

Citizen Brief

Modernizing the Oversight of the Health Workforce in Ontario

11, 18 and 25 August 2017



EVIDENCE >> INSIGHT >> ACTION

The McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

About citizen panels

A citizen panel is an innovative way to seek public input on high-priority issues. Each panel brings together 12-14 citizens from all walks of life. Panel members share their ideas and experiences on an issue, and learn from research evidence and from the view of others. The discussions of a citizen panel can reveal new understandings about an issue and spark insights about how it should be addressed.

About this brief

This brief was produced by the McMaster Health Forum to serve as the basis for discussions by the citizen panel on modernizing the oversight of the health workforce in Ontario. The brief includes information on this topic, including what is known about:

- the underlying problem;
- three elements of a potentially comprehensive approach to addressing the problem; and
- potential barriers and facilitators to implement these approach elements.

This brief does not contain recommendations, which would have required the authors to make judgments based on their personal values and preferences.

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Key Messages

What's the problem?

The current approach to the oversight of the health workforce in Ontario may not be the best possible for many reasons, including:

- the oversight mechanisms in place have not kept pace with the changing health system;
- the current oversight framework is focused on regulating individual categories of health workers, rather than groupings of them, and captures many but not all health workers;
- the oversight framework has a different focus than the framework used in the education and training of health workers;
- the financing and funding of oversight bodies are not explicitly designed to improve public-protection efforts;
- it is difficult to find information on how the health workforce and its oversight bodies are performing; and
- patients are not consistently engaged in meaningful ways in oversight activities.

What do we know about elements of a potentially comprehensive approach for addressing the problem?

- **Element 1:** Use a risk-based approach to health workforce oversight
 - Little research evidence is available, but what that evidence suggests is that a risk-based approach may contribute to a more efficient allocation of resources, and can improve the decision-making process, however, collectively agreeing on one definition of risk can be a challenge.
- **Element 2:** Use competencies as the focus of oversight
 - The available research evidence indicates that training health workers using a competency-based approach improved their communication and collaboration. Furthermore, using competencies as a focus of recruitment was found to improve the identification of strong candidates.
- **Element 3:** Employ a performance measurement and management system for the health workforce and its oversight bodies
 - The available research evidence suggests that successful mandatory reporting schemes for health workers require a high bar for reporting impairment, a fair and timely response, and the availability of preventive assistance, and that an inclusive approach to developing performance measures improved the commitment of stakeholders to implementing and reporting on the measures.

What implementation considerations need to be kept in mind?

The upcoming provincial election in 2018 combined with the increasingly constrained resources in the health system may help to spark changes to the oversight of the health workforce. However, a number of barriers to change exist, including getting key stakeholders to agree on a common path forward.

Questions for the citizen panel

>> We want to hear your views about a problem, three elements of a potentially comprehensive approach to addressing it, and how to address barriers to moving forward

This brief was prepared to stimulate discussion during the citizen panel. The views and experiences of citizens can make significant contributions to finding the best ways to meet their needs. More specifically, the panel will provide an opportunity to explore the questions outlined in Box 1. We encourage you to glance at them now, and to return to them after you have read the brief. Although we will be looking for common ground during our discussion about these and other questions, the goal of the panel is not to reach consensus, but to gather a range of perspectives on this topic. To help you better understand some of the terminology when considering these questions and reading through the brief, we provide a glossary of key terms in Box 2.

Box 1: Questions for citizens

Questions related to the problem

- Do you have any worries about the oversight of the health workforce in the health system in Ontario?
 - Do you think there are more risks associated with some health workers compared to others?
 - Do you think differently about these risks when they are faced in some settings (for example, private clinics) or sectors (for example, primary care) compared to others, or for some conditions (for example, cancer), types of treatment (for example, prescription drugs) or populations (for example, Indigenous peoples, recent immigrants and refugees, and older adults) compared to others?
- Based on your interactions with health workers in Ontario, are there any services that some health workers should be providing but are not (or services that some health workers should not be providing)? If yes, what types of services and for which categories of health workers?
- What challenges have you encountered if you have tried to:
 - access information about an individual health worker or how the health workforce, and its oversight bodies (currently called regulatory colleges), are overseen;
 - register a complaint about a health worker; or
 - engage in a disciplinary process for a complaint?

General questions related to the elements of a potentially comprehensive approach to address the problem (with more specific questions included later for each element)

- To protect patients from harm, are there any categories of health workers that require more attention from oversight bodies than others?
- Are there any categories of health workers that require less attention because they pose less of a risk to public safety?
- What types of services would you like to see specific categories of health workers provide?
 - What types of skills do you think are important for health workers to have to perform these services?
- Who should be accountable for ensuring appropriate oversight of the health workforce to protect public safety?
- What types of information about health workforce oversight should be collected and publicly reported in Ontario?
- Do you think that citizens should be actively involved in the oversight of health workers in Ontario? Why or why not?
 - If yes, what do you think would be the most meaningful way to engage citizens in this oversight?

Question related to implementation considerations

- What do you see as the main challenges to improving the oversight of the health workforce?

Box 2: Glossary

Regulated health professional: Any member of one of the 29 professions that are governed under the *Regulated Health Professions Act, 1991* (RHPA) (1)

Regulatory college: “Regulatory colleges are the designated bodies responsible for ensuring that regulated health professionals provide health services in a safe, professional and ethical manner.” (1)

Controlled acts: A set of 14 acts that the provincial government has determined are only to be performed by select categories of health professionals as designated in the *Regulated Health Professions Act*.(2)

Scope of practice: A general description of what a profession does and the methods that it uses. The scope of practice statement is not protected in legislation in the sense that it does not prevent other health workers from performing the same activities.

Risk-of-harm: The chance (or probability) of any serious physical, emotional or psychological harm that may result from the treatment, advice or omission of a healthcare provider.

Risk-based approach: Prioritizing the allocation of resources to prevent the most risk

Competency: A broader way of conceptualizing the skills or set of skills that health professionals need to be able to perform their roles, and include: 1) ‘hard’ skills (for example, technical medical knowledge); 2) ‘soft’ skills (e.g. listening and communication); and 3) mental and physical ability to perform both the hard and soft skills in practice.



Ontario's health system has evolved substantially in the past two decades, however, the way in which the health workforce is overseen has not kept pace with these changes

The context: Why is the oversight of the health workforce important?

As with the health systems of other jurisdictions across the country and around the world, Ontario's health-system is changing in response to the evolving needs of its patients, including the aging population and increased rates of chronic conditions, as well as to emerging technologies. Some of the ways the health system in Ontario has changed in the past two and a half decades include:

- the development of Local Health Integration Networks (that plan, integrate and fund care in Ontario's 14 regions) and Community Care Access Centres (that play a key role in providing home care and that have recently been integrated into Local Health Integration Networks);
- the creation of Health Quality Ontario, the agency responsible for the measurement and reporting on the quality of care being delivered; and
- introducing interprofessional team-based care such as in Family Health Teams and shifting the roles and responsibilities of select providers through the development of Nurse Practitioner led-Clinics and of pharmacists playing a large role in community settings.(3)

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These and many other reforms have greatly changed the services that health workers provide, the way in which they practise, and the settings in which they practice. However, very few changes have been made to the oversight of the health workforce to reflect these changes. Yet this oversight has important implications for patients, including:

- what they can expect from which health workers in the health system, like who can call themselves a nurse or physician and who can perform ‘controlled acts’ like diagnosing an illness, prescribing a drug or glasses, or injecting a drug or performing a surgical procedure (which are called ‘controlled acts’); and
- what they can expect in terms of the supports provided to health workers to reduce the risk of harm to patients, and in terms of the recourse available to themselves as patients or caregivers if harm happens.

There are four reasons that many health-system leaders may believe that the oversight of the health workforce in Ontario can be improved to better protect the public:

- 1) the primary legislation that frames the oversight of the health workforce now, including which and how categories of health workers are regulated in Ontario – the *Regulated Health Professions Act, 1991* (RHPA) – has not been adapted to reflect changing public expectations for the services health workers should be providing, the need to deliver high-quality care, and the introduction of new delivery models (for example, through team-based care models);
- 2) a variety of complementary legislation to the *Regulated Health Professions Act* has been passed that complicates the regulatory framework, making it difficult for organizations, health workers and patients to understand;
- 3) the recent debate over a legislative bill in Ontario has highlighted differences in how key concepts, such as ‘self-regulation,’ are defined and understood by health workers; and
- 4) many new models of health workforce oversight have been developed and tested in other countries (for example, Australia and the U.K.) that may be more appropriate to our current health system and allow for greater flexibility as the system continues to evolve.

To further this reflection on the current approach, citizen perspectives about how to modernize the oversight of the health workforce in Ontario are needed to inform the efforts of those who are able to champion changes in these oversight mechanisms.

Box 3: The health system in Ontario

Key features of the health system and the health workers in it

- Healthcare provided in hospitals and by physicians is fully paid for as part of Ontario's publicly funded health system; healthcare provided in other settings or by other health workers may or may not be covered by the government.
- Ontarians receive services from many categories of health workers, however, only 29 categories of these workers are regulated by the *Regulated Health Professions Act, 1991*. (1)
- These 29 categories range from medicine, nursing and dentistry, which citizens may be very familiar with, to homeopathy, naturopathy and traditional Chinese medicine, with which some Ontarians may have relatively little experience.
- The Act, along with accompanying profession-specific legislation, regulates what controlled acts any given category of health worker is permitted to perform; these controlled acts are services that the government has deemed to be of a sufficient level of risk, that when not properly executed could result in harm to a patient. (1)

How health workers are overseen in Ontario

- The 29 categories of health workers regulated under the Act are members of 26 regulatory colleges, with a unique college for almost every profession.
- These regulatory colleges are responsible for protecting the public's safety when they receive services.
- The work of the regulatory colleges includes setting standards of practice, maintaining a list of all of the health practitioners in their category, listening and following up with patient complaints, disciplining any health workers who act unprofessionally, and coordinating and administering continuous professional development. (1)

Features for specific populations (those who receive the majority of their services from health workers who aren't regulated under the Act)

- Despite there being many more categories of health workers than professional colleges, other mechanisms, including additional legislation, are in place to ensure that the public safety is protected when receiving services from other categories of health workers, such as paramedics and personal support workers.



Existing approaches to health workforce oversight could be improved to account for the evolving role of health workers in the system

The problem: Why is modernizing the oversight of the health workforce timely?

Many factors contribute to the need for modernizing the oversight of the health workforce. Some of the factors that emerged in discussions with health-system stakeholders, which are revisited in detail below, include:

- the oversight mechanisms in place have not kept pace with the changing health system;
- the oversight framework is focused on regulating individual categories of health workers, rather than groupings of them, and captures many but not all health workers;
- the oversight framework has a different focus than the framework used in the education and training of health workers;
- the financing and funding of oversight bodies (which are called regulatory colleges) are not explicitly designed to improve public-protection efforts;
- it is difficult to find information on how the health workforce and its oversight bodies are performing; and
- patients are not consistently engaged in a meaningful way in oversight activities.

The oversight mechanisms in place have not kept pace with the changing health system

As previously mentioned, the legislative framework for the oversight of health professionals in Ontario, which is largely based on the *Regulated Health Professions Act, 1991*, has not been adapted to keep pace with many changes in the health system, which include: shifting population health needs; ongoing changes in how care is delivered; evolving roles of health workers delivering care; changing public expectations; and the growing need to deliver high-quality patient-centred care.

Table 1: Challenges to the current oversight framework

Challenge	Example/description of the challenge
Population health needs	<ul style="list-style-type: none"> • Ontario has an increasingly older population, with the proportion of individuals over the age of 75 having grown significantly in the past decade. (4) • An increasing number of Ontarians are living with at least one, and sometimes multiple chronic illnesses. (4) • These trends, alongside other changes in the populations' needs, have necessitated a shift away from hospital-based care and towards community-based services, changing the settings within which health workers are operating as well as the risks involved in providing care.
How care is being delivered	<ul style="list-style-type: none"> • The current oversight framework does not address the shift towards interprofessional team-based care (for example, Family Health Teams) which has changed the relationship among health workers, the way in which they practise together, and their reporting responsibilities.
Evolving roles of health workers delivering care	<ul style="list-style-type: none"> • The number and importance of certain categories of health workers has changed significantly in the past two decades. • While amendments to the <i>Regulated Health Professions Acts, 1991</i> and accompanying legislation has in some cases acknowledged these changes (for example, in adding categories of health workers under the legislation), many other groups lack oversight mechanisms that are equal to their increasing importance in the system (for example, personal support workers).
Changing public expectations	<ul style="list-style-type: none"> • The legislative framework for overseeing health workers does not acknowledge the flexibility needed for health workers to meet patient expectations, including their call for increased use of technology in the delivery of care, increased choice in the settings where they receive care, the delivery of new services, or enhanced levels of personalization.
Delivering high-quality patient-centred care	<ul style="list-style-type: none"> • The current framework is focused on protecting the public from harm, but does not adequately consider the role that oversight could play in improving the quality of care being delivered.

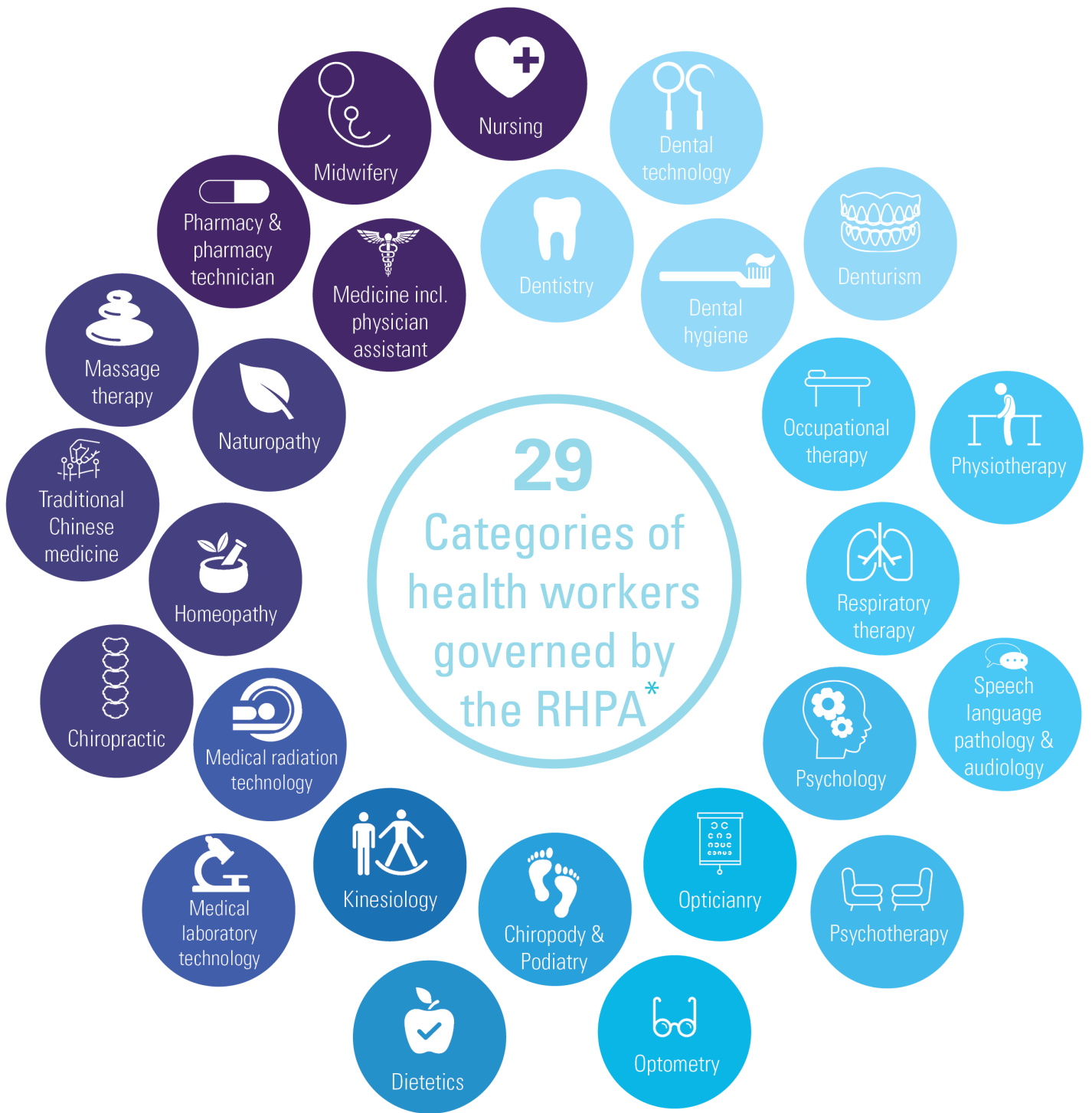
The oversight framework is focused on regulating individual categories of health workers, rather than groupings of them, and captures many but not all health workers

The oversight framework for the oversight of health workers (that is, *Regulated Health Professions Act, 1991*) has focused on regulating each of 29 categories of health workers individually (or in two cases, in pairs) by creating 26 oversight bodies, which are commonly called ‘regulatory colleges.’

This is a different approach than that taken by many other jurisdictions (for example, Australia, New Zealand and the United Kingdom), which have chosen to group categories of health workers together under a smaller number of oversight bodies. These groupings of categories of health workers are determined either by the types of services they provide (for example, oral health services or physical therapies) or through a risk-based approach (for example, where categories of health workers who are performing services that carry more risks than others may be grouped together). Grouping categories of health workers has allowed oversight bodies to allocate their resources to where they’re most needed. Instead, in Ontario, each of the regulatory colleges is responsible for funding the same set of activities (for example, registration of health workers and complaints management), leading to questions about whether this could be done more efficiently through fewer bodies.

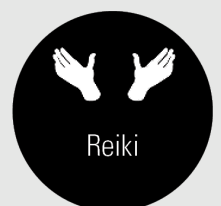
In addition, despite having 26 oversight bodies, many categories of health workers have been left out of the *Regulated Health Professions Act, 1991*, including paramedics, assistants of many types (for example, physician assistants), and the personal support workers who provide a great deal of care in the home and in long-term care homes, to name a few. While other legislation specific to these unregulated health workers is often in place to protect the public, these regulations have often failed to keep pace with the changing health system and to adapt to the shifting importance of many of these health workers’ roles (for example, personal support workers increasingly providing care in the home). Collecting data about the number of health workers in these other categories, and standardizing their education and training, have also proven challenging.

Categories of health workers in Ontario



* Regulated Health Professions Act, 1991

Examples of health workers governed by other means



The oversight framework has a different focus than the framework used in the education and training of health workers

The approach to health workforce oversight in Ontario has focused on controlled acts (that is, a set of 14 acts that are only to be performed by select categories of health workers as designated by the *Regulated Health Professions Act, 1991*) and professional scopes of practice (that is, who can perform what services in the health system). While oversight bodies have accommodated the recent shift towards the competencies that are now the focus of health workers' educational programs, entry-to-practice exams and continuing professional development requirements, they continue to have to work within an oversight framework that stops a health worker from engaging in a controlled act or embracing a broader scope of practice even if the health worker can demonstrate that they have developed an appropriate level of competency.

These distinct areas of focus create a gap between how health workers think about what they have been trained to do and what they are actually allowed to do. This gap may mean that access to high-quality care is being unnecessarily limited.

The financing and funding of oversight bodies are not explicitly designed to improve public-protection efforts

Ontario's oversight bodies (the regulatory colleges) are currently funded by their members (that is, by individual health workers) with the annual dues set by the oversight bodies themselves. This approach creates differences among oversight bodies in the resources they can draw on to fulfill their mandate, with higher-earning categories of health workers or categories with more paid members having access to larger amounts of resources (or paying lower membership fees).

Differences also exist between categories of health workers regulated under the dominant oversight framework (that is, *Regulated Health Professions Act, 1991*) and other frameworks, with the latter often relying on voluntary payments to associations that contribute towards public-protection efforts (rather than mandatory membership fees to oversight bodies).

These differing levels of resources beg the question of whether the financing and funding of oversight could be designed in ways that more efficiently protects the public.

It is difficult to find information on how the health workforce and its oversight bodies are performing

While regulatory colleges are required to publish some information on their websites, such as the number of registrants and their basic regulatory history, this information is not always as useful to the public as information about whether health workers are adhering to their professional and ethical codes, and the volume of activities being undertaken to address non-adherence. Though some regulatory colleges openly provide this type of information, it is not consistently available or easily accessible to the public. For example, patients may need to read through the lengthy annual reports to find this information.

To further complicate matters, there are many organizations that work in parallel to the oversight bodies, which makes it difficult to determine who is responsible for collecting and publicly reporting on the performance of health workers, and for taking action to reduce the risk of harm and to address harm when it happens. For example, if some avoidable harm occurred during a procedure in hospital:

- 1) a patient or caregiver could complain to as many regulatory colleges as there were categories of health workers involved in the care, to the hospital where the care was provided, to the hospital's funder for that care in some circumstances (for example, Cancer Care Ontario for cancer care), to the hospital's regulator and funder (the Ministry or Minister of Health and Long-Term Care), to the Patient Ombudsmen (who can address complaints about hospitals, among select other settings), to the local coroner, or to the court system; and
- 2) that harm would be recorded separately and reported alongside many other similar types of harm by Health Quality Ontario, Cancer Care Ontario (if it involved Cancer Care), and possibly other organizations.

There is also very little information available that supports patients in judging the extent to which oversight bodies are meeting their mandate of protecting the public interest. In other words, no one is 'watching the watchers,' as happens in countries like the U.K.(5)

Patients are not consistently engaged in meaningful ways in oversight activities

While all 26 oversight bodies are required to have a set proportion of their governance board be members of the public, these bodies differ substantially in the extent to which they have made efforts to meaningfully involve patients and fully understand their perspectives, including efforts such as convening panels or advisory committees and producing resources specifically for patients.

Without such efforts, particularly those that help to explain the available oversight mechanisms to patients, many individuals are unaware of the oversight bodies and how to access them, even for routine activities such as registering complaints.



A comprehensive approach to health workforce oversight will require the consideration of a number of elements

Elements of an approach to address the problem

>> To promote discussion about the pros and cons of potential solutions, we have selected three elements of a potentially comprehensive approach to modernizing the oversight of the health workforce

Many approaches could be selected as a starting point for discussion. We have selected the following three elements of an approach for which we are seeking public input:

- 1) use a risk-based approach to health workforce oversight;
- 2) use competencies as the focus of oversight; and
- 3) employ a performance measurement and management system for the health workforce and its oversight bodies.

These elements should likely not be considered separately. Instead, each should be considered as contributing to a potentially comprehensive approach to addressing the problem. New elements could also emerge during the discussions.

Element 1 – Use a risk-based approach to health workforce oversight

Overview

This element focuses on taking a risk-based approach to health workforce oversight, which means considering three key factors – 1) the potential harms that could be caused by the individual health worker; 2) the likelihood of these harms occurring; and 3) the severity of the consequences should the identified harms occur – and using these factors to guide the type of oversight put in place and how resources get distributed.⁽⁵⁾ This could mean pursuing any of the following sub-elements:

- develop a common definition of risk and determine how it should be applied to health workers; and
- use a risk-based approach to:
 - choose categories of health workers for oversight;
 - categorize health workers under a smaller number of regulatory bodies; and
 - allocate resources to regulatory functions (for example, health-worker registration and complaints management).

Evidence to consider

A number of benefits may stem from risk-based approaches to oversight, including:

- improving the efficiency of oversight by targeting resources to where the greatest risk exists;
- providing decision-makers with defensible reasons for how resources are allocated and for shifts in these allocations; and
- prompting reflection about potential risks that had not been considered and about ways of managing them efficiently.⁽⁵⁾

However, it is also possible that some categories of health workers that aren't covered by the *Regulated Health Professions Act, 1991*, may have concerns about becoming incorporated in this approach, especially if they are bundled in with other categories of health workers under the same oversight body. In particular, their concerns may relate to:

- the financial burden of oversight (for example, paying membership fees);
- restrictions in their scopes of practice;
- registration standards (for example, having to ensure that education and training are standardized across health workers); and

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- ‘medicalization’ of their practice (in the case of categories of health workers such as, say, naturopaths, who operate under a different paradigm than physicians and many other categories of health workers).(6)

Questions to consider

- Should a standard process for assessing the risks posed by health workers be established in Ontario? Why or why not?
- If a routine process for assessing harm was established in Ontario, who would need to be involved in its development?
 - o Ministry of Health and Long-Term Care?
 - o Existing oversight bodies?
 - o Patients?
- Should the same approach for assessing risk of harm be applied to all categories of health workers, or should some be treated differently? Why or why not?
- Are there important differences that need to be considered when assessing the risk of harm to patients that may be posed by health workers who are:
 - o practising in different settings or sectors (for example, those working in home and community care compared to those working in specialty care);
 - o treating different conditions (for example, those focused on treating multiple chronic conditions compared to cancer);
 - o using different treatments (for example, those who are prescribing drugs compared to those performing surgical procedures); or
 - o focusing on different prioritized populations (for example, those providing care to Indigenous peoples)? Why or why not?

Element 2 – Use competencies as the focus of oversight

Overview

The focus of this element is on using competencies rather than scopes of practice and controlled acts to guide health workforce oversight. Competencies differ from skills in that they can be considered to be a broader approach that includes whether or not the individual health worker has the technical skills, but also the soft skills (for example, listening and communication) needed, and the ability to perform all this in practice.

Adopting a competency-based focus to oversight may allow for health workers to more easily adapt the services they are allowed to provide, after demonstrating that they have the necessary competencies to perform them. This approach, however, also comes with a number of considerations, including the possible benefits (for example, improving access to services) and harms (for example, more health workers offering services with a particular competency, but possibly not the full spectrum of competencies required to react to the full range of things that could go wrong during the service).

This shift in focus could mean pursuing any of the following:

- develop a process to get input from patients, health workers and existing oversight bodies about how to define the core competencies for each category of health worker;
- determine an approach to update the core competencies as the health system evolves;
- expand the use of competencies across all categories of health workers in:
 - educational programs preparing candidates for entry to the profession,
 - training programs preparing candidates for entry into a specialty,
 - training programs involved in preparing health workers for changes to what they are allowed to do,
 - continuing professional development programs that help ensure that health workers can safely do what they are allowed to do under the existing oversight mechanisms;and

use competencies – instead of scopes of practice and controlled acts – as the focus of health workforce oversight, including to evaluate the seriousness of complaints and other investigations.

Evidence to consider

We identified one review of studies and one individual study which found that there was often a lack of consensus among those involved in choosing core competencies for health workers.(7; 8) However the individual study also found that having an environment that was supportive of this change and high-quality administrative support might make this process easier.(7)

Two other individual studies that were identified looked at the use of competencies in practice, one in training health workers and the other focused on using competencies to recruit health workers.(9; 10) The first found no overall improvement in learning between the status quo and a competency-based approach, but did find significant improvements in health workers' abilities to communicate and collaborate.(9) The other study found that using competencies as the focus of interviews when recruiting health workers led to identifying stronger candidates.(10)

Questions to consider

- What are some key attributes or qualities that you think all health workers need to be able to provide high-quality care?
- What services would you like to see certain categories of health workers provide that they currently are not (or not provide if they are providing them now)?
- Who do you think should be involved in determining what the core competencies of a category of health workers are (for example, government, existing regulatory colleges, health workers and/or patients)?
- How often do you think a health workers' core competencies should be revised?



Element 3 – Employ a performance measurement and management system for the health workforce and its oversight bodies

Overview

The focus of this element is on employing a performance-measurement and -management for the health workforce and for its oversight bodies. In other words, this element is about regularly collecting and publishing information on whether the health workforce and its oversight bodies are meeting their objectives (for example, delivering high-quality care and protecting the public from harm) and ensuring they are kept accountable for the outcomes achieved. The rationale for this element is that this transparency should make it easier for patients and policymakers to judge when changes to oversight are necessary. Implementing a performance measurement and management system may include:

- introducing an independent body to develop and implement a performance-measurement and -management system;
- develop metrics that allow patients and policymakers to judge and, when needed, demand improvements to the performance of the health workforce or its oversight bodies; and
- establishing clear processes for regular audits of the performance of oversight bodies, which would include:
 - clarifying who should be accountable for what parts of the performance -management system,
 - separating out complaints management from professional registration,
 - allocating the licensing and registration of all categories of health workers to one large independent body, and
 - giving an explicit role in the oversight mechanism to key health-system organizations such as Local Health Integration Networks or hospitals.

Evidence to consider

In reviewing the evidence, we found one review of studies and two individual studies that looked at aspects of performance measurement and management for the health workforce.(11-13) The review of studies focused on the characteristics of complaints registered with oversight bodies,(13) while the two individual studies focused on mandatory reporting (that is, notifying the oversight body that patients have been at risk of harm or harmed in the provision of care, or that health workers are impaired while practising).(11; 12)

The review found that those who are less likely to register a formal complaint with an oversight body are significantly older, live with a disability, or reside in either an economically deprived area or a rural community.(13) The review suggested that these categories of individuals should be kept in mind when making changes to a complaints processes.(13)

One of the two individual studies examined the characteristics of reports from a mandatory reporting scheme in Australia and found that most reporting of health worker misconduct came to the attention of regulators through a third party – usually a patient or a colleague – and was often from those within the same category of health worker. The study found that even with wide-reaching mandatory reporting there are still four types of barriers to notifying oversight bodies:

- 1) uncertainty or unfamiliarity with legal requirements;
- 2) fear of retaliation;
- 3) lack of confidence that appropriate action will be taken; and
- 4) loyalty to colleagues.(11)

The second of the two individual studies found that successful mandatory reporting schemes relied on three key factors:

- 1) a high bar for the reporting of impairment;
- 2) appropriate response to reports that are considered fair and timely; and
- 3) availability of preventive assistance (for example, quickly identifying concerns of health workers and providing appropriate treatment).(12)

With regards to performance measurement and management of oversight bodies, we found only one individual study that focused on improving the transparency of oversight bodies. The one study focused on the need to develop metrics through an inclusive approach that involved all stakeholders.(14) The study found that this facilitated the development of a framework and a set of measures that meets the needs of stakeholders and maximized their commitment to implementing and reporting on the measures.(14)

Questions to consider

- Who should be accountable for ensuring appropriate oversight for health workers to protect public safety?
 - Ministry of Health and Long-Term Care?
 - Existing oversight bodies?
 - A newly created arm's-length agency?
- What kinds of information would help you judge whether health workers and health workforce oversight bodies are doing enough to ensure the safety of patients?
- How would you prefer to access public information related to health workforce oversight?
- Do you think that patients should be actively involved in the oversight of health workers in Ontario? Why or why not?
 - If so, what do you think would be the most meaningful way to engage patients in the oversight of health workers?



Implementation considerations

It is important to consider what barriers could be faced if the proposed approach elements are implemented. These barriers may involve different groups (for example, patients and health workers), different types of health organizations, or the health system as a whole. While some barriers could be relatively easily overcome, others could be so substantial that they force us to re-evaluate whether we should pursue that element. Some potential barriers to implementing the elements are summarized in Table 2.



Table 2: Potential barriers to implementing the elements

Element	Description of potential barriers
Element 1 – Use a risk-based approach to health workforce oversight	<ul style="list-style-type: none"> • Some categories of health workers may resist being grouped with other categories of health workers for fear of reducing their independence in their practice • Some categories of health workers may not agree with the approach chosen for how to assess risk of harm • Policymakers will face a one-time cost associated with making the change towards a risk-based approach
Element 2 – Use competencies as the focus of oversight	<ul style="list-style-type: none"> • Some categories of health workers may be concerned that they will not be given as fulsome an opportunity to provide input in defining core competencies as other categories • Some categories of health workers may interpret expanding competencies to include soft skills such as professional demeanour as infringing on their autonomy to determine how they practise • Some categories of health workers may not agree with the chosen set of core competencies for each profession • Policymakers and oversight bodies will likely be required to allocate additional resources towards updating performance measurement standards to reflect these new competency-based approaches
Element 3 – Employ a performance measurement and management system for oversight bodies	<ul style="list-style-type: none"> • Health workers and their oversight bodies may oppose having more detailed information on their performance publicly available • Oversight bodies may resist the administrative burden of recording and reporting significant amounts of data • Oversight bodies may resist the additional layer of accountability for fear that it infringes on their autonomy

The implementation of each of the three approach elements could also be influenced by the ability to take advantage of potential windows of opportunity. A window of opportunity could be, for example, a recent event that was highly publicized in the media, a crisis, a change in public opinion, or an upcoming election. A window of opportunity can facilitate the implementation of an option.

Examples of potential windows of opportunity

- **Upcoming provincial election:** The 2018 election may provide an opportunity to discuss how the health system should look for the next 20 years, and with that how the oversight of the health workforce may be adapted.
- **Increased tightening of resources in the health system:** The financial constraints being faced by many health workers and organizations may help to initiate a discussion about how to more efficiently allocate resources towards oversight mechanisms.
- **Increased transparency:** Increasing the transparency of health workforce oversight bodies may increase public trust of health workers.



Box 4: Reminder of the questions considered for your deliberations

Questions related to the problem

- Do you have any worries about the oversight of the health workforce in the health system in Ontario?
 - Do you think there are more risks associated with some health workers compared to others?
 - Do you think differently about these risks when they are faced in some settings (for example, private clinics) or sectors (for example, primary care) compared to others, or for some conditions (for example, cancer), types of treatment (for example, prescription drugs) or populations (for example, Indigenous peoples, recent immigrants and refugees, and older adults) compared to others?
- Based on your interactions with health workers in Ontario, are there any services that some health workers should be providing that they currently are not (or services that some health workers should not be providing)? If yes, what types of services and for which categories of health workers?
- What challenges have you encountered if you have tried to:
 - access information about an individual health worker or how the health workforce, and its oversight bodies (currently called regulatory colleges), are overseen;
 - register a complaint about a health worker; or
 - engage in a disciplinary process for a complaint?

General questions related to the elements of a potentially comprehensive approach to address the problem

- To protect patients from harm, are there any categories of health workers who require more attention from oversight bodies than others?
- Are there any categories of health workers who require less attention because they pose less of a risk to public safety?
- What types of services would you like to see specific categories of health workers provide?
 - What types of skills do you think are important for health workers to have to perform these services?
- Who should be accountable for ensuring appropriate oversight of the health workforce to protect public safety?
- What types of information about health workforce oversight should be collected and publicly reported in Ontario?
- Do you think that patients should be actively involved in the oversight of health workers in Ontario? Why or why not?
 - If yes, what do you think would be the most meaningful way to engage patients in this oversight?

Question related to implementation considerations

- What do you see as the main challenges to improving the oversight of the health workforce?

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Conflict of interest

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Merit review

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