Newsletter of the Ontario Physiotherapy Association

PHYSIOTHERAPY TODAY

Providing Healthcare to Indigenous Peoples

Student Research on COVID-19

Providing Care To People With Intellectual Disabilities Initiative

Autumn 2021 / Issue #174

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ONTARIO PHYSIOTHERAPY ASSOCIATION

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Ontario Physiotherapy Association
110 Sheppard Ave E. Ste 810
Toronto, Ontario M2N 6Y8
Tel: 416.322.6866
Toll Free: 1.800.672.9668
physiomail@opa.on.ca
www.opa.on.ca

MANAGING EDITOR
Sara Pulins
spulins@opa.on.ca

GRAPHIC DESIGN
Amanda Roberts

ADVERTISING SALES
Diane Unção
dianeu@opa.on.ca

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All items for the Winter edition should be submitted to the OPA office no later than January 10, 2022.

PRESIDENT'S ADDRESS

By Paulette Gardiner Millar, PT, BScPT, MScHQ, FCAMPT

Lately, in both my personal and professional life, I have been thinking about and challenging my perspective. We all base our thoughts and opinions on our experiences, our culture, and the knowledge that we have, and put weight behind at the time. What if our experience is limited, our cultural beliefs biased, or our knowledge incomplete?

What if there are different ways to think that we just have not been exposed to, been open to, or considered?

> *"What you see depends not only on what you look at, but also on where you look from - James Deacon"*

I moved my eldest child into university residence over the Labour Day weekend. I was proud and so very excited for him to embark on the new journey ahead. As I got back into my car to drive home, I felt a wave of emotion and began to understand the reference to becoming an "empty nester". I still have another son at home, but I could *feel* emptiness as I drove away. I allowed myself some time to embrace what I was feeling and then after some time passed, I started to wonder if there was a way to flip this from a scenario of loss to one of gain. I looked for a way to reframe the situation in my mind – initially feeling like I was losing a piece of my son or saying goodbye to a stage in his growth. Then I started to see how this could be an opportunity for me to share the amazing person that I had helped to nurture and support, with the rest of the world. The change in perspective was not immediate, did not change my emotions right away, but it did start me on a path of positive thinking and it has helped me work through the transition in a more productive way. Changing my perspective changed what I was feeling and how I moved forward.

We all strive to provide care to patients that is evidence informed and rooted in what the patient's rehabilitation goals are. In order to be successful in that we need to consider their perspective. What is important to them as they begin and continue to work through their rehabilitation journey? What activities or roles would *they* like to return to, taking into account that our own experience or cultural beliefs may not align with theirs? In order to gain insight into their perspective we must actively and openly listen, without inserting our own underlying preconceived ideas or beliefs. We must ask questions to fully understand and help guide them on the path that best suits *their* needs.

As a leader, we are often tasked to help build teams with the goal of being high functioning and productive. The most effective teams that I have been on, worked purposefully to build trust, ensured the right skills were present, and fostered an environment where the respectful sharing of differing perspectives was encouraged and expected. Without considering different perspectives, we risk missing important stakeholder views and stifling innovation.

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President's Address continued >>

Perspective can help us be better people, better health care professionals and better leaders. In order to gain perspective we must open ourselves to other ways of thinking, ask ourselves "is there another way to see this?" and seek out differing opinions to challenge the way we think. If we are all open to considering a different perspective, perhaps we will see things differently and it may even change how we feel.

Wishing you and your family good health,

Paulette Gardiner Millar,
President, Ontario Physiotherapy Association *

THE SNAPSHOT

By Amanda Smart, PT, MSc PT, Director, Practice, Policy, Member Services

UPDATE ON PATH TO FULL REGISTRATION FOR CANDIDATES IN ONTARIO

OPA continues to regularly meet with the College of Physiotherapists of Ontario (CPO) to move solutions forward. There are two main issues:

- Address the current and urgent need to establish a path to full registration for the close to 1000 and growing number of candidates in Ontario affected by the delays in the delivery of the clinical component of the national exam.
- Beyond the immediate crisis, address questions regarding the national examination and entry to practice processes through a multi-stakeholder inclusive approach for the physiotherapy community of Canada.

At the CPO Council special meeting on September 20 the Council directed the evaluation of the results of the CPO's request for proposals (RFP) for an alternative examination, the investigation of a collaborative exam in partnership with other Canadian regulators using existing CAPR questions and the assessment of the viability of the solution proposed by the Ontario Physiotherapy University Programs. In follow up to that meeting OPA wrote to the CPO restating the urgency of the situation and proposing the following actions to find timely solutions to the current situation:

- Propose regulatory changes to the Ministry including the removal of the requirement of the clinical component and greater flexibility in determining entry to practice processes, especially in times like the pandemic.
- Investigate the implementation of the proposed solutions submitted by the Ontario University Physiotherapy Programs.
- Fully and quickly, examine the potential of granting exemptions (using the existing discretionary authority of the Registration Committee to do so) and register individuals or groups within the current regulatory structure.

The Council met again on October 14 and approved work that would move ahead options to explore the utilization of their QA program, the granting of exemptions and proposed changes to the registration regulation. Read OPA's response to the decisions made by Council. Please continue to follow our e-mail updates for developments.

OPA remains committed to using all resources available and to working with the College, the Academic programs and all stakeholders on behalf of candidates to arrive at a pathway that will ensure candidates can be registered to provide safe and effective care to patients in Ontario. Read more about OPA's advocacy.

WSIB CONSULTATION ON COMMUNITY PROGRAMS AND STAKEHOLDER ENGAGEMENT

Over the summer, the Priority Health Consulting group (contracted by the WSIB) met with health care professionals who provide services to injured workers. OPA secured 12 PTs from across Ontario and of different types and sizes of businesses to participate in the consultation. The PTs brought their experiences of working with the WSIB and injured workers to the discussions as well as their perspectives on opportunities for program improvement. In OPA's meeting with the consultants, questions focused primarily on the association's relationship and history working with the WSIB. OPA took the opportunity to also point to specific issues impacting the profession's current and future participation in WSIB programs. These key issues included the following:

- The need for professions to continue to have the opportunity to engage in bilateral conversations with the WSIB on profession specific issues while also maintaining a process to engage with all the health professions on shared issues

Continued on page 6 >>

The Snapshot continued >>

- Low physiotherapy fee for service schedule
- The streaming of patients away from community providers towards WSIB contracted providers
- Data collection and sharing with the health professions/ associations to inform policies and program development
- Communication challenges at both the level of individual members and OPA

In addition, the Health Professionals Forum of which OPA is the Chair, met with the consultants to receive a high-level overview of the results from their meetings with the individual associations and were asked additional questions related to governance structures and opportunities for better collaboration and communication between the professions and the WSIB. The consultant's report which will include a series of recommendations to inform WSIB's work on community programs and stakeholder relations will be submitted to the WSIB in October. In a letter sent to the WSIB regarding the consultation process, the Forum has requested that the final report be made available to us for further consultation not only to have the opportunity to validate the recommendations, but also as a signal of WSIB's commitment to building better engagement of the professions in WSIB's work. In addition, the Forum extended its offer to actively engage with the WSIB to implement the recommendations.

OPA will follow up specifically with the WSIB for our profession specific issues including those listed above.

COMMUNITY PHYSIOTHERAPY CLINICS UPDATE

In July and August 2021, OPA communicated multiple times with the Ministry in continuation of ongoing discussions about the current issues related to the pandemic and the overall structural problems with the CPC program. The Ministry indicated they were looking into options to delay the reconciliation process for the current fiscal year to later in 2022. They are also exploring options related to the current TPAs and possibly extending them beyond the March 31, 2022 expiration date. The Ministry indicated that due to pandemic pressures resources for a full program review may not be available.

OPA strongly stated our concerns about extending the current TPA without addressing the significant structural issues of the program (including but not limited to the issue of the fees, what is included in the EOC, requirement for referrals and costs associated with financial reporting and other burdensome administrative issues) and the need to ensure that the program is pandemic-responsive (able to adapt and be viable for providers and the system).

OPA also used the announcement by the Minister of Health regarding the restart of surgeries and procedures to seek more clarity on what additional funding will be available for rehabilitation post-surgical/procedures, as well as to push the Ministry to deal with the program and structural problems with publicly funded physiotherapy including hospital-based out-patient programs, home care, bundled-care funding and the CPC program. In a meeting on September 14 with leads in the Ministry of Health, OPA stressed the importance of a province wide plan to ensure resources and access are sufficient to meet demand and that issues impacting available services are addressed in all sectors from hospitals to home care to community clinics. In the meeting we also pointed to changes to the CPC program that must be implemented prior to the extension of the TPAs to ensure the sustainability of the program and that critical rehab services are preserved in the community. Feedback provided by OPA CPC members on recent impacts of the pandemic on their ability to meet service volumes and their projections on whether they will be able to continue providing the program was critical to our conversation with the Ministry and will continue to be used in our advocacy on this matter.

To access up-to-date information on OPA's various advocacy initiatives, responses and submissions on behalf of members, please visit: https://opa.on.ca/advocacy-positions/where-we-stand/.✱

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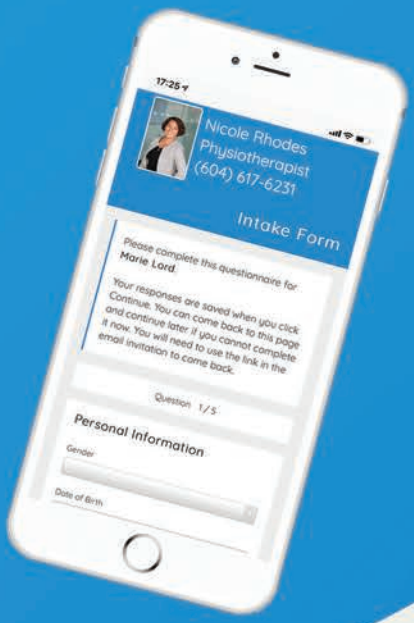

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PROVIDING HEALTHCARE TO INDIGENOUS PEOPLES

Balancing the Interaction: The Medicine Wheel in Clinical Practice

By Derek Debassige RPT, GCOMPT, CMAG, BHscPT, BKin

In 2019 I was invited by OPA President at the time Wendy Smith to present my career path alongside a panel of highly recognizable physiotherapists at OPA's InterACTION conference. A twenty-year career of opportunities, decisions and directions reduced to a single page and a 15 minute presentation gave the appearance of a carefully thought out trajectory. However, a linear path couldn't be further from the truth. This exercise forced deep reflection of how I got to where I am, and why I'm happy with my choices. At every turn, behind every career altering decision, there were people that came clearly to mind. Meaningful relationships had formed the foundation of this path.

Much of each day of my career has been spent working together with First Nations people and communities in a myriad of ways. I was enticed to come back to Gchi-Aazhoogami-gichigami (Ojibway for the Great Cross Waters, aka *Lake Huron*) to work at Mamaweswen, the North Shore Tribal Council, for a fledgling pilot homecare program where physiotherapy would be offered to area First Nation communities. As a shiny new PT grad I welcomed the opportunity, not fully appreciating the challenges ahead. This was a new program, with uncertain long-term funding, providing access to rural Indigenous communities where so many challenges and barriers have existed for so long, amidst a team of primary health care providers who themselves had limited experience working alongside physiotherapists. Complicated patient presentations were commonplace, as were complex health politics. Over time navigating complex interactions became an expected part of the day and I was grateful to have such a highly developed tool in the Medicine Wheel to guide my learning and decision making.

Having grown up in M'Chigeeng First Nation on Mnidoo Mnising (Manitoulin Island), the Medicine Wheel basics were not foreign. Awareness was there but the *utilization level* of knowing was not. There are many 'stories' grounded in the Medicine Wheel's circle. A relatively simple visual tool, four equal quadrants of different colours making a complete circle is used to illustrate many principles necessary to understand the essentials of healing. This teaching tool serves as somewhat of a guide, helping us better understand ourselves and our relationships. The four seasons and the traditional ecological knowledge that accompanies them; the stages of life and the processes of change, and; the natural diversity amongst all humankind are examples of such teachings; formative things I'm grateful to have learned as a child. Although this setting is far too brief to do any **Continued on page 10 >>**

Balancing the Interaction continued >>

single teaching justice, I will attempt to offer a collection of insights from the Medicine Wheel, so graciously shared with me by people seeking help, by my elders, by traditional healers and by family over the past 46 years - offered within the context that we are all bearers of culture. That said, there is a little Ojibway language sprinkled throughout this share. Please take a second to give it a try. Miigwetch - thank you.

Navigating complex interactions: our patients have inherent strengths and weaknesses - when understood - both can be allies.

One of the fundamental teachings from the Medicine Wheel helps us understand our place by providing scope. Each of the four quadrants represents a way in which we can both perceive the world around us and express ourselves within it. We perceive and express ourselves physically, emotionally, mentally, and spiritually. We move, we feel, we think, and we have a sense of connectedness to something greater, often experienced as a search for meaning. Each of us has an individualized range in our ability to perceive and express that is formed by our beliefs, experiences, and capacity. For example, one patient might have an athletic background and a high movement competence resulting in the physical domain being a source of confidence, where another may have been embarrassed to run in front of others from a young age. Understanding where our patients are resilient and where they may need more help can be an advantage as we attempt to navigate the physical rehabilitation process. Employing motivational cueing and language that supports a variety of individual strengths and weaknesses can be enlightening, disarming, and encouraging to an individual wondering if you are the person who can help. Listening carefully through the subjective portion of the interaction, making a call in the early stages of a relationship (be open to amending) as to which of these domains are assets along with identifying the domain requiring more attention **can** help contextualize which communication skill set is best to present (ie. the empathic listener vs the challenge-based motivator). Note: developing a range of options takes time.

There is often a visual cue at the centre of a medicine wheel, where the four quadrants converge (a small pouch, silver bead or even a feather). This symbol draws our attention to the seventh direction teaching. Each of the four quadrants represents a cardinal direction (East, South, West, North) while laying the wheel flat illustrates the dimension of above and below, or the sky and the earth. The bead in the middle represents the direction of inwards, or one's ability to reflect. To develop a utility belt as a mindful healer, we will have to engage in challenging conversations with ourselves. Consider starting with something simple, which engagement strategies worked today, which didn't, and why?

Common values across cultures: the seven teachings of the Grandfathers

The teachings of the Medicine Wheel offer that there exists a set of values that are, for the most part, common to us all. Wisdom (Nbwaakawin), Compassion (Zaagidiwin), Respect (Mnaadendomowin), Courage (Aakdewin), Honesty (Gweekwaadziwin), Humility (Dbaandendiziwin), and Truth (Debwewin).

Our most memorable moments are either imbued by a combination of these values (balanced interactions, or positive experiences), or absent of them (unbalanced interactions, or one might say negative). Leaving specific examples from your own experience for you to ponder for yourself, this series of teachings helps to illustrate that interactions are in a variable state of balance that we as clinicians can affect. Our challenge as a facilitator along a patient's healing journey is to be attentive to the quality of the interaction itself such that it becomes more balanced, more memorable, more meaningful. At significant risk of reductionism: pay specific attention to which values are not in the room. As we endeavour to become architects of the interaction, our challenge is to infuse it with as many common values as we can, contributing to the creation of an *authentic* point of intervention and if we are successful, more points of intervention will follow. Healing takes time and commitment - both can be nurtured.

Consider practicing by identifying (inaudibly) the absence of specific values in personal situations and utilizing reflective language to nudge the interaction toward that value. Clinically speaking, I find humility is a value commonly absent in a patient's journey through the medical system. With practice, this can be relatively simple. An example infusing courage, respect, compassion, and humility might sound like:

"Thank you for sharing this difficult problem with me. It sounds like this is affecting your ability to (insert the 'patient's why' here). I believe you are in the right place and I'm here to help. I want to understand this issue even better. Can we collect a little more information with a movement-based assessment?"

Following a challenging rehab session, illustrating courage, respect and wisdom might include:

"You did well through those challenging movements. Here is what I think is going on (insert appropriate patient education). Here's what to expect over the coming days (insert prognosis). Do you have any questions for me?"

Honouring the Gift: the healer's mindset is in play

Our patients have something for us. A Gift. Their presenting problem is an opportunity for us to do what we do – that is, to help. This gift allows us to share knowledge, build a relationship, improve the quality of someone else's life and

in turn our own. It grants us the ability to work, to grow and ultimately to provide for our own families. To truly embrace this approach, begin with this humbling and honest starting position: honour the gift by giving it your full attention mentally, physically, emotionally and spiritually, as a human being with great knowledge and in a powerful position to help another. Vested interest is an asset in most situations. Just as the investment in attaining a deeper understanding of a patient's 'why' (the reason and meaning behind our exchange) lends passion to the pursuit of a positive outcome, so does contextualizing the clinician's deeper rationale for being in the room. We are an active part of this relationship and our mindset matters.

Having not received much formal training in the 'soft skills' that form the undercurrents of our interactions, these brief extrapolations are intended to provide an introduction to an alternate perspective as we apply the ever-evolving evidence-based knowledge in our diverse clinical settings. This continent's original biopsychosocial approach has contributed greatly to the healing path of so many, for hundreds of years and it has surely been a significant source of any patient, personal and career success for me. I am indebted to this approach and am grateful for the opportunity to share. I encourage new and experienced clinicians alike to revisit these concepts, discuss with colleagues and develop this skill set in pursuit of better balance in our interactions and better access to care across all cultures.*

Derek Debassige is a member of the M'Chigeeng First Nation on Manitoulin Island. He is the owner and Clinical Director of Manitoulin Physio Centre with locations in M'Chigeeng, Aundeck Omni Kaning, and Wiikwemkoong First Nations serving Manitoulin Island and the surrounding area. Currently his multi-disciplinary team (PT, OT, RMT, AT, RKin, DC) provides services to the general outpatient population in the region (including MVA, VAC, EHB and WSIB); PT and OT homecare services to seven First Nation communities; PT and OT school health support services to four First Nation school boards; along with Community Physiotherapy Clinic (EoC) and Primary health care (PHC) public access to a collaborative of AHACs and FHTs.

Relationships with Indigenous Clients

By Katie Gasparelli, BSc PT, MSc Rehabilitation and Skylar Powless, R.Kin

Indigenous people are relational. The belief that all things are connected is embedded as a way of being, as a core value. This is true across all of Turtle Island, regardless of Nation, location and differing traditions. Relationships are what foster connectedness and there is a direct correlation between positive relationships and the positive outcomes that rely on that connectedness. Therefore, the value and effectiveness of your interactions will depend largely on the relationship you build with others.

The experience of Indigenous people with health systems in Canada has not been one that supports positive relationships. The Truth & Reconciliation Commission of Canada Call to Action #18 asks for Canada to "acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties"[1]. The first National Day for Truth and Reconciliation on September 30 of this year supported an increase in the dialogue about Indian Residential Schools and their impact on the health and wellbeing of First Nations, Métis and Inuit people and communities.

Other policies such as the establishment of Indian hospitals are less well known but just as important for health care providers and health system leaders to learn about. The book, *Separate Beds: A history of Indian hospitals in Canada 1920's-1980's*[2], written by Maureen Lux describes the history of Canada's segregated health care system. Stories of terrible patient experiences are told and despite how hard they are to read, they do help to achieve the first step towards reconciliation which is to create an awareness of the past. Understanding the history of the healthcare system and its relationship with Indigenous people can help the provider better understand the need for a trauma-informed approach to relationship building.

The death of Joyce Echaquan on September 28, 2020 was a clear reminder that racism is present in the health system and can have significant implications for patient safety[3]. Joyce presented to hospital with an exacerbation of her chronic health condition and was subject to abusive remarks from healthcare staff which were recorded. Her family, her community, and many others believe that racism played a part in the quality of care she received. Joyce's story is an unfortunate reminder to Indigenous people that the systems they rely on for health care can be unsafe. A 2020 report about Indigenous-specific racism from British Columbia highlighted that "Indigenous respondents to their questionnaire were three or four times more likely to report feeling <*not safe at all*> than non-Indigenous respondents"[4].

An essential part of our ability to support people with our knowledge and skills rests in our ability to develop relationships. So how do we build relationships when there is a perceived lack of safety as Indigenous clients step into our health facilities? As providers we know we have the knowledge to help. Oftentimes, that's why we've chosen to be in this field - we want to help, we want people to be living their best quality of life. And usually people are choosing to come see us, so we make the assumption that they trust us. Indigenous people however, are coming to the relationship with a distrust of the system and healthcare providers are an extension of that system. Experience and history have proven too many times that the system is not always safe for them. Even when they don't personally carry bad experiences, they carry the stories.

So again, what can we do to turn it around? What are the attributes of a healthy relationship? Communication, trust, mutual respect, active listening, power balance? What else would you add? Your relationship with your clients and patients is not a personal one, but these attributes still hold true. As healthcare providers, we don't often view our

patient-provider relationship in these terms, or reflect on these as areas of growth to improve this relationship. We all know that relationships can be hard and difficult. Patient-provider relationships are no different. They still require interactions that foster connectedness and growth. Put down your checklist, assessment plans, and YOUR goals and have a genuine conversation with them. Learn about them, ask them what their goals are. What does "better" look like to them? What is their biggest concern in that moment? These conversations will likely still answer most of your questions, and they'll also meet the attributes of a healthy relationship. The environment you create that allows these positive interactions to occur will turn into trust and relationship reciprocity. Yes, reciprocity. Without a doubt, your client will have something to offer that fosters your growth - professionally and maybe personally. Trust and relationship reciprocity will be how your client measures the value of your relationship. And the success and effectiveness of your treatment will largely be based on how your Indigenous client values your relationship. Treatment needs to be valuable to them, not just us. Oftentimes when working with an Indigenous population, you as the provider have to do more work in order to develop that relationship. You are working toward gaining trust, in a colonial system with a history of oppression and racism. You must model mutual respect and active listening to ensure there is an equal power balance. You must self-reflect and likely challenge your own biases, some you are aware of and some you are not. These are all skills that you can learn and grow as you have interactions with any one that you treat. The key is to navigate these relationships and skills with self-reflection and humility to put you on a positive path forward.

Lastly, in an Indigenous perspective of health and wellbeing we don't compartmentalize parts of ourselves. We are whole, and consider the relationship between our physical, emotional, mental and spiritual wellbeing to be intertwined in a delicate yet dynamic relationship balance. An imbalance in one area will affect another, and makes shifting to a holistic perspective with any type of therapeutic interaction and intervention an important consideration. A consideration that we hope one day becomes best practice, regardless of what type of health service is provided.

Relationship development takes time and our systems don't always support us to work in this way. Limits such as time permitted per client or number of visits based on physical diagnosis can be barriers to developing reciprocal relationships that allow for the best outcome possible. We have work to do so that everyone can benefit fully and equitably from our health system. As a provider, you can help to move the needle one relationship at a time.*

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Katie Gasparelli is a member of Six Nations of the Grand River and has worked as a physiotherapist in her community and other First Nations communities in the Northwest of Ontario. She currently works for Healthcare Excellence Canada and is a board member for the Ontario Physiotherapy Association. She is an advocate for equitable access and culturally safe healthcare for First Nations, Inuit and Métis people and participates in the Indigenous Health Subcommittee of the Global Health Division at CPA.

Skylar Powless is an Onondaga (Nation) Snipe (Clan) and member of Six Nations of the Grand River. She has worked as a registered Kinesiologist within her community at Six Nations Health Services. Currently, she works at Six Nations Health Services in a Clinical Lead role. She is passionate about providing culturally safe care and advocating for a change in healthcare to integrate Indigenous and Western practices of health and well-being.

Supporting Elders Living with Frailty in Remote Indigenous Communities in Northwestern Ontario: Developing the Role of a Community Rehabilitation Worker

By Denise Taylor, North West Regional Rehabilitative Care Program, St. Joseph's Care Group; Dr. Helle Møller, Department of Health Sciences, Lakehead University; Joan Rae, Health and Social Services, Sandy Lake First Nation; Robert Baxter, Health and Social Services, Eabametoong First Nation; Wes Nothing, Health, Michikan (Bearskin) First Nation; Marlene Quequish, Health, North Caribou Lake First Nation; Dr. Mary Ellen Hill, Centre for Rural & Northern Health Research - Lakehead University; Dr. Taryn Klarner, Lakehead University, School of Kinesiology; Kirsti Reinikka, Northern Ontario School of Medicine, Eabametoong First Nation/Sandy Lake First Nation; Shane Strickland, Confederation College-School of Health, Negahneewin & Community Services; Alison Denton, Regional Seniors' Care Program, St. Joseph's Care Group; Esmé French, NWO Regional Stroke Network-Thunder Bay Regional Health Sciences Centre; Robin Cano, Health Canada – Indigenous Services Canada, First Nations Inuit Health Branch - Ontario Region Home and Community Care; Katie Wantoro, Primary Care Team, Sioux Lookout First Nations Health Authority; Patty Everson, Home and Community Care, Windigo First Nations Council

Northwestern Ontario (NWO) has the highest regional proportion of Indigenous people across Ontario. Indigenous Elders[1] and seniors aged 75+ are 45–55% more frail than the average senior in Ontario[2]. Although present for many years, in 2017, the region formally identified significant gaps in rehabilitative services throughout remote Indigenous communities.

These gaps include a strong need to improve prevention and rehabilitation programming to support transitions from hospitals to home, and support healthy aging to improve quality of life and reduce chronic disease.[3] As essential rehabilitation programs common in an urban context are not available in most rural, remote, and predominantly Indigenous communities, Indigenous Elders are particularly at risk of frailty and compromised health when disabilities occur. Elders are often required to travel out of their home community to receive specialized care, which can lead to isolation, as they are removed from their familiar environment and support systems.[4] Over the last few years, many rural and remote communities have started to receive services by a rehabilitation Primary Care Team, including physiotherapy (PT). The team provides rehabilitation in person on a monthly or bi-monthly basis, and supports clients virtually between visits. However, there is a persistent need for local healthcare providers with a focus on rehabilitation to support care needs in between clinicians' visits.

Other regions with similar access challenges have developed creative local solutions.[5-9] They recognize that training local people with an understanding of the environment and social conditions of the area helps to build community capacity, fosters a person-centered approach and continuity of care, and enhances effectiveness of rehabilitation efforts.[10,11]

Based on this knowledge, we envision a Community Rehabilitation Worker (CRW) role within existing Home and Community Care (HCC) programs that specifically employs local community members trained in rehabilitation principles and skills to support Elders and other HCC clients. Our ultimate goal is to build capacity in each community to improve continuity of care and supports, allowing Elders to remain in their home and community. The development and evaluation of a CRW program is funded by the Canadian Frailty Network.

This project is inspired by, and aligns with the Truth and Reconciliation Calls to Action[12], **Continued on page 16 >>**

COMMUNITIES

- Michikan (Bearskin Lake)
- Sandy Lake
- North Caribou Lake
- Eabametoong

Supporting Elders continued >> in particular #19 "to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities" and #23 "to increase the number of Aboriginal professionals working in the healthcare field".

Before starting the project, we held community engagement sessions in four communities (North Caribou Lake, Eabametoong, Sandy Lake and Bearskin). These sessions confirmed a need for the CRW role in supporting and enhancing community participation in traditional activities, safety and well-being among Elders. The engagement sessions also identified that CRWs required the following skills and knowledge: the ability to communicate in a local language and in English including medical terminology; knowledge of common chronic conditions; proficiency in assisting Elders with mobility, safety and ADLs; the ability to identify mental health concerns and appropriate resources; and, the ability to facilitate social and exercise groups. In addition, the community engagement sessions highlighted a preference for an in-person, condensed training program, using a distributed learning model in the four communities and the two larger urban centres (Thunder Bay and Sioux Lookout); and providing a supervised clinical experience between the learning modules.

The curriculum for the CRW program was co-developed with the communities and members of the project team. In addition, rehabilitation providers in the area and those with experience delivering care in Indigenous communities across Canada were consulted on each module and provided input, enhancing the final product. The development of the program started in November 2020 and the curriculum was finalized in September 2021.

This new CRW certificate program consists of eight modules being delivered over the course of ten months. The modules cover the following topics: Introduction to Rehabilitation Practice; Communication Skills in Rehabilitation; Musculoskeletal Conditions; Neurological Conditions, Aging & Dementia; and Care at Home. The second last module comprises a Supported Student Success Week to accommodate unexpected schedule changes or areas identified as needing additional attention. And, lastly, the final module, consists of standardized training programs in Mental Health First Aid for Indigenous People, Standard First Aid and CPR. Other online training modules (e.g. hand hygiene, back care etc.) are assigned as independent learning to be completed during the program. Each module is a minimum of 42 hours, which includes one week in person in a classroom, assignments, and associated clinical training. In between courses, students work as a member of the HCC team, supervised by the HCC Coordinator, as well as having dedicated time to complete course assignments during their work day. Learning takes place in Thunder Bay at Confederation College and participating communities within Northwestern Ontario.

With the support of Indigenous Services Canada Home and Community Care-Ontario branch, the inaugural class of eight students will begin the training in January 2022. ✱

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‘HERE WHEN YOU NEED US’ CAMPAIGN 2021

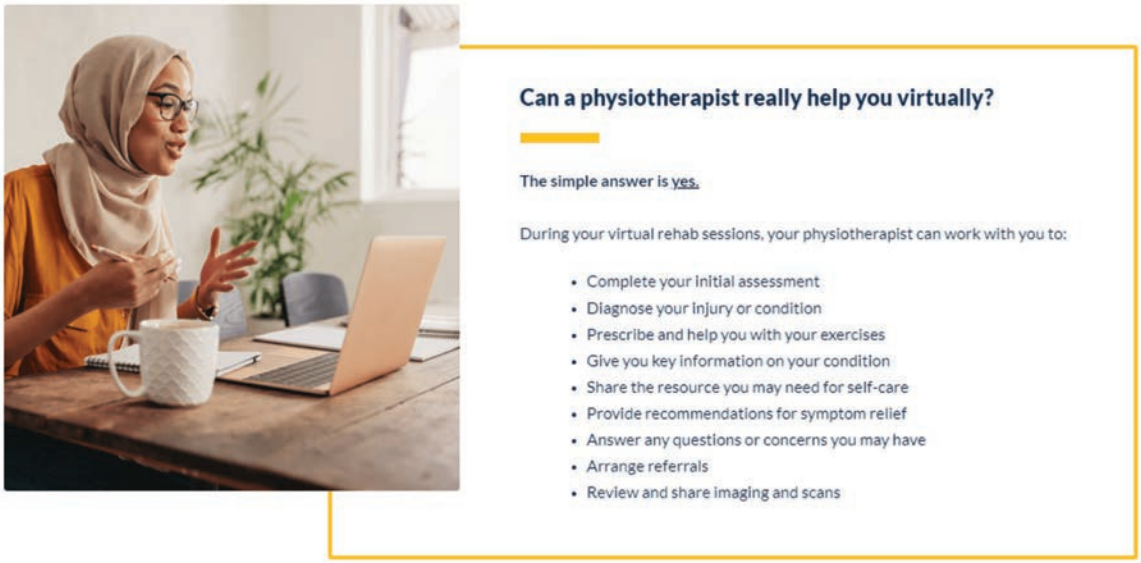
By Sara Pulins, Manager, Marketing and Communications

#WEAREPT

OPA’s ‘Here When You Need Us” public marketing campaign promotes the benefits of physiotherapy to Ontarians with monthly updates keeping the campaign current. We are showing Ontarians that physiotherapy clinics are open, and providing safe and effective care, whether in-person or virtually and directing them to OPA’s Find a Physiotherapist tool.

Facebook ads and landing pages demonstrate how physiotherapy is essential - to movement, recovery and living pain-free and now also includes information on how physiotherapy can help with Long-COVID.

Check out the main campaign page: causes.discoverphysiotherapy.ca/here-when-you-need-us/



IS YOUR CLINIC LISTED ON OPA'S FIND A PHYSIOTHERAPIST?

Add your listing by logging in here: physiotherapists.opa.on.ca/members-login/

Once logged in, go to “About Physiotherapy/Add Clinic Listing” (2nd navigation from the left)

Complete the form, submit and your listing will be live within 48 business hours.

Once your listing is live, you will have access to edit your own listing(s) as needed under “Edit Clinic Listing”.

Questions? Contact Sara Pulins at spulins@opa.on.ca.

SHARE YOUR SELFIES!

Be sure to share pictures for use in our campaign this year. We want to show Ontarians our member PTs and PTAs!

Check out some of the member picture submissions so far:

Andy Wang

Thank you Deepha Romuwalt for submitting this picture

David Evans, PT, treating Heather Imrie, PT

WHAT YOU CAN SUBMIT

PT/PTA Pictures: Picture(s) of yourself at your clinic/workplace.

Patient Pictures: Invite patients to submit a picture. Include a patient quotation about how physiotherapy has helped them.

Casual images work best, and selfies are great! *Including other individuals in the picture? Including company logos or other organization identifiers?* Ensure you've obtained permission to include them in the submitted photos.

Submit here: opa.on.ca/about-physiotherapy/discover-physiotherapy/campaign-submissions/

Please note: pictures of patients and physiotherapists in treatment scenarios need to be in accordance with IPAC protocols (e.g. mask and eye protection for the PT, mask for patient). If outside, and a casual picture (not in treatment), and physically distanced, then PPE may not be required or the appropriate PPE may only be a mask as per guidance.

Questions? Contact Sara Pulins. ✱

PROVIDING CARE TO PEOPLE WITH INTELLECTUAL DISABILITIES INITIATIVE

By Gonxhe Kastrati, Policy Analyst

OPA has partnered with Special Olympics Ontario (SOO) on an initiative to increase the skills, knowledge and capacity of physiotherapists to work with people with intellectual disabilities and to create a network of physiotherapists to support their "Healthier Communities" program.

As part of this initiative, OPA launched our *Understanding the Experiences of Physiotherapists and Physiotherapist Assistants in Providing Care to People with Intellectual Disabilities (ID)* survey, which ran from May 25 to June 4 and had 52 respondents. The survey intended to better understand the needs of members in caring for individuals with any degree of intellectual disability (mild-to-moderate and severe-to-profound).

Many respondents (79%) reported that over the last year, they had assessed patient(s) with an intellectual disability, or a patient they believed had an intellectual disability. Although many respondents were comfortable with providing care to a patient with mild-to-moderate ID (92%), fewer respondents indicated the same for a patient with severe to profound ID (61%). Many respondents (45%) also indicated that their educational training did not adequately prepare them to care for people with ID. Only 30% of respondents felt that their educational training adequately prepared them to care for people with ID.

Respondents indicated that a key barrier to treating patients with ID was having limited access to publicly funded physiotherapy for patients with ID (62% rated this as a 'significant' or 'high' barrier), followed by having limited training in assessing or treating patients with ID (46% rated this as a 'significant' or 'high' barrier). Other barriers they described included:

- Low compensation and other funding issues in certain sectors
- Accessibility issues related to transportation
- Lack of recognition of expertise with physiotherapists in treating this population
- Lack of referral since the patient's rehab needs are not recognized
- Lack of time required to treat patients with ID, which is not supported by the design of publicly funded programs
- Determining strategies to engage the patient to achieve their goals and have their healthcare team use these strategies
- Ensuring patient follows safety procedures

Respondents also indicated that there are missed opportunities for persons with ID who are not referred to physiotherapy but would benefit from receiving physiotherapy.

While many respondents indicated that people with ID receive similar quality care to people without ID (83% 'strongly agreed' or 'agreed'), they also indicated a strong level of interest in receiving more training (78%) and additional resources (81%) to help them provide better care to people with ID. They were interested in receiving education in many ways, including prerecorded learning modules (76%), online live webinars (70%), one pager/fact sheets (63%), evidence-based resources/literature (61%), and in person workshops (30%).

As a next step OPA, SOO and a group of physiotherapists with clinical and research expertise in ID are working on developing an educational series for physiotherapists and physiotherapist assistants. OPA recognizes the importance of partnering with key stakeholders, such as SOO, in order to provide members with continuing education opportunities that meet the needs of their practice and patients served. In addition, this partnership is helping to build a community of local providers with the skills, knowledge and competencies to provide care to local SOO athletes and others with ID.*

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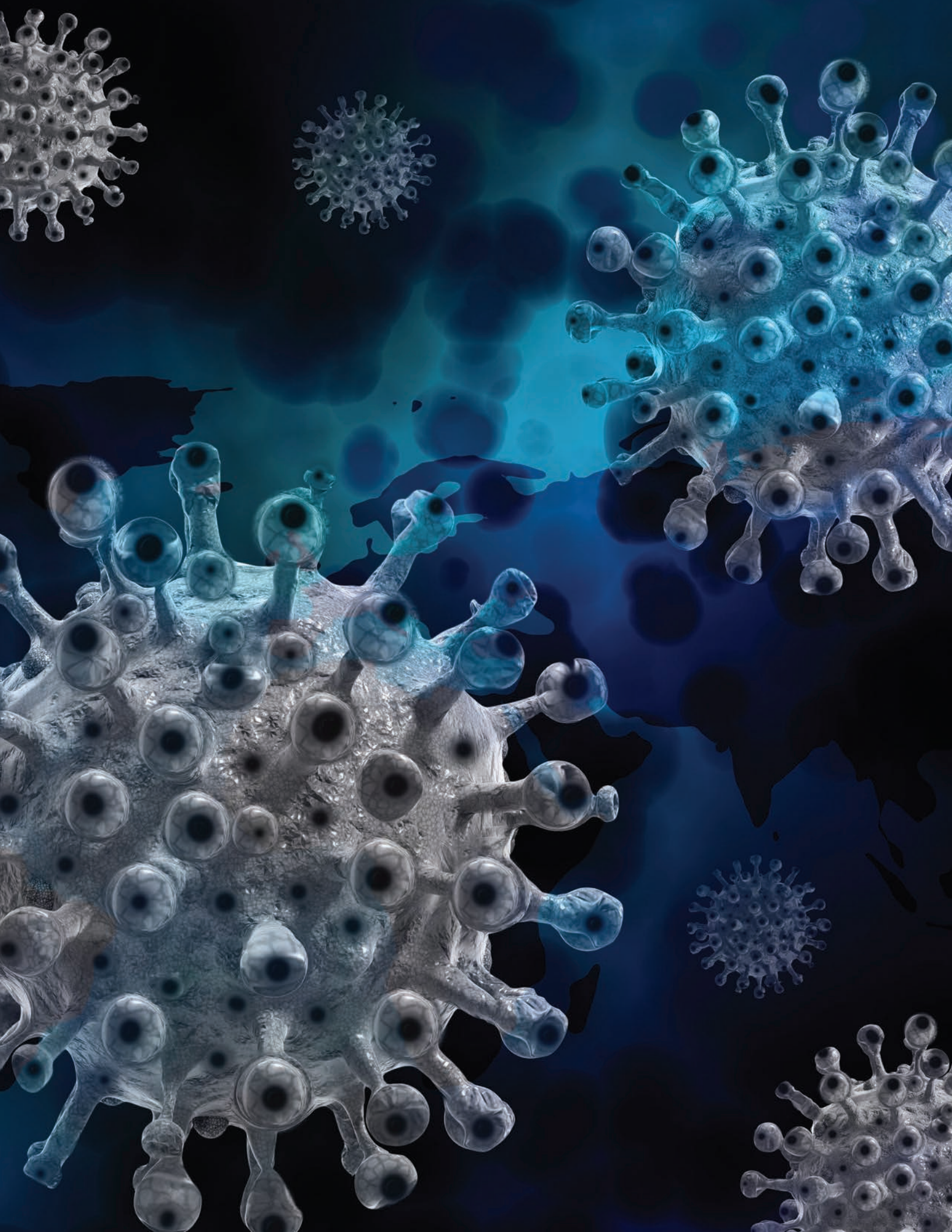


Student Research on COVID-19

The Ontario Physiotherapy Association asked all five physiotherapy programs in Ontario to share research being conducted by students on COVID-19 and physiotherapy.

The following students and researchers submitted their summaries.

WESTERN UNIVERSITY

Examining the effectiveness of online case-based teaching pedagogy in professional programs: A systematic review and narrative synthesis.

Authors: Meagan Miranda, BHSc, MPT, Ariel Zacharias, BSc, MPT, Ashley Murray, BMSc, MPT, Amy Pogue, BA, MPT, Carissa Smith, BHSc, MPT, James Lobb, BPHE, BEd, MPT

Supervisors: Heather Gillis, PT, MSc, FCAMPT, Greg Alcock, PT, BA, BHSc, MSc, FCAMPT, Katie Kowalski, DPT, PhD

Summary: Case-based learning (CBL) has been integrated as a learning and teaching method for professional programs globally. However, there is limited evidence of the effectiveness of CBL using an online delivery model. Our group aimed to identify, evaluate and thematically synthesize the available evidence on the effectiveness of CBL in an online delivery model compared to in-person CBL, in professional programs. This systematic review included nursing, medicine, physical therapy, and business programs, and utilized the McGill Mixed Methods Appraisal Tool (MMAT) to assess quality of the studies.

Despite great heterogeneity of study design and professional program, it was found that online CBL demonstrated equal or greater effectiveness of online CBL compared to in-person CBL. Numerous barriers and facilitators were identified that contributed to the effectiveness of online CBL including flexibility, effective use of technology, online communication skills, hesitancy to change, as well as technical, goal setting, and communication difficulties.

The results of this paper prompt further investigations to be conducted following the recent domestic changes in curriculum development and delivery due to the COVID-19 pandemic. As the advancement of online CBL progresses, professional programs/disciplines would benefit from further investigations tailored to online CBL in their respective fields.

Evaluating Patient and Physical Therapist Experience with Virtual Care Models for Treatment and Assessment

Authors: Jenna Campbell[1], Alicia Dings[1], Leigh Jeffries[1], Donavon Nickerson[1], Katie Rubinger[1]

Supervisors: Dr. Adam Cann, PT, PhD [1,2], Dr. Tania Larsen, PT, PhD [1,2]

1 School of Physical Therapy, Western University

2 Physiotherapy, London Health Sciences Centre

The COVID-19 pandemic necessitated a rapid shift towards virtual care for continued delivery of outpatient physiotherapy services following total knee or hip joint arthroplasty (TKA/THA). Understanding patient and physiotherapist experiences with virtual care helps inform future virtual care models and strategies to optimize patient safety and experience. The purpose of our research was to describe physiotherapist and patient experiences with virtual care following TKA/THA. Using convenience sampling 6 physiotherapists and 13 patients following TKA/THA who participated in virtual care were recruited. All study participants completed a written survey. All physiotherapists and a random group of patients (5) participated in semi-structured interviews describing their virtual care experiences. Results demonstrated high patient satisfaction with virtual care. Patients reported positive experiences with the quality of communication, availability of supports and satisfaction with the convenience of virtual care. Physiotherapists demonstrated a lower overall satisfaction compared to patients, recognizing value in mixed models of care combining both virtual and in-person methods related to individual patient needs. Physiotherapists reported the need to learn to adapt their practice to virtual care, emphasizing the importance of establishing processes to support service delivery. This research builds on the existing literature describing clinician and patient virtual care experiences and informs delivery of future virtual models of care.

Continued on page 24 >>

UNIVERSITY OF OTTAWA

Testing the Concurrent Validity of Total Joint Arthroplasties Performance Based Tests in Person vs. Distance: a Cross Sectional Study

Authors: Amélie Fecteau, Andrée-Anne Roy, Elizabeth Thibault, Alyssa Yu

Supervisors: Stéphane Poitras, PT, PhD, Lissa Pacehco-Brousseau PT PhD (c).

Summary: With more than 137,000 total joint arthroplasties (TJA) performed per year in Canada and the explosion of the COVID-19 pandemic, telerehabilitation has become an alternative method to physiotherapy treatment. Recent research has shown high levels of approval through TJA patient-reported outcome measures done via telerehabilitation, but there is a lack of evidence regarding performance-based tests, which are essential for a complete TJA patient assessment. It is therefore our objective to determine concurrent validity of TJA performance-based tests in a telerehabilitation setting as compared to in-person using a cross-sectional study format. It was hypothesized that the telerehabilitation condition would show similar results, and thus concurrent validity. 25 participants chosen via convenience sampling were separated into groups of two, and given written and video instructions by the evaluators regarding the three chosen standardized TJA tests (5TSTS, TUG, SCT). Outcome data was collected when participants carried out the tests within their groups and again by the evaluator thereafter. All participants completed the study. Bland-Altman plots used for each performance-based test showed concurrent validity between conditions. ICC (95%) values calculated for each test were 5TST=0.60 (moderate validity), TUG=0.81 (good validity), SCT=0.92 (excellent validity). The results suggest asynchronous testing conditions are equally practical and valid when carrying out TJA performance-based tests as compared to in-person.

UNIVERSITY OF TORONTO

Facilitators and Barriers for the Adoption and Use of Telerehabilitation by Ontario Physiotherapists in Outpatient and Community Settings During the COVID-19 Pandemic

Authors: Bryan Hague, BSc, Kin, MScPT Candidate, Leah Taylor, BHSc, Kin, MScPT Candidate, Chelsey Quarin, BSc, MSc, MScPT Candidate, JC Grosso, BKin, MPK, MScPT Candidate, Dylan Chau, BHSc,Kin, MScPT Candidate, Rebecca Kim, BA, Kin, MScPT Candidate,

Supervisors: Alison Bonnyman, BScPT, MScRS, Molly Verrier, Dip P&OT, MHSc, Sharon Gabison, BSc, BScPT, MSc, PhD

ABSTRACT

Purpose: To describe the impact of COVID-19 on the adoption and use of telerehabilitation (TR), and to identify facilitators and barriers of the provision in Ontario physiotherapy outpatient/community settings.

Methods: A cross-sectional design, a web-based survey was disseminated to Ontario physiotherapists working in outpatient/community settings. Descriptive statistics were used for data analysis.

Results: Responses from 243 physiotherapists were included in the analysis. Respondents reported increasing and initiating TR to maintain continuity of care, limit patient COVID-19 exposure, and enhance patient outcomes. Facilitators for adopting TR were physiotherapists' attitudes and access to technology, convenience and ease of scheduling sessions, and perceived patient satisfaction and comfort in their home environment compared to in-person care. Barriers for adopting TR perceived by respondents were patient factors including patients' attitude, suitability and ability to address their needs, ease of adoption, and internet connectivity. More than 50% of respondents perceived that financial factors did not impact TR adoption.

Conclusion: Physiotherapists increased their use of TR throughout the COVID-19 pandemic. Effective implementation of TR should include both patient and physiotherapist education, and best practice guidelines in order to deliver high quality therapeutic interventions directed towards health and well-being.*

ONTARIO PHYSIOTHERAPY ASSOCIATION ANNUAL MEETING OF MEMBERS

The Annual General Meeting of the Ontario Physiotherapy Association will be held Saturday, March 26, 2022 in order to:

1. Receive the 2021 financial statements of the Association.
2. Consider the appointment of auditors.
3. Consider the election of Directors.
4. Consider such other business as shall properly come before the meeting.*

CALL FOR RESOLUTIONS – 2022 ANNUAL GENERAL MEETING

General submission requirements:

To submit a resolution, you must be a member or committee of OPA and ensure that the issue is well researched. Determine if the resolution is within the OPA's mandate, and whether or not another form of communication would be more appropriate, such as a letter to the Board of Directors. The resolution format consists of a "Whereas" Clause(s), a "Resolving" Clause, a Fact Sheet and the designation of a Contact Person. Resolution format guidelines can be obtained from the OPA office.

Please submit your resolutions early, as the Governance Committee must review each submission. The Governance Committee may suggest revisions to the resolution sponsors. Once these suggested revisions have been addressed, the resolution is re-submitted to the Governance Committee. Resolutions must be received before **December 10, 2021**. Only resolutions submitted before this date will be voted on at the Annual General Meeting in March 2022, unless they meet the criteria of an Emergency Resolution.

Submit resolutions to:

Resolutions c/o Ontario Physiotherapy Association

110 Sheppard Avenue East, Toronto, ON M2N 6Y8

physiomail@opa.on.ca *

OPA HOLIDAY HOURS 2021-2022

The Ontario Physiotherapy Association office will be closed Monday, December 27, 2021 to Monday, January 3, 2022.

Regular hours resume on Tuesday, January 4, 2022.

Phone and email messages will be checked upon return to the office on January 4, 2022 during regular business hours. Thank you for your patience.

Best wishes to all for a safe and happy holiday season!*

Thank You to Our Volunteers!

These dedicated volunteers joined us on Saturday, October 16 to take part in our campaign video shoot.

Alison Pinto, The Centre for Sports & Recreation Medicine

Elliot Tse, Times Physiotherapy and Rehabilitation Centre

Melissa Wong, Markham Pelvic Health

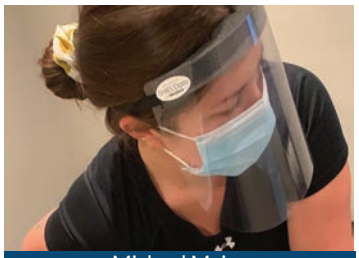
Raj Suppiah, Foundation Physiotherapy & Wellenss

Thank you to these amazing members who contributed pictures to our 'Here When You Need Us' public campaign.

Ruth Wentzell

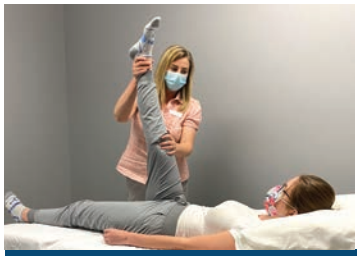
Sarah Rydahl

Andy Wang



Michael Major
(Strive Physiotherapy and Performance)

Beverley Biggs



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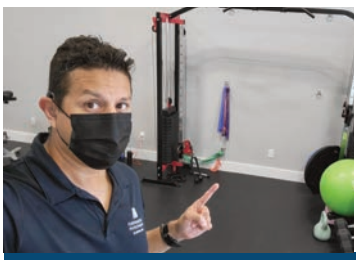

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