Interprofessional Collaborative Care: Integrating Non-Physician Clinicians in a Changing Canadian Health Care System

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CFMS
Canadian Federation of Medical Students

FEMC
Fédération des étudiants et des étudiantes en médecine du Canada

Background

Inconsistencies in physician distribution coupled with increased demands on the health care system have contributed to the opening of a policy window for the expansion of non-physician clinicians (NPCs) and interprofessional models of health care delivery. We recognize that the face of health care is changing, and the role of physicians in the medical community is shifting from autonomous practitioners to key members of an interprofessional team. As future physicians, we will have to be more responsive to patient demands for alternative health care provision and consequently, we must expand our training and skills to ensure we can contribute effectively in this environment. Additionally, we have a unique interest in the health care system of the future and therefore, we continue to advocate for long-term solutions in place of short-term fixes when facing health human resource (HHR) challenges. The aim of this policy paper is to highlight the CFMS/FEMC's principles and values related to interprofessionalism and NPCs, to explore challenges integrating NPCs into the health care system, and provide possible policy solutions to address these problems.

Non-Physician Clinicians (NPCs)

In 1998, Dr. Richard Cooper defined the cohort of non-physician clinicians as 10 disciplines within three categories: traditional services (nurse practitioners, nurse midwives and physician assistants), alternative disciplines (naturopaths, chiropractors and acupuncturists), and specialty disciplines (optometrists, podiatrists, certified nurse anesthetists and clinical nurse specialists) (1). In the current Canadian context though, we question the comprehensiveness of this list (i.e. absence of pharmacists or dietitians in the definition) and the utility of categorizing disciplines in this way. We believe a better distinction may be to separate regulated professions from unregulated professions, especially when considering policy changes and possible legislation. For the purposes of this paper, we will focus on regulated NPCs in Canada (i.e. advanced practice nurses, pharmacists, dietitians, midwives and physician assistants[1]). Among these disciplines, advanced practice nurses (including nurse practitioners and clinical nurse specialists) have shown the largest growth in numbers over the last few years and have been studied the most in their role as a NPC, therefore warranting special consideration in this paper (2). With this being said, there is a consistent trend across the country in increasing NPC legislation and regulation, such as pharmacist scope of practice changes in Alberta and Ontario with other provinces having proposals in the works (3) or proposals for formal regulation of physician assistants in Ontario (4). We believe this suggests that NPC roles will continue to increase in the health care system of the future and ensuring appropriate integration of NPCs is critical to maintaining efficiency and cost-effectiveness.[2]

Physician maldistribution and NPC substitution

There was – and to some extent still is – a perception that increasing the number of NPCs, such as nurse practitioners (NPs) would alleviate issues with geographic physician maldistribution and increase the health professional supply to meet demand (i.e. the creation of NP-led clinics in rural

[1] At the time of writing, physician assistants were regulated in Manitoba and undergoing consideration for regulation in Ontario

[2] It is beyond the scope of this paper to examine the effectiveness of NPCs in improving outcomes, however there is an extensive decision support synthesis on advanced practice nursing in Canada available, which demonstrates that NP care is safe and has the ability to influence patient and system indicators (5). There are no such syntheses we identified for other NPCs at this time.

Ontario regions) 18% of the Canadian population lives in rural and remote areas, yet only 8.5% of physicians are located in these regions (6). This geographic discrepancy is likely a significant contributor to the reduced access to care in rural areas. An analysis of the 2003 Canadian Community Health Survey demonstrated that rural patients were less likely to visit family physicians and specialists, have access to a regular medical doctor, or receive influenza vaccinations (7). As all Canadians are aware, the difficulties with access to healthcare are not limited to rural areas alone. Significant wait times for emergency consults, surgeries, or specialist appointments frustrate patients across the nation.

There is substantial evidence to suggest that NPs can improve access to services and reduce wait times (5,8). However, as we have seen with physicians, an indiscriminate increase in the number of NPCs will not solve the supply and demand issues. Only 9.5% of nurse practitioners in Canada work in rural areas (2) and current trends show that NPs are increasingly leaving community practices for higher-paying, more stable hospital positions (9). One reason for this may be that NP remuneration traditionally has come from separate funding mechanisms that are perennially in doubt of being renewed (i.e. salaried NPs in fee-for-service physician practices in British Columbia or NP-led clinics in rural Ontario) (8,10).

The CFMS believes that while NPC services are valuable to Canadian patients, they should not be seen as a solution to a physician shortages or distribution issues. The understanding of a team is that each member brings individual skills and tools to the table – this presupposes that one member cannot replace another, regardless of the external pressures imposed on the system. As medical students and future physicians, we believe that the physician plays a unique and indispensible role in the care of patients and that alternative solutions should be sought to address the HHR distribution challenges.

Scopes of practice and role definitions

Expanding the scope of practice of NCP (i.e., nurse practitioners and pharmacists) has been one potential solution proposed to address the complex issue of physician misdistribution within Canada. However, policies aimed at replacing physicians with NPCs not only fail to address the HHR supply and demand issues, they also contribute to confusion with health care delivery, specifically with respect to overlapping roles and undefined scopes of practice. Lack of role clarity, conflicting expectations and vague job descriptions – all of which can result from undefined scopes of practice – have been cited as the most significant barriers to the integration of NPCs (11,12,13).

NPC educational standards and scopes of practice are regulated and implemented at a provincial and territorial level. This results in differences in educational standards and scopes of practice for NCP across Canada. This may lead to challenges in role definition and integration within the Canadian health care system broadly. This issue is particularly important in the context of the 2009 amendments to the Agreement on Internal Trade, which allows unrestricted mobility of NPCs across Canada (8). Other factors which may contribute to challenges integrating NPCs in Canadian health care systems include: Decision-makers' lack of knowledge on the "value-added" of NPCs; and Absence of formal negotiating arrangements between NPCs and governments. There is very limited research on the effectiveness of physician assistants and other NPCs, making it difficult for decision-makers to choose what roles these health professionals should be licensed to undertake (4). Lastly, unlike medical associations in Canada, NPCs do not have formal contract negotiations (usually on two to four year cycles) whereby they can directly influence policy development and

implementation (8). In fact, during physician-government negotiations there are often decisions made that affect other health care professionals.

Principles

1. **CFMS believes that patient-centred care should be at the forefront of all discussions on health care delivery models, including NPC integration**

2. **CFMS recognizes the value of interprofessional delivery of health care and supports the continued focus on this model**

3. **CFMS believes NPCs should be integrated members of a health care team and should not be relied on as a substitute for physician care**

4. **CFMS believes dialogue on policy solutions to NPC integration should include stakeholders from a variety of health professional disciplines, NPCs, as well as medical residents and students**

5. **CFMS supports the continued development of interprofessional education in Canadian medical curricula**

Recommendations

1. **Appoint and fund an interprofessional strategic-planning task force for national health human resource planning**

A federal government-appointed task force could bring together policymakers, administrators, practitioners, trainees and citizens to discuss and negotiate solutions to key HHR issues such as the integration of NPCs. DiCenso *et al.* highlight a pan-Canadian HHR strategy as a key factor that could influence the integration of NPs across the country in a variety of settings (11). A national taskforce was also a consensus recommendation coming from stakeholder dialogue convened to discuss the integration of NPs in primary and acute care settings (8). It is also worth noting that the Canadian government has recently employed a similar strategy to raise mental health awareness, secure funding and implement programming through a multi-stakeholder taskforce – the Mental Health Commission of Canada (15). Preliminary responses to the commission have suggested it has been a successful strategy.

The task force could be responsible for producing a national interprofessional HHR strategy that clarifies the value-added of each clinician and their role in the health care system. Including a variety of stakeholders, with direct communication to governmental officials, could provide an avenue for physicians and NPCs to engage in policy development together and ensure a consistent approach across Canada. From the policymaker perspective, they will be able to engage this task force to elicit feedback on proposed policies as well as accelerate the implementation of new policies and programs to ensure these changes are meeting the unique needs of each region. This task force

could also be responsible for securing and maintaining a stable funding pool for NPCs, possibly engaging in Canada Health Transfer negotiations.[3]

2. Standardize education standards and licensing requirements for non-physician clinical disciplines across Canada

Once consistency in the scope of NPCs is consistent across Canada, it is important to standardize education requirements and licensing requirements across the country, especially since amendments to Canada's Agreement on Internal Trade now make it illegal to refuse license to any health professional previously licensed in another province or territory[4] (16). A pan-Canadian approach provides two important benefits: 1) It improves the mobility of regulated health care professionals across the country and ensures that the education they received will prepare them to practice in a new P/T; and 2) It provides a mechanism for clarifying the role of NPCs and building on lessons learnt from each province to identify key principles that should guide NPC integration across the country.

This process should be developed through consultation with provincial professional associations and regulatory bodies and must be unique for each NPC, depending on their current roles, numbers and supporting evidence. Physician assistant education programs are nationally accredited through the Canadian Medical Association (CMA) conjoint accreditation process and there is a national certification examination as well as a national competency profile to guide regulation (14). These national standards and connection with the CMA have created a top-down approach to help provinces create their own practice standards and preliminarily, utilize physician assistants appropriately. As another strategy to nationally standardize education and regulations, provincial regulatory bodies for dietitians have created a national alliance where they can discuss issues and progress the regulation of dieticians uniformly across the country (17). In contrast, NP and pharmacist educational and licensing have been traditionally developed at the provincial level and have led to significant differences in role implementation across provinces. Though there are documents exploring a NP competency framework and guidance from the Canadian Nurses Association (CNA) and Canadian Nurse Practitioners Initiative (CNPI), implementation and uptake by the provinces has been slow and disjointed (18,19). This may signal the immediate need for a pan-Canadian approach to advanced practice nursing regulation and accreditation (11).

3. Launch an information/education campaign to increase public and decision-maker awareness of NPCs

[3] As of April 2014, the Canadian government implemented a set formula for the delivery of the transfer monies to the provinces without ties

[4] P/Ts can apply for specific exemptions to this agreement (i.e. Quebec does not recognize nursing licenses from other provinces)

It is critical to the integration of NPCs that policymakers, administrators, health professionals and patients are all aware of the effectiveness of various NPCs and their role in health care. Much of the general public is still uncertain about the care they will receive from NPs, although evidence demonstrates that patient safety is equal to that of a primary care physician (5,8). Furthermore, policymakers and administrators may also be unaware of how best to utilize NPCs to meet the increasing demands for health care in Canada. While there are no systematic reviews that evaluate the effectiveness of mass media in increasing awareness of stakeholders to a policy issue, there are systematic reviews that demonstrate the effectiveness of education campaigns in increasing utilization of specific health services (20). In addition, a dialogue on engaging civil society in supporting evidence use in policymaking recommended the use of new media (i.e. social media) to influence the health policy decision-making (21).

4. **Encourage progressive medical education that reflects the importance of interprofessional teams**

As future physicians, we embrace appropriately trained and accountable NPCs as essential members of the interdisciplinary team, who are able to contribute to and augment health care for patients. Knowledge and understanding of the skills that each of these providers hold, if instilled in the medical curricula, could improve their participation and collaboration. Cohesive team work will result in a renewed system that is responsive to the changing demands of patients and the communities in which they live. The interest in multidisciplinary health care delivery and its role in the current health care paradigm is reflected in the inclusion of interprofessional education in medical school curricula today (22). The CFMS will continue to advocate for progressive medical education at the university level as well.

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