the IHP team. Their approach focuses on the person in their environment, using a psychosocial lens to assess for and address factors that contribute to improving overall health. RSWs support patients across the lifespan and are adept at assisting them in restoring, maintaining, and enhancing their functioning by mobilizing strengths, building coping capacities and linking them to needed resources. They provide counselling and psychotherapy for a range of mental health concerns including anxiety, depression, grief, trauma, substance use and chronic disease management.

RSWs facilitate community referrals, act as consultants to other members of the IHP team and support patients with accessing social programs to address items like financial stess and housing (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown, 2018). In addition, many RSWs have unique training to work with diverse populations including children and youth, surviviors of violence, those living in poverty, the elderly, and newcomers to Canada.

RSWs play a critical role in supporting individuals to build their health confidence and become activated in their care by providing psychoeducation related to well-being, understanding the factors outside the immediate health system that influence individual and community health and advocating for patients

within these systems. RSWs represent the third largest group of interprofessional health professionals in FHTs, following physicians and nurses (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown, 2018).

Impact/Outcomes of Interventions – Registered Social Worker

- Improved patient health outcomes through addressing behavioural elements of overall health and wellbeing including adherence to prescribed treatments (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown, 2018).
- Through addressing the psychosocial needs of patients, compliance to treatment and overall well-being can significantly improve, thus appropriately redirecting care in the community and reducing follow-up visits and hospital admissions (Blount, et al., 2007; Wodarski, 2014).
    - Studies suggest that most primary care visits are partially driven by behavioural health problems. As member of IHPs, RSWs assist patients/caregivers/families in finding community services, which can influence uptake and adherence (Fraser, et al., 2018).
- Improved patient health outcomes through addressing resource needs and functional quality of life that may mitigate barriers caused by negative social determinants of health.
- RSW involvement in primary care can lead to patients reporting fewer somatic symptoms (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown, 2018).
- Support upstream care through non-direct patient care interventions such as community development and outreach, some health promotion activities, education and training, supervision and taking on various formal and informal leadership roles.
- The social work role can facilitate the process of identifying gaps in the patient-care process as well as working in collaboration with physicians to improve patient outcomes (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown, 2018).

I. Roles and Responsibilities:

Primary care team Social Workers work with individuals and groups to:

- Assess psychosocial and ethnocultural needs of the patient and their support systems including screening for risk, determining need/eligibility for services, identifying strengths/coping capacities, and assessing informal networks of support. This information is shared with the broader team to support with integrated planning and care.
- Provide counselling and psychosocial interventions that facilitate patient and family adaptation and well-being, enhancing coping capacities through early assessment and addressing mental health concerns. This may include individual or group services to support complex biomedical and psychosocial situations (Tadic, Ashcroft, Brown, & Dahrouge, 2020). Therapeutic modalities and methods may vary across practice settings and practitioner expertise but commonly include cognitive behavioural therapy, solution-focused approaches, motivational interviewing, and crisis intervention (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown, 2018).
- Provide resource counselling and advocate for required services while navigating complex social systems. This includes identifying and addressing barriers caused by social/economic factors; identifying options and supports, facilitating referrals and applications to government/community agencies; coordinating referrals, care coordination, and case management (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown, 2018).

- Develop and deliver education to individuals, families, and communities. This may include facilitating an understanding of health care status, supporting patient self-management skills, mobilizing existing resources, health promotion, community development and outreach (Tadic, Ashcroft, Brown, & Dahrouge, 2020).
- Represent the patient's point of view, working collaboratively with the care team to develop treatment and discharge plans, based on patient strengths, needs, and goals.
- Work with patients and families to understand goals of care and offer crisis intervention and mediating conflict that relates to the goals of care.
- Perform community health needs assessments and participate in community health planning.
- Link patients, caregivers, and families to community physicians, services, home health care, long-term care facilities, and medical equipment providers.
- Contribute to research initiatives and collect data, as required.
- Build a safe and inclusive environment that recognizes each patient's history, honors diversity, as well as different values and ways of knowing.
- RSWs may also be involved in supervision and leadership roles within primary care teams.

II. Collaboration with Team Members

Primary care team Social Workers work collaboratively to:

- Provide psychosocial assessment and follow-up to improve patient adherence and self-management, and to reduce the potential for conflicts, complaints and/or litigation.
- Provide leadership and support in program planning, development, and evaluation to ensure patient-centred goals are met.
- Offer expert knowledge and liaise with community and government resources; often participating on community committees and boards.
- Conduct and support psychosocial research initiatives addressing psychosocial dimensions of illness and outcomes of interventions.
- Develop and participate in teaching activities with the interdisciplinary team, presenting expertise at workshops and in services.
- Communicate patient/family/caregiver wishes regarding necessary services. Collaborate with team regarding patient's needs.
- Communicate status of services obtained by patient and implications for discharge.
- Work with Case Manager in coordinating all written information that will go home with the patient/family/caregiver.
- Ensure that all patients/caregiver/family, health care team members, and other stakeholders are treated with dignity and respect at all times.

III. Additional Resources

- Ontario Association of Social Workers: How a Social Worker Can Help You
- Ontario College of Social Workers and Social Service Workers: Code of Ethics and Standard of Practice Handbook (2018)
- Canadian Association of Social Workers: Social Work Scope of Practice

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