Ontario Chiropractic Association

June 17, 2020

Valerie Quioc Lim
Committee Clerk
Standing Committee of the Legislative Assembly
99 Wellesley Street West
Room 1405, Whitney Block
Queen's Park
Toronto, ON M7A 1A2

Dear Committee Clerk and Members of the Standing Committee of the Legislative Assembly:

Re: Recommendations for Amendments to proposed new regulation under Bill 175, The *Connecting People to Home and Community Care Act 2020*

The Ontario Chiropractic Association (OCA) appreciates the opportunity to provide feedback on the new legislation and regulations proposed under Bill 175, the *Connecting People to Home and Community Care Act, 2020.* The OCA supports the proposal to add four new community care services that are currently being provided by Local Health Integration Networks (LHINs) but are not captured under the current framework. We were especially pleased to see the addition of pain and symptom management and diabetes education.

The OCA has a proven track record of identifying opportunities to reduce costs to the health care system, increase patient access, and make more effective use of limited physician resources (family physicians and specialists). Initiatives involving chiropractors, such as Rapid Access Clinics (RACs) for Low-Back Pain and the Primary Care Low Back Pain programs are helping to address the challenges facing Ontario's health care system, including supporting the government's efforts to end hallway healthcare, reducing regulatory burden and red tape, and addressing the opioid crisis.

Ontario chiropractors are similarly well placed to assist the Ministry of Health in achieving its goals in the areas of pain and symptom management and diabetes education. They are recognized by their peers across the health care ecosystem as pain and symptom management experts. The OCA, in partnership with the Centre for Effective Practice (CEP), has developed an evidence-based clinical tool to help reduce opioid use in patients with chronic back, shoulder or arm pain. The tool has recently been approved for use by the Center for Addiction and Mental Health (CAMH) as part of their opioid de-implementation strategy. This will result in reduced wait times and better outcomes, by helping chiropractors, other musculoskeletal (MSK) experts and physicians work together to ensure that patients get the right care in the right place from the right expert.

We have two recommended amendments for consideration in Bill 175 that are intended to *eliminate barriers for inclusion of relevant MSK professionals such as chiropractors in the patient's circle of care,* thus providing better access and quality of MSK care services.

201 - 70 University Ave.
Toronto, ON
M5J 2M4

Tel: 416-860-0070
Toll-free: 1-877-327-2273
Fax: 416-860-0857

chiropractic.on.ca

First, it appears that the Bill, as drafted, intends to transfer the definition of professional services that can be delivered in home care and community services settings from legislation to regulation. The OCA welcomes this change and the flexibility that it brings. However, we are concerned that the definition of professional services will be taken directly from historical legislation, namely the repealed *Home Care and Community Services Act, 1994.*

The eligibility requirements of some health care positions immediately prevent patients from accessing qualified health professionals—in certain instances the most qualified health professionals. In some cases, eligibility for clinical roles and funding are limited to a specific profession, as opposed to being determined based on patient need and practitioner competency. The consequence of these policy inconsistencies creates inequities and gaps in patient care.
If eligibility to deliver care, such as is offered in community physiotherapy clinics, was determined based on competency rather than professional title, patients would be given new options and access would be enhanced.

It is the view of the OCA that the definition of professional services should be based on patient need and practitioner competency, the types of services and professional competencies offered, instead of being profession specific. This would be consistent with the *Connecting Care Act, 2019,* which currently refers to the type of services provided, and not to the title of the provider (see Recommendation #2, below).

RECOMMENDATION #1:

The definition of professional service authorized to provide home care and community services outlined in regulations under the *Connecting People to Home and Community Care Act*, *2020* should be based on the care the patient needs and practitioner competency required to provide that care, instead of using a profession-specific definition to define the service. The requirement should be profession agnostic and include a reference to “musculoskeletal care” and/or “musculoskeletal care experts” to determine which professions are authorized to provide the care.

Alternatively, if the definition remains profession specific, the list of professions contained in the repealed *Home Care and Community Services Act, 1994* should be amended and updated to include chiropractors.

Second, we note that amendments are being made to several pieces of legislation to modernize definitions in accordance with the *Connecting Care Act, 2019.* As part of this process, and for consistency with the above recommendation, we suggest that the list of services should include reference to musculoskeletal care or musculoskeletal care services.

Currently, section 1 (2) of the *Connecting Care Act, 2019* defines a health service provider to include:

12. “A person or entity that provides primary care nursing services, maternal care or inter-professional primary care programs and services.”

14. "A person or entity that provides *physiotherapy services* in a clinic setting that is not otherwise a health service provider."

RECOMMENDATION #2:
Amend section 1 (2) of the *Connecting Care Act* by adding an additional definition of "health service provider" as:

"A person or entity that provides primary care nursing services, maternity care, musculoskeletal care or interprofessional primary care programs and services."

Or alternatively,

"A person or entity that provides musculoskeletal care services in a clinic setting that is not otherwise a health service provider."

By addressing these two concerns - allowing the eligibility to deliver health care based on patient need and on health care provider competency, rather than professional title - the Ministry of Health can strengthen consistency and standardization of services while being responsive to local differences. Moreover, the inclusion of MSK services will improve patient satisfaction and health outcomes.

Given the early successes of new funded models of MSK care that are currently in place by the Ministry, including the Rapid Access Clinics (RACs) for Low-Back Pain, which employ clinicians based on their professional competencies and expertise, we recommend that Bill 175 build on these success by adopting the recommendations outlined above. With greater emphasis on integrated MSK care models across the health care continuum of primary, hospital, community, home, and long-term care, chiropractors can help enhance patient access and outcomes and improve quality and care coordination.

The OCA appreciates the opportunity to comment on this significant piece of legislation and policy reform.

Sincerely,

C Brereton.

Caroline Brereton, RN, MBA
Chief Executive Officer

c. Tina Yuan, Senior Policy Analyst, Minister's Office
Ben Levitt, Manager, Stakeholder Relations, Minister's Office

BACKGROUND

The Ontario Chiropractic Association (OCA) represents over 3,700 chiropractors, many of whom are small business owners. Chiropractors are highly trained health care professionals who are expertly equipped to provide musculoskeletal assessment, diagnosis, and treatment.

Chiropractors:

- Complete 4 years of accredited chiropractic education following three-four years of undergraduate education.
- Are eligible to work in primary care interprofessional teams such as Family Health Teams, Nurse Practitioner Led Clinics, and Community Health Centres.
- Have been hired by surgeons (over 50) to work in the Rapid Access Centres (Interdisciplinary Spine Assessment and Education Clinic) and chiropractors are involved in leading roles in six of the province's Primary Care Low Back Pain programs.
- Play an important role in helping injured workers get back to work through the WSIB program and the care provided to auto accident victims.

Low back pain (LBP) and other musculoskeletal (MSK) conditions:

- The prevalence and impact of low back pain (LBP) and other musculoskeletal (MSK) conditions is well-documented:
    - Three of the top four leading causes of disability in North America are musculoskeletal in nature: LBP ranks second; the category of "other" MSK conditions ranks third; neck pain ranks fourth.[i]
    - In 2013-14, there were approximately 38 million adult primary care physician visits, of which nearly six million were related to MSK disorders - that amounts to 15% of all primary care physician visits in Ontario.[ii] Over 400,000 Ontarians with MSK conditions visit an emergency department annually.[iii]
- It is very common for older adults[iii] or patients with other chronic conditions[iv] [v] to suffer from MSK conditions which contribute to pain and limit activity. Consequently, population aging is strongly associated with increased demand for, and utilization of musculoskeletal care.[vi]
- For low-back and neck pain diagnoses that are comparable across medical and chiropractic treatment settings, research has found that patients treated by chiropractors have significantly lower use of resource intensive technologies and treatments, including x-rays, MRIs, radiographs, surgery, and inpatient care.[vii] [viii]
- Forty-nine percent of seniors over the age of 70 suffer from osteoarthritis[ix] and disability risk among older adults increases with more areas of the body experiencing MSK pain.[x]
- Diabetes can lead to a variety of MSK challenges, and MSK pain is reported 1.7–2.1 times as frequently among people with type 2 diabetes. Individuals with type 2 diabetes are more likely to suffer from shoulder or neck pain (52% vs. 31%), low back pain (60% vs. 30%), and arm, hand, knee and/or hip pain (71% vs. 34%).[xi] [xii]
- Both diabetes and MSK pain are associated with higher instances of falls in older adults for reasons including lower limb dysfunction, cardiovascular disease, polypharmacy, and impaired balance. Research has shown that targeted exercise

programs and comprehensive geriatric assessment and interventions play an important role in preventing falls, reducing disability and increasing life expectancy.[xiii] [xiv]

Musculoskeletal conditions are not only a leading health concern for ageing Ontarians, but very costly to our health care system. There are opportunities to significantly improve patient care and increase cost-efficiency. To improve MSK care for these patients, community-based MSK care—including patient education, therapeutic exercise, manual therapy and coaching for self-management strategies—can be economical and lead to improved health outcomes.
Regulated health professionals such as chiropractors—who are expertly equipped to provide MSK assessment, diagnosis, and treatment—offer a compelling option for managing MSK care in elderly populations. Indeed, chiropractic education consists of four years of training focused exclusively on the MSK system.

As is being demonstrated by the two projects in the government's *Low Back Pain Strategy*, chiropractors and advanced practice physiotherapists are in an excellent position to lead community-based MSK care, which serves to greatly enhance system efficiency. However, throughout the system and across clinical programs and environments, patient access to MSK care is limited by programmatic and clinical inconsistencies.

---

[i] Vos, T., Flaxman, A., Naghavi, M., Lozano, R., Michaud, C., Ezzati, M.… Murray, C. (2012). Years lived with disability (ylds) for 1160 sequelae of 289 diseases and injuries 1990—2010: A systematic analysis for the global burden of disease study 2010. The Lancet, 380(9859), 2163 – 2196

[ii] Personal communication with Michael Paterson, Institute for Clinical Evaluative Sciences, November 2015.

[III] MacKay, C., Canizares, M., Davis, A. and Badley, E. (2010). Health care utilization for musculoskeletal disorders. Arthritis Care & Research, 62(2), 161-169

[iv]Borgundvaag, B., McLeod, S., Khuu, W., Varner, C., Tadrous, M., & Gomes, T. (2018). Opioid prescribing and adverse events in opioid-naive patients treated by emergency physicians versus family physicians: a population-based cohort study. CMAJ open, 6(1), E110.

[v]Deyo, R. A., Von Korff, M., & Duhrkoop, D. (2015). Opioids for low back pain. BMJ, 350, g6380

[iii] Leveille, S., Jones, R., Kiely, D., Hausdorff, J., Shmerling, R., Guralnik, J. ... Bean, J. (2009) Chronic musculoskeletal pain and the occurrence of falls in an older population. JAMA, 302(20), 2214-2221.

[iv] Roberts, M., Mapel, D., Hartry, A., Worley, A., & Thomson, H. (2013). Chronic pain and pain medication use in chronic obstructive pulmonary disease. Annals of the American Thoracic Society, 10(4), 290-298.

[v] Haj Ghanbari, B., Holsti, L., Road, J., & Reid, D. (2012) Pain in people with chronic obstructive pulmonary disease (COPD). Respiratory Medicine, 106(7), 998-1005.

[vi] Rampersaud YR, Power JD, Perruccio AV, Paterson M, Veillette C, Badley EM, Mahomed NN. Ambulatory and Hospital Care for Osteoarthritis and Other Musculoskeletal Disorders in Ontario, Canada. Osteoarthritis and Cartilage 2017; 25(S1):S33.

[vii] Legorreta, Antonio P, R. Douglas Metz, Craig F. Nelson, Saurabh Ray, Helen Oster Chernicoff, Nicholas A. DiNubile. Comparative Analysis of Individuals With and Without Chiropractic Coverage Patient Characteristics, Utilization, and Costs. Arch Intern Med. 2004;164(18):1985–1992.

[viii] Nelson, Craig F, R. Douglas Metz, Thomas LaBrot, Effects of a Managed Chiropractic Benefit on the Use of Specific Diagnostic and Therapeutic Procedures in the Treatment of Low Back and Neck Pain, In Journal of Manipulative and Physiological Therapeutics, Volume 28, Issue 8, 2005, Pages 564-569.

[ix] Bombardier, C., Hawker, G., & Mosher, D. (2011). The impact of arthritis in Canada: Today and over the next 30 years. Arthritis Alliance of Canada. Retrievable from: www.arthritisalliance.ca/images/PDF/eng/Initiatives/20111022_2200_impact_of_arthritis.pdf

[x] Buchman, A., Shah, R., Leurgans, S., Boyle, P., Wilson, R. and Bennett, D. (2010) Musculoskeletal pain and incident disability in community-dwelling older adults. Arthritis Care and Research, 62(9), 1287-1293. Retrievable from: www.ncbi.nlm.nih.gov/pubmed/20853470

[xi] Molsted, S., Tribler, J., Snorgaard, O. (2012). Musculoskeletal pain in patients with type 2 diabetes. Diabetes Research and Clinical Practice, 96, 135-*140. Retrievable from: www.ncbi.nlm.nih.gov/pubmed/22244365*

[xii] Arthritis Foundation. (2015). What do diabetes and arthritis have in common? Plenty. Retrievable from: http://www.arthritistoday.org/about-arthritis/arthritis-and-your-health/diabetes/diabetes-arthritis.php

[xiii] Sinclair, A., Conroy, S., & Bayer, A. (2008). Impact of diabetes on physical function in older people. Diabetes Care, 31(2), 233-235. Retrievable from: care.diabetesjournals.org/content/31/2/233.full.pdf

[xiv] Badley, E. (2014). Inactivity, disability, and death are all interlinked. British Medical Journal Editorials. Retrievable from: www.bmj.com/content/348/bmj.g2804