

Report of the Nurse Practitioner Integration Task Team
submitted to the
Ontario Minister of Health and Long-Term Care

March 2007

EXECUTIVE SUMMARY

Established by the Minister of Health and Long-Term Care in November 2004, the mandate of the Nurse Practitioner (NP) Integration Task Team was to review, prioritize, implement, or advise on the implementation of the recommendations of *The Integration of Primary Health Care Nurse Practitioners into the Province of Ontario* report. Establishing the NP Task Team was a significant marker of the Minister's commitment to integrating this role into the Ontario health system.

Since the release of the NP "integration report", the number of NPs, as well as the breadth of settings in which they work, has increased. A number of Ministry initiatives place emphasis on team-based health care and integrated health human resources initiatives and will directly influence the province's NP workforce.

Two key initiatives directly relate to the Task Team's mandate. First is *HealthForceOntario*, the government's health human resources strategy to ensure that Ontario has the right supply and mix of health care professionals to meet current and future population health needs. Second is the *Canadian Nurse Practitioner Initiative (CNPI)* funded through Health Canada's *National Primary Health Care Transition Fund* to support pan-Canadian efforts to integrate the NP role. These and other positive developments in the health system have contributed to the beginning of a cultural shift, one that the Task Team strongly believes is conducive to a more complete integration of NPs into the health care system.

In fulfilling its mandate, the Task Team completed a thorough review and analysis of the twenty-nine recommendations included in the "integration report". In this report, the Task Team presents for implementation 31 key strategies within one of five main priorities:

- ⇒ Supporting NP Transition to Practice,
- ⇒ Promoting Integration of NPs into Health Care Teams,
- ⇒ Promoting Effective Utilization of NPs,
- ⇒ Funding Issues, and
- ⇒ Health Information Management and HR Planning.

Many of the strategies presented in this report build on initiatives already underway. Other strategies will present unique challenges and will require strong government leadership to see that they are implemented. The Task Team believes that these strategies are vital to and consistent with the government's pledge to integrate NPs into health care. Further, the Task Team believes that it is in the public interest that the Minister move forward with the strategies presented in this report.

SUMMARY OF RECOMMENDED STRATEGIES

Supporting NP Transition to Practice

1. Support efforts to change Ontario's Primary Health Care Nurse Practitioner Program from a post-baccalaureate certificate to a Masters degree. This will better prepare NP graduates for practice and make Ontario more competitive with other jurisdictions.
2. Expand the *New Graduate Initiative* to explicitly include newly graduated NPs working in all sectors. Consider policy modifications to address the unique realities of the primary health care sector and the needs of new NP graduates.
3. Include NPs in all new graduate and professional practice support policies moving forward.
4. Require that any new proposal for NP funding include a plan for mentorship and other relevant supports for novice NPs. This should include both inter and intra professional mentorship supports.
5. Include NPs in projects funded through the *Interprofessional, Mentorship, Preceptorship, Leadership and Coaching Fund*.

Promoting Integration of NPs into Health Care Teams

6. That the MoHLTC Interprofessional Practice Secretariat include in the interprofessional care blueprint the creation of an on-line "best practice" clearinghouse of resources and information on team collaboration. This recommendation is not unique to NPs, but rather is meant to provide a trusted source of current information on interprofessional practice for all health professions.
7. Include NPs in projects supported by the *Interprofessional Health Education Innovation Fund*, in efforts to enhance interprofessional education in both basic and continuing education programs and that the Nursing Secretariat monitor the outcomes of projects funded through the innovation fund. If NPs are not included in funded initiatives, the Nursing Secretariat to identify other opportunities to ensure this objective is met.
8. That the MoHLTC request that NPAO develop, and present for consideration, a proposal to establish an on-line best practices information clearinghouse specific to the NP role, with a link to the interprofessional clearinghouse proposed in Strategy # 6.
9. Incorporate relevant steps outlined in the CNPI Integration Toolkit as requirements in the application process for organizations applying for NP funding.
10. Provide one-time start up funding to cover orientation costs in new NP funding programs.

Promoting Effective Utilization of NPs

11. That the Minister take action to amend the *Schedule of Benefits for Physician Services* to recognize the NP as a direct referral source for which specialists can claim a consultation fee from the Ministry.
12. That the Ministry review existing accountability mechanisms to ensure appropriate referrals to specialists from all referral sources, including NPs.
13. Recognizing the accountability of regulated health professionals to practice within their individual scope and area of competence, draft legislation that provides members of the Extended Class the authority to:
 - i) order diagnostic or laboratory tests available in Ontario; and
 - ii) prescribe drugs approved in Ontario.
14. Support CNO's commitment to:
 - i) Adapt its quality assurance program to include assessment and feedback mechanisms (both generally and individually) in regard to NP practices related to ordering diagnostic tests and prescribing drugs.
 - ii) Develop a Standard for RN(EC)s that clarifies the basic principles of appropriate prescribing and the regulatory framework that governs prescribing practices.
15. The Ministry to use the best practices clearinghouse (Strategies #6, 8) as a mechanism to promote the further development and collaborative use of best practice guidelines and evidence-based research within practice settings.
16. Develop monitoring systems for all prescribers in order to create a profile of trends and issues to be addressed through quality improvement processes.
17. Repeat the nursing media campaign every six months in order to maintain the public's awareness of the NP role.
18. Provide funding to NPAO to develop a template to assist local agencies in developing pamphlets and other resources to allow them to tailor NP information to their specific needs and priorities.
19. Include in the application process for organizations seeking NP funding in the future the mandatory requirement to articulate their vision and mission statements and team strategy for incorporating the NP role.

Funding Issues

20. Monitor new physician incentives and funding mechanisms to ensure they do not impede NPs from providing comprehensive primary health care services and that the Ministry take corrective action should it become aware of such practice.
21. Consider team-based incentives where groups of providers are remunerated for achieving targets for practices that are known to improve patient outcomes. This practice would be more congruent with efforts to promote interprofessional collaborative practice.
22. Involve relevant provider groups in the negotiation of policies or pilots that could potentially affect their practice, in this case, the MoHLTC's Nursing Secretariat should be engaged in any negotiations that impact NP practice.
23. Similarly, involve relevant provider groups in the implementation of policies or pilots that affect their practice. Consider the development of an 'interprofessional' subcommittee of the *Physician Services Committee* to promote collaboration and to ensure NPs – or other providers, as relevant - are directly involved in planning and implementing initiatives that impact their practice.
24. That the Ministry take action, as soon as possible, on the remainder of the funding-related recommendations in the integration study report to develop a comprehensive policy for a stable funding mechanism for NP positions; and that the policy allow for a review every two years, including inter-jurisdictional comparisons, of salary and overhead allocations to ensure Ontario remains competitive.
25. Commit funding to create and sustain NP positions once clear targets are established for NP positions through appropriate population-based HHR planning.

Health Information Management and HR Planning

26. Explore mechanisms to track relevant information about patient needs and outcomes - both in terms of NPs' individual contributions to care, as well as team based contributions.
27. Collect NP clinical activity data.
28. Include NPs in future IT and electronic medical record initiatives.
29. Involve the Nursing Secretariat in Ministry-wide IT initiatives.
30. Review CNPI's HHR planning model to determine its applicability for Ontario; specifically whether the model can be used or adapted to support NP planning within an interprofessional team-based environment.
31. Provide NPs the opportunity to participate in shaping integrated HHR initiatives through membership on the HHR planning body.

TABLE OF CONTENTS

INTRODUCTION	7
Ontario’s Current Health Policy Context – A Time Of Change	7
Task Team Approach	8
RECOMMENDED STRATEGIES: FIVE KEY AREAS	10
I) Supporting NP Transition to Practice	11
<i>Educational Preparation</i>	<i>11</i>
<i>New Graduates</i>	<i>11</i>
<i>Mentorship</i>	<i>12</i>
II) Promoting Integration of NPs into Health Care Teams.....	13
<i>Collaborative Practice.....</i>	<i>13</i>
<i>Sharing Resources and Best Practices.....</i>	<i>14</i>
III) Promoting Effective Utilization of NPs	15
<i>Referral to Specialists.....</i>	<i>15</i>
<i>Prescriptive and Diagnostic Authority</i>	<i>16</i>
<i>Understanding the NP Role.....</i>	<i>19</i>
<i>Support of the NP Role</i>	<i>19</i>
IV) Funding Issues.....	20
<i>Physician Consultation Fee</i>	<i>20</i>
<i>NP Salary and Benefits</i>	<i>21</i>
V) Health Information Management and HR Planning.....	22
<i>NP Data</i>	<i>22</i>
<i>NP Workforce Planning.....</i>	<i>22</i>
Appendix A	25
Terms Of Reference	25
Appendix B	27
Working Groups – Overview	27
Appendix C	
Recommendations – Overview.....	31

NURSE PRACTITIONER INTEGRATION TASK TEAM REPORT

INTRODUCTION

The Nurse Practitioner (NP) Integration Task Team was established by the Minister of Health and Long-Term Care in November 2004. The mandate of the Task Team was to review, prioritize, implement, or advise on the implementation of the recommendations of *The Integration of Primary Health Care Nurse Practitioners in the Province of Ontario* report. The Task Team's terms of reference are attached as Appendix A.

At the time of releasing the report, the Minister said "We cannot have real primary care reform without NPs. We need to overcome barriers to make NPs full participants in the primary health care team."¹ Establishing the NP Task Team was a significant marker of the Minister's commitment to integrating this role into the Ontario health system.

This report is a summary of accomplishments to date, initiatives in progress, and future steps required to fulfill the Minister's commitment to implement the recommendations of the "integration report".

The term NP as used throughout this report refers to a member of the College of Nurses of Ontario's Extended Class, also known as a Registered Nurse in the Extended Class - RN(EC).

Ontario's Current Health Policy Context – A Time Of Change

Ontario's health system has experienced significant change in the time since the release of the NP "integration report". The number of NPs has increased, as well as the breadth of settings in which they work, now including family health teams, public health units, hospital out-patient units, emergency departments, and long term care homes. Currently, of the 639 RN(EC)s employed in nursing in Ontario², 75.9% indicate that they work in primary health care NP positions. RN(EC)s also report working in acute care nurse practitioner, staff nurse, faculty and public health nurse positions, to name a few. Ministry initiatives that will directly influence the province's NP workforce include:

- ⇒ Creation of *HealthForceOntario*, the province's health human resources strategy – with greater emphasis on team-based health care and integrated health human resources initiatives;
- ⇒ 14 Local Health Integration Networks to begin full operations in April 2007;
- ⇒ 150 Family Health Teams (FHTs) to provide primary health care in communities across the province;
- ⇒ 150 NP education seats, up from 75 two years ago;
- ⇒ Over 20 registered nurses participating in the "Grow Your Own NP" program;
- ⇒ NP led clinic in Sudbury

In recognition of the growing need for NP services, the Minister recently announced his intent to expedite the education seat expansion, exceeding original targets by one year. In addition, new employment opportunities are emerging through FHTs. New NP positions have also been created

¹ Minister of Health & Long Term Care, NP Research & Practice Conference (January 2004).

² College of Nurses of Ontario: 2006 Membership Statistics Report.

through the government's expansion of Community Health Centres. All of these developments are indicators that more Ontarians will be receiving health services from NPs in the years to come.

Task Team Approach

Given its mandate, the Task Team completed a thorough review and analysis of the twenty-nine recommendations included in the "integration report". It identified and considered separately those recommendations thought to be the primary responsibility of the MoHLTC, either because they were directly related to NP program administration or program funding. Other recommendations were categorized into themes and assigned to one of four working groups to assist in developing options and strategies. An overview of each working group, their mandates and memberships are provided in Appendix B. An overview of the strategies to address other "integration report" recommendations, not highlighted in this document, is included in Appendix C.

This report presents the key strategies recommended by the Task Team within one of five main priorities:

- ⇒ Supporting NP Transition to Practice,
- ⇒ Promoting Integration of NPs into Health Care Teams,
- ⇒ Promoting Effective Utilization of NPs,
- ⇒ Funding Issues, and
- ⇒ Health Information Management and HR Planning.

As part of its review, the Task Team scanned the current environment to identify various initiatives underway directly related to its mandate. Two key initiatives are *HealthForceOntario*, the government's health human resources strategy, and the *Canadian Nurse Practitioner Initiative* (CNPI).

⇒ *HealthForceOntario*

Introduced in May 2006, *HealthForceOntario* is the government's strategy to ensure that Ontario has the right supply and mix of health care professionals to meet current and future population health needs. This strategy is meant to make Ontario the employer of choice in health care. Interprofessional collaboration is the cornerstone of the overall strategy.

⇒ *Canadian Nurse Practitioner Initiative (CNPI)*

In 2005, Health Canada provided \$8.9M under the *National Primary Health Care Transition Fund* to the Canadian Nurses' Association to fund CNPI. The purpose of the investment was to support pan-Canadian efforts to integrate the NP role. A wide range of Ontario stakeholders, including Ministry staff, were included in CNPI's broad consultation process. This level of investment specifically to support integration of the NP role is unprecedented in Canada. Many of CNPI's tools and resources will prove useful to the MoHLTC, stakeholders, sponsoring agencies, and NPs in implementing the recommendations of the integration report. CNPI completed its mandate in June 2006.

These and other positive developments in the health system have contributed to the beginning of a cultural shift, one that the Task Team strongly believes is conducive to a more complete integration of NPs into the health care system. Many of the strategies presented in this report build on initiatives already underway. Other strategies will present unique challenges and will require strong government leadership to see that they are implemented. The Task Team believes that these strategies are vital to and consistent with the government's pledge to integrate NPs into health care.

Further, the Task Team believes that it is in the public interest that the Minister move forward with the strategies presented in this report.

Because the Task Team believes strongly that the strategies presented in this report are vital to the effective integration of the NP into health care, it recommends that the Nursing Secretariat track the implementation of the strategies identified in this report, and that the Task Team reconvene in two years to assess progress. In preparation for that assessment, the Nursing Secretariat has agreed to commission a nursing Doctoral student to develop an evaluation strategy in the Spring of 2007. Further, the Task Team sees the need for additional educational opportunities to accompany the government's efforts to create new employment opportunities for NPs. It recommends that the Nursing Secretariat monitor trends in new practice areas for NPs and work with the Council of Ontario University Programs in Nursing (COUPN) to develop priorities for NP continuing education programs.

RECOMMENDED STRATEGIES:
FIVE KEY AREAS

I) Supporting NP Transition to Practice

Educational Preparation

Consistency in educational preparation promotes confidence in the role and qualifications of the NP both within the health sector and among the public at large. It also is important to NP credibility and mobility. The *Canadian Nurse Practitioner Initiative (CNPI)* recommends that NPs graduate at the master's level and that all provinces strive to meet this standard by 2010. The majority of NP programs in Canada (18/23) currently are at the master's level.

The Task Team supports efforts to move the current *Ontario Primary Health Care Nurse Practitioner Education Program* to the master's level and sees it as essential for making Ontario competitive with other jurisdictions. The integration study found a large proportion (54%) of NPs felt educationally unprepared when they first started practicing, this dropped to 14% when they were asked if they currently felt educationally prepared. Forty-seven percent of those who felt educationally unprepared in the early stages of their practice indicated that Masters level education would have addressed this issue.

Ontario has an aging population. There are more people living longer with higher incidences of chronic illness and co-morbidities. There is growing recognition of how physical and social environments impact health, and greater attention paid to mental and emotional wellbeing – in addition to physical health. Advances in biotechnology and best practices are rapid. All of these realities point to the conclusion that Ontario's population health needs – and the health care environment - are increasingly complex. Masters level education will better prepare NPs for managing the realities of patient care in such a system. NP education requires greater emphasis in the areas of research, theory, evidence-based practice, ethics, and health and social policy, to prepare NPs for advanced clinical experience. Masters preparation may also provide learners with a longer clinical practicum that NPs have said is necessary for their educational preparedness and will further support their ability to transition to practice post-graduation.

To ensure graduates are equipped with the competencies required for practice, the Council of Ontario University Programs in Nursing (COUPN) is taking steps to change the current NP Education Program from a post-baccalaureate certificate to a Masters degree. This includes a proposal to the Pan-Canadian Coordinating Committee responsible for reviewing requests to change entry to practice credential for health professionals.

Recommended Strategy

1. Support efforts to change Ontario's Primary Health Care Nurse Practitioner Program from a post-baccalaureate certificate to a Masters degree. This will better prepare NP graduates for practice and make Ontario more competitive with other jurisdictions.

New Graduates

Every health professional needs support to ease the transition from a student role into practice - from novice to expert. This is becoming increasingly important for Ontario's NP workforce. As education seats have doubled, there are more new NP graduates entering the system than ever before.

The Task Team notes that the government has begun to recognize the critical role that post-graduate professional practice supports play in promoting retention. Specifically, the *New Graduate Initiative* offers new nurse graduates extended transition periods and the opportunity to consolidate

the knowledge and skills learned in school. NPs have had limited opportunity to participate in this innovative program as it has not been available to primary health care employers, the sector in which most NPs work. The MoHLTC is in a key position to assist the organizations that hire NPs to recognize the unique needs of novice NPs and the supports they require as they transition to more expert practitioners. The Task Team is aware that the degree of support currently varies from one organization to the next.

Another relevant program, the *Nurse Mentorship/Preceptorship Initiative*, was also limited to sectors where a minority of NPs worked (e.g., public health, long-term care, home care and hospitals). This initiative was expanded in 2006 to become the *Interprofessional Mentorship, Preceptorship, Leadership and Coaching Fund*, available to any health care sector employer, professional association, or educational institution in Ontario. These recent changes to the mentorship initiative are a positive step, making it more accessible to NPs in primary health care.

Recommended Strategies

2. Expand the *New Graduate Initiative* to explicitly include newly graduated NPs working in all sectors. Consider policy modifications to address the unique realities of the primary health care sector and the needs of new NP graduates.
3. Include NPs in all new graduate and professional practice support policies moving forward.

Mentorship

The Task Team recognizes the value of and need for a collaborative relationship between an NP and a physician and acknowledges that a certain degree of mentorship will result from that relationship. The Supporting Interdisciplinary Practice (SIP) project, sponsored by the Ontario Primary Health Care Transition Fund, was designed to support interprofessional collaboration between NPs and physicians working in 117 NP sites. Among the outcomes of the three-year project, completed in 2006, was the development of a mentoring support system including a mentor training workshop and tools, and orientation workshops. This project offers an example of mentorship support that may ease NP transition from novice to expert.

Notwithstanding the value of the NP/physician collaborative relationship, it is important to recognize that the NP scope of practice is unique and different from that of a physician. Therefore, the Task Team sees the need for intraprofessional setting-specific mentorship - NP to NP - in addition to the collaborative relationship with a physician. In order to build and foster mentorship among NPs, the Task Team favours such initiatives as the development of preceptor/mentor recognition programs, identification of NP champions and leaders for mentorship, and development of a mentorship toolkit and clearinghouse of mentorship resources.

Recommended Strategies

4. Require that any new proposal for NP funding include a plan for mentorship and other relevant supports for novice NPs. This should include both inter and intra professional mentorship supports.
5. Include NPs in projects funded through the *Interprofessional Mentorship, Preceptorship, Leadership and Coaching Fund*.

II) Promoting Integration of NPs into Health Care Teams

Collaborative Practice

In Ontario and nationally, there has been a significant cultural shift towards collaborative interprofessional practice in health care. This is evident in the educational system, the health service delivery system, the regulatory system, as well as within governments. Some of the initiatives underway that illustrate this shift include:

- ⇒ The *Interprofessional Education for Collaborative Patient Centred Practice* initiative, established in 2003 by Health Canada, which has resulted in a \$3.6M investment in Ontario to start building the foundation for true interprofessional education in the province.
- ⇒ The *Ontario Primary Health Care Transition Fund*, which has supported a number of initiatives to promote interprofessional learning and practice. A number of these initiatives have included NPs; for example, the *Supporting Interdisciplinary Practice (SIP)* project, mentioned previously, and the *Working Together in Long-Term Care Project* that focused on the development of resources to help teams work together to improve long-term care for the elderly. One of the resources is a learning module on collaboration for pharmacists, nurses, NPs and physicians in long-term care.
- ⇒ The creation of 150 Family Health Teams - interprofessional teams of health care providers working together to meet the primary health care needs of communities.
- ⇒ Close to \$20M investment through *HealthForceOntario* initiatives, such as the *Interprofessional, Mentorship, Preceptorship, Leadership, and Coaching Fund* mentioned above, and the *Interprofessional Health Education Innovation Fund* which will create new curricula to help encourage collaboration among different health professions working as a team to enhance patient care.

Ontario's current emphasis on integrated HHR initiatives and interprofessional health service delivery is seen by the Task Team as a positive development. Recently, the MoHLTC, the Ministry of Training, Colleges and Universities and the University of Toronto co-hosted a summit on interprofessional care. As a result of the summit, a blueprint for interprofessional care will be developed.

Although developing an NP-specific vision statement was recommended in the "integration report", in the absence of such statements for other providers, it is inconsistent within the current context. Instead, the Task Team advises the Ministry to continue to include NPs as part of the government's broader vision for health care in Ontario. One caveat to this approach is that, because the NP workforce is relatively new and few in numbers, NPs may be overlooked in province-wide initiatives. This risk can be avoided by making a conscious effort to include NPs in opportunities to participate in shaping HHR strategies, such as the blueprint for interprofessional practice.

Recommended Strategies

6. That the MoHLTC Interprofessional Practice Secretariat include in the interprofessional care blueprint the creation of an on-line "best practice" clearinghouse of resources and information on team collaboration. This recommendation is not unique to NPs, but rather is meant to provide a trusted source of current information on interprofessional practice for all health professions.

7. Include NPs in projects supported by the *Interprofessional Health Education Innovation Fund*, in efforts to enhance interprofessional education in both basic and continuing education programs and that the Nursing Secretariat monitor the outcomes of projects funded through the innovation fund. If NPs are not included in funded initiatives, the Nursing Secretariat to identify other opportunities to ensure this objective is met.

Sharing Resources and Best Practices

The Task Team supports wide dissemination of the information and resources developed through investments to date (e.g., Health Canada investments through CNPI, interprofessional education initiatives, Ministry investments through the *Ontario Primary Health Care Transition Fund*.)

Best practices are developed in a range of practice settings. The challenge is in how to communicate and build on them. The Task Team supports the development of a clearinghouse to promote wide dissemination of best practices related to the NP role, including those that promote role clarity within a variety of practice settings. This involves a long-term commitment, including dedication of appropriate resources, to ensure sustainability of the clearinghouse and to keep the resources current.

Recommended Strategy

8. That the MoHLTC request that NPAO develop, and present for consideration, a proposal to establish an on-line best practices information clearinghouse specific to the NP role, with a link to the interprofessional clearinghouse proposed in Strategy # 6.

Health Canada's investment in CNPI has allowed for progress on many "integration report" recommendations that otherwise may not have been possible. One outcome of CNPI was the development of an evidence-based NP Integration Toolkit, which provides step-by-step guidelines to support successful implementation of the NP role. The toolkit provides practical advice, starting with a comprehensive needs assessment, to guide organizations through determining whether they in fact require an NP to meet their population and practice needs. It also includes an evaluation framework that has undergone some preliminary testing.

The Task Team supports broad dissemination of the CNPI toolkit to offer support to organizations seeking to integrate the NP role and believes that it provides the necessary components for meeting a number of the "integration report" recommendations. Therefore, it is key that the toolkit be used.

Recommended Strategies

9. Incorporate relevant steps outlined in the CNPI Integration Toolkit as requirements in the application process for organizations applying for NP funding.
10. Provide one-time start up funding to cover orientation costs in new NP funding programs.

III) Promoting Effective Utilization of NPs

Referral to Specialists

In the “integration report”, NPs identified factors in their practice settings that facilitate and/or create barriers to their ability to fulfill their role. The report identified the issue of health care financing as a key issue, specifically that the fee-for-service specialist can claim a consultation fee under the Schedule of Benefits for Physician Services only when a physician refers the patient. Specialists are not prohibited from assessing a patient who has been referred by an NP, another non-physician provider, or a patient who has self-referred. However, when a specialist sees a patient without a physician referral, he or she is may only claim an assessment fee, which is less than a consultation fee.

Nevertheless, as stated in the “integration report”, over 90% of NPs “refer” patients to specialists. The majority (88%) reported that they write the consult request and the physician signs the note without assessing the patient or discussing the matter with the NP. In these cases, physicians provide their signatures and billing numbers to facilitate the referral. The remainder either refer the patient to the physician who assesses the patient, or discuss the situation with their collaborating physician. A physician-written consult request is the outcome in both situations. The requirement that physicians sign referrals to specialists was seen as unnecessary by both NPs and physicians interviewed in the integration study. They stated that it is time-consuming, inefficient and results in fragmented or duplicated care. NPs confirm that these practices continue to be a barrier to providing their patients with timely access to health care services. Clearly, all of these situations are inconsistent with the government’s goals presented in *Laying the Foundation for Change: A Progress Report on Ontario’s Health Human Resources Initiatives* to ensure effective use of system resources and promote access to appropriate, timely care within a sustainable health care system.

It is well within the NP’s scope of practice to make referrals to physicians. The RN(EC) Standards of Practice state that consultation occurs with a family physician; however, RN(EC)s may consult with a specialist physician if appropriate to the situation and practice setting”³.

The Task Team also notes that the *Physician Schedule of Benefits* does not reflect current realities of interprofessional care and collaboration.

The multidisciplinary working group of the Task Team charged with developing a strategy to address this issue was unable to reach consensus - a clear indication of the sensitivity that surrounds payment matters. In light of the fact that the Ontario Medical Association has indicated it does not support NP to specialist referrals, the Task Team firmly believes that further consultation will not lead to resolution. Rather, it advises the government to take the necessary action to remove the administrative barriers to NPs being recognized as a referral source.

Currently, the *Health Insurance Act* includes the following accountability provision regarding physician referral to specialists.

“The General Manager may request the Medical Review Committee to review the provision of a service by a physician, practitioner or health facility when the service was provided at the request of

³ College of Nurses of Ontario: *Practice Standard: Registered Nurses in the Extended Class* (2005). p 6

another physician and the General Manager is of the opinion that the service was not medically necessary. 2002, c. 18, Sched. I, s. 8 (7).”⁴

The Ministry appreciates that a wide variety of considerations factor into a professional’s decision regarding patient referrals, including practice setting, location, and patient preference. This provision exists to address the potential for significant or severe trends of inappropriate referrals, and to date, has never been used. The Task Team believes that Ministry accountability provisions should be reviewed for applicability to other health professions, in this case NPs.

Recommended Strategies

11. That the Minister take action to amend the *Schedule of Benefits for Physician Services* to recognize the NP as a direct referral source for which specialists can claim a consultation fee from the Ministry.
12. That the Ministry review existing accountability mechanisms to ensure appropriate referrals to specialists from all referral sources, including NPs.

Prescriptive and Diagnostic Authority

Current legislation requires that specific drugs and laboratory tests that NPs may order be listed in regulation. Cabinet approval is required on any changes to the drug and laboratory list. Other diagnostic tests, such as specific x-rays, are listed in legislation - changes to this list require Royal Assent.

In an effort to keep the lists current, the College of Nurses of Ontario (CNO) oversees a process through which new drugs and diagnostic tests may be added. The overall approval process takes well over a year from the compilation of submissions made by NPs to government approval. The multidisciplinary working group charged with exploring this issue concluded that there was little room to increase efficiencies in the existing process. The ‘integration report’ included a recommendation to develop a process to ensure the timely dissemination of information about updates to the list of approved drugs. The Task Team believes that despite the inadequacies of the process to keep the lists current, the processes to disseminate the “updates” are comprehensive.

Ontario’s system for regulating health professionals is based on the principle of self-regulation, the relevance of which was recently re-affirmed by the Health Professional Regulatory Advisory Council (HPRAC). Self-regulation is based on the concept that members of a profession are in the best position to determine entry to practice and ongoing competencies. Regulatory bodies are responsible for setting and enforcing standards of practice for their particular profession, and for having the appropriate quality assurance mechanisms to ensure ongoing competence.

⁴ Bill 171, the *Health Service Improvements Act*, proposes to amend this section, to replace the Medical Review Committee with a new Review Board. If these amendments are passed, the new provision will read:

“If the General Manager is of the opinion that a service performed by a physician, practitioner, health facility or independent health facility is not medically necessary, and that service was requested by another physician, the General Manager may give a notice to the Review Board requesting it hold a hearing to review the provision of the service that was requested.”

The current approach to NP diagnostic and prescriptive authority is inconsistent with the principle of self-regulation. In the case of NP standards of practice, CNO has in place a specific requirement to consult with members of other health professions, including physicians, to develop the lists. The Task Team notes that, in the past, the current process has lent itself to inappropriate stakeholder influence on NP practice that is not in the public interest.

The Task Team believes that the current system of regulating diagnostic and prescriptive authority does not allow for full utilization of knowledge and skills of the NP workforce and has created an unnecessary barrier for NPs and their patients. It results in delays in patient care and system inefficiencies - both in health care and government - and subsequently is inconsistent with the objectives of *HealthForceOntario*. Specifically, due to the timing and length of the drug and laboratory list review processes, there is significant delay in the ability of NPs to conform to clinical practice guidelines because new tests and/or drugs have not yet been included in the lists. This leads to delays in treatment while waiting for a potentially unnecessary physician referral, duplication of service, increased health care costs and/or decreased access to drugs of choice. In addition, the government approval process for the frequently required regulation changes to update the lists requires a policy review, efforts to obtain stakeholder consensus and Cabinet involvement, all of which consume valuable government time and resources. To illustrate the impact of lengthy approval processes, the most “current” NP drug and diagnostic list was approved in 2004, and was based on a 2002 consultation and subsequent submission made by CNO. The College has since submitted lists for 2005 and 2006.

Ontario’s legal framework for NP practice is one of the most restrictive in the country, making it difficult to compete with other jurisdictions⁵. Many other Canadian jurisdictions have introduced more flexible legal frameworks to govern the diagnostic and prescriptive authority of NPs. Ontario’s more restrictive approach will impede its ability to fulfill requirements for mutual recognition agreements with other jurisdictions, which require common practice parameters. In its report⁶, HPRAC outlines the need to update profession-specific acts and to examine whether legislation should be modified to keep pace with new technology and human resource requirements. It also recommends that the individual listing of drugs in regulation be examined for all non-physician professionals with prescriptive authority.

CNO has proposed changes to NP regulation, including a proposal that the drug list be removed from regulation. In its consultation process, CNO received overall positive feedback to the proposal from all stakeholders, with the exception of the Ontario Medical Association. The substantial consultation on this issue has involved emotion, concerns about individual livelihood, and overall resistance to change. These factors distract from the core issue at hand: patient access to timely and appropriate health care services. The Task Team believes that additional consultation on this issue is unlikely to generate new findings.

In considering the recommendations in the “integration report” to consult on improving and streamlining the process of updating the lists of drugs and tests that NPs can order, the Task Team proposes a broader strategy that is more consistent with the MoHLTC’s objectives and with the direction NP practice is taking in other jurisdictions. The recommended strategy removes existing

⁵ Bill 171, *Health Service Improvements Act*, proposes to amend the *Nursing Act*, 1991 to allow for “categories” of drugs to be designated in regulations - in addition to listing individual drugs, which is the current state. The implications of these amendments, including what is meant by “categories”, is unclear to the Task Team.

⁶ HPRAC report pp 76-77 and p 90

restrictions on the drugs and diagnostic tests that NPs may order, accompanied by revisions to CNO's RN(EC) Practice Standard to re-affirm NP practice parameters and quality assurance requirements. The Task Team believes that, ultimately, this approach addresses the spirit of the "integration report" recommendation and will improve patient access to appropriate health care services. However, it requires strong government leadership to implement.

In proposing this strategy, the Task Team wishes to emphasize two important factors. First, the NP educational program courses are geared to enabling future NPs to make patient-centred and evidence-based decisions to optimally manage a wide variety of acute and chronic health conditions across the lifespan. Students are not taught a "list" of drugs and diagnostic tests; rather, the focus is on critical thinking, assessment, problem-solving and decision making skills that are required to assess, diagnose and treat patients. The program also emphasizes the situations that require consultation with a physician.

Second, members of all health professions are required to practice according to their individual knowledge and competency level within their respective scopes of practice, regardless of their actual legal authority. The broad authority given to many of Ontario's health professions assumes this requirement and recognizes that individual scopes of practice, and hence the range of drugs and diagnostic tests that individuals will order, vary widely depending on the needs of the patient population within particular settings.

This key issue must be resolved, not only to address the ability of NPs in primary health care to provide comprehensive care within their scope of practice, but also to create a consistent approach to the regulation of future NPs whose practice will focus on adult and pediatric care and on anesthesia. Listing specific drugs or classes of drugs, laboratory and other diagnostic tests for each stream of practice in regulation is neither practical nor feasible.

Recommended Strategies

13. Recognizing the accountability of regulated health professionals to practice within their individual scope and area of competence, draft legislation that provides members of the Extended Class the authority to:

- iii) order diagnostic or laboratory tests available in Ontario; and
- iv) prescribe drugs approved in Ontario.

This means that specific drugs and diagnostic tests will no longer be listed in regulation and / or legislation, eliminating the requirement for Cabinet and / or Legislative Assembly approvals.

14. Support CNO's commitment to:

- iii) Adapt its quality assurance program to include assessment and feedback mechanisms (both generally and individually) in regard to NP practices related to ordering diagnostic tests and prescribing drugs.
- iv) Develop a Standard for RN(EC)s that clarifies the basic principles of appropriate prescribing and the regulatory framework that governs prescribing practices

15. The Ministry to use the best practices clearinghouse (Strategies #6,8) as a mechanism to promote the further development and collaborative use of best practice guidelines and evidence-based research within practice settings.

16. Develop monitoring systems for all prescribers in order to create a profile of trends and issues to be addressed through quality improvement processes.

Understanding the NP Role

The government recently completed a media campaign in collaboration with the Registered Nurses' Association of Ontario, the Registered Practical Nurses' Association of Ontario, and the Ontario Nurses' Association to raise public awareness of the variety of roles that nurses play in our health care system. NP roles were featured in the television and print ads. As more NPs enter the system, more Ontarians will be accessing primary health care services from NPs who are part of interprofessional teams. Although information about the teams is available, the Task Team believes that more specific information is required to educate patients about the role NPs will fill within their community.

Recommended Strategies

17. Repeat the nursing media campaign every six months in order to maintain the public's awareness of the NP role.
18. Provide funding to NPAO to develop a template to assist local agencies in developing pamphlets and other resources to allow them to tailor NP information to their specific needs and priorities.

Support of the NP Role

The Ontario government currently funds over 400 NP positions through a variety of program areas. To ensure the appropriate and effective use of the NP role, the Task Team advises the Ministry to require that organizations seeking funding articulate their vision and mission statements and team strategy for incorporating the NP role.

Recommended Strategy

19. Include in the application process for organizations seeking NP funding in the future the mandatory requirement to articulate their vision and mission statements and team strategy for incorporating the NP role.

IV) Funding Issues

Physician Consultation Fee

The *NP Consultation Fee Pilot Project*, included in the 2004 Physician Services Agreement, begins to address the “integration report” recommendation that the MoHLTC remunerate physicians for consultation and collaboration with NPs with whom they have established formal collaborative relationships. At the end of the project in October 2007, an evaluation is planned that will identify the amount of time that NPs and physicians are spending in consultation and collaboration, and the associated benefits of this collaboration. This information will assist the MoHLTC in determining the appropriate level of remuneration for physician consultation and collaboration services provided to NPs. Overall, the Task Team recognizes the pilot project as a good start in remunerating physicians for the time spent in collaboration. However, much more is required to align financial incentives with patient and system outcomes the Ministry wishes to achieve.

The Task Team is concerned that there has been no direct NP involvement in the pilot’s development and implementation. The Task Team also is concerned about situations where physicians receive a collaboration fee while also receiving capitation payments – particularly in situations where the NP is the primary provider for the patient.

Other concerns related to funding are not directly associated with the *NP Consultation Fee Pilot Project*. The implementation of newer physician incentives introduced through the FHT Initiative has raised philosophical concerns among Task Team members. Specifically, some of the funding policies undermine progress in achieving NP integration and are inconsistent with Ministry objectives regarding appropriate HHR utilization. They also are inconsistent with the spirit of interprofessional collaboration. Examples include situations in which NP procedures are counted towards physician volumes and associated bonuses, and the subsequent expectation at some sites that NPs focus their practice on specific procedures that will generate volume incentives for physicians, rather than provide comprehensive patient care.

Recommended Strategies

20. Monitor new physician incentives and funding mechanisms to ensure they do not impede NPs from providing comprehensive primary health care services and that the Ministry take corrective action should it become aware of such practice.
21. Consider team-based incentives where groups of providers are remunerated for achieving targets for practices that are known to improve patient outcomes. This practice would be more congruent with efforts to promote interprofessional collaborative practice.
22. Involve relevant provider groups in the negotiation of policies or pilots that could potentially affect their practice, in this case, the MoHLTC’s Nursing Secretariat should be engaged in any negotiations that impact NP practice.
23. Similarly, involve relevant provider groups in the implementation of policies or pilots that affect their practice. Consider the development of an “interprofessional” subcommittee of the *Physician Services Committee* to promote collaboration and to ensure NPs – or other providers, as relevant - are directly involved in planning and implementing initiatives that impact their practice.

NP Salary and Benefits

The “integration report” recommendations include that the MoHLTC oversee the development of a policy for a stable funding mechanism for NP positions, develop guidelines for sites to use in relation to salary equity, develop a plan to align salaries between newly funded positions and current positions, develop a long-term plan for funding to account for cost of living and other increases, and re-examine the amount allocated to sites for overhead costs to ensure comprehensive and appropriate coverage.

In November 2005, the Ministry addressed one aspect of this recommendation with its \$2.2M investment to align funding of “older” NP sites to reduce salary disparities. The investment applied to 129 positions across the province to correct historical inequity across program areas and to set the stage for a future coordinated funding approach. The Task Team identifies the funding alignment announcement as a positive first step. However, ongoing funding issues and pressures persist across the province. Both NPs and their employers have reported that current funding levels are unrealistic, do not keep pace with growing costs, and fail to promote fair NP remuneration. In some cases, RN salaries are now exceeding NP salary rates, and there have been anecdotal reports of NPs returning to RN positions that offer fairer wages. It is evident that there still is not a sustainable funding policy in place to ensure longer-term retention of NPs.

Recommended Strategies

24. That the Ministry take action, as soon as possible, on the remainder of the funding-related recommendations in the integration study to develop a comprehensive policy for a stable funding mechanism for NP positions; and that the policy allow for a review every two years, including inter-jurisdictional comparisons, of salary and overhead allocations to ensure Ontario remains competitive.
25. Commit funding to create and sustain NP positions once clear targets are established for NP positions through appropriate population-based HHR planning.

V) Health Information Management and HR Planning

NP Data

Three recommendations of the “integration report” centred on the need for information and collection mechanisms regarding NP human resources and activity. The Task Team believes that NP data collection should support four key objectives:

- ⇒ health service delivery planning,
- ⇒ health human resources planning,
- ⇒ MoHLTC accountability requirements, and
- ⇒ research.

It is unclear if the data collected to date are meeting these objectives, and NPs themselves are unclear on how the information they report is being used, if at all. NP reporting compliance has been a long-standing issue. The Task Team believes that the lack of information technology supports has contributed to this issue. To date, Ministry financial support for IT and electronic medical records in primary health care has failed to routinely include NPs. A positive first step was taken in 2006 when the *Primary Care NP Program* provided one-time funding in the amount of \$5,000 to each NP position to purchase information technology deemed necessary by the sites.

The Task Team suggests that any major activity on these recommendations be postponed until the Ministry has fully established the health information and data requirements needed to support HHR planning and primary health care delivery. The Task Team further suggests that the Ministry pursue these recommendations within the context of broader health information and data initiatives already underway and anticipated.

Recommended Strategies

26. Explore mechanisms to track relevant information about patient needs and outcomes - both in terms of NPs’ individual contributions to care, as well as team based contributions.
27. Collect NP clinical activity data.
28. Include NPs in future IT and electronic medical record initiatives.
29. Involve the Nursing Secretariat in Ministry-wide IT initiatives.

NP Workforce Planning

While there is support for piloting new models of health care delivery that include NPs, the Task Team would like to see an end to the practice of conducting pilot evaluations of the role itself. The NP role should become a permanent consideration in HHR planning.

As part of *HealthForceOntario*, the Ministry will develop a strategy for integrated HHR planning province-wide. This includes the establishment of an external HHR planning body. In addition, CNPI has developed a population health needs based simulation model that is available for provinces to use to support their NP workforce planning efforts. The Ministry and Ontario stakeholders were involved in the development of this model which can be used for primary health care NP planning in community health services in both rural or urban settings, emergency departments and long-term care homes. The Task Team supports Ontario’s current efforts towards

integrated HHR planning. At the same time, CNPI's planning model presents a unique opportunity for Ontario.

Recommended Strategies

30. Review CNPI's HHR planning model to determine its applicability for Ontario; specifically whether the model can be used or adapted to support NP planning within an interprofessional team-based environment.
31. Provide NPs the opportunity to participate in shaping integrated HHR initiatives through membership on the HHR planning body.

Appendices

Appendix A

Terms Of Reference **Nurse Practitioner (NP) Integration Task Team**

PURPOSE & MANDATE

The Nurse Practitioner (NP) Integration Task Team will be an action-oriented group responsible for developing strategies to integrate NPs in Ontario's health system. The Task Team will provide a forum to review, prioritize, and implement, or advise on implementation of, the recommendations of *The Integration of Primary Health Care Nurse Practitioners in the Province of Ontario* report. Its mandate and membership will be re-visited in one year.

The Task Team's work will support the government's commitment towards "healthier Ontarians in a healthier Ontario", as NP integration is a key component of increasing access to, and improving delivery of primary health care for people across the province. This initiative is consistent with Canada's First Ministers' recent commitment to solve barriers to progress in primary health care renewal.

REPORTING

The Task Team will provide quarterly reports and updates to the Joint Provincial Nursing Committee (JPNC), inviting ongoing feedback to the Task Team.

The Task Team will provide quarterly progress reports to the Minister.

DELIVERABLES

The Task Team will establish short, medium and long term priorities for implementing the report recommendations. The team will determine which recommendations it can implement in the short term, and advise the MoHLTC on medium and longer term priorities. This may include resolving outstanding issues impacting successful implementation, and/or establishing processes to eliminate the barriers to NP integration identified in the report.

At the conclusion of its mandate, the Task Team will submit a draft report to JPNC, summarizing its activities and recommendations, including recommendations for the evaluation and inviting feedback prior to submission of the final report to the Minister.

MEMBERSHIP

The Task Team is comprised of seven members, appointed for their expertise and knowledge of the issues. Members were invited to participate by the MoHLTC and were nominated by various stakeholder organizations. Only members may attend meetings and not assign substitutes / proxies. The process for any member needing temporary leave will be decided by the Task Team on an ad hoc basis.

Co-Chairs

Sue Matthews, Provincial Chief Nursing Officer

Alba DiCenso, Professor McMaster University, Canadian Health Services Research Foundation (CHSRF)/Canadian Institutes for Health Research (CIHR) Chair in Advanced Practice Nursing

Members

Theresa Agnew, Chair, Nurse Practitioner Association of Ontario
 Ken Hook, Family Physician, Tavistock Family Health Network
 Anne Coghlan, Executive Director, College of Nurses of Ontario
 Chris Edwards, Community Member
 Robert Watson, Community Member

Secretariat, communications and policy support from the Nursing Secretariat, MoHLTC.

STRUCTURE

The Task Team will establish working groups to address the following four categories, which flow from the report's recommendations .

1. funding and allocation
2. scope of practice
3. human resource planning and education
4. communications and public education.

MEETINGS

- The Task Team will meet face to face a minimum of four times a year.
- Other meetings as necessary via teleconference.
- Members cannot assign alternates.
- Quorum of four (must include at least one co-chair) is required for decision making.

BACKGROUND

The Advanced Practice Nursing Strategy was developed by the MoHLTC and announced in April 2002. One of the components of this strategy was to conduct a study that would identify the facilitators and barriers to the full integration of Primary Health Care NPs in Ontario.

A steering committee was formed to guide the research. The committee was co-chaired by Dr. Alba DiCenso (McMaster University Professor, CHSRF/CIHR Chair in Advanced Practice Nursing), and Ms. Gail Paech (Assistant Deputy Minister, MoHLTC). Following approval by the steering committee, the final report was submitted to the former Minister on June 30, 2003. Minister Smitherman released it on January 30, 2004, with an announcement that a task team would be struck to develop the strategies required to implement the recommendations.

Appendix B

Working Groups – Overview

Education & NP Human Resources Working Group

Mandate

The Education and NP Human Resources Planning WG will develop options and strategies to support implementation of the following recommendations:

- #5 Educational institutions, with the support of MoHLTC, to plan opportunities for NPs, physicians and other allied health care professionals to learn about respective roles during professional training.
- #6 Council of Ontario University Programs in Nursing (COUPN), with the support of MoHLTC, to plan for internship opportunities for NPs that build on the basic NP education and recognize the transition from novice to expert. These opportunities should also recognize the differences in skills and experiences across practice settings
- #8 MoHLTC, in collaboration with stakeholder groups, to develop an orientation package for sites funded for an NP. The package could include specific information about NP skill sets and guidelines for education and orientation to the NP role for all members of the health care team.
- #17 MoHLTC to develop a centralized process to maintain current information about funded NP positions.
- #28 MoHLTC and COUPN to review strategies for increasing the educational preparedness of the NPs including longer clinical practica, addition of an internship year, raising the level of the PHCNP educational program to a Master's level, increasing the length of the educational program, and increasing the emphasis on and access to continuing education.
- #29 MoHLTC and COUPN, in consultation with nursing associations, to develop an educational strategy that would respond to the basic and on-going education needs of NPs related to specific primary health care clinical practice areas.

Membership

Ms. Suzanne Doucette (Co-Chair)

Council of Ontario University Program's in
Nursing
NP Co-ordinator

Ms. Mary Woodman (Co-Chair)

Faculty, Queen's University
Nurse Practitioner

Ms. Allison Henry

Acting Manager
Health Professions Regulatory Policy and
Programs Branch
Ministry of Health & Long Term Care

Ms. Monique Wernham

Senior Policy Analyst
Ministry of Training, Colleges, & Universities

Ms. Debbie Lora / Mr. Allen Paul

Grants Officer, Primary Health Care Policy
Development & Program Design
Ministry of Health and Long Term Care

Ms. Gwen Gignac

Regulatory Policy Analyst
Health Professions Regulatory Policy and
Programs Branch
Ministry of Health & Long Term Care

Scope of Practice & Accountability Working Group

Mandate

The Scope of Practice & Accountability WG will develop options and strategies to support implementation of the following recommendations:

- #15 To facilitate planning and monitoring, the MoHLTC to develop with the program areas and selected stakeholders, standard information collection and reporting mechanisms regarding NP human resources and activity. This information could be used to facilitate planning for resource allocation, NP education and to support the development of performance measures.
- #19 MoHLTC and selected partners to develop NP activity benchmarking and disseminate this information to sites with funded NP positions.
- #21 Consistent with the RHPA, MoHLTC to consult with nursing and medical associations and regulatory bodies to develop a review process related to approved drugs NPs can prescribe and laboratory tests that NPs can order. This is intended to improve and streamline the process and ensure inclusion of tests and drugs to manage conditions within the NP's scope of practice.

Membership

Ms. Janet Anderson (Chair)

Manager, Practice
College of Nurses of Ontario

Ms. Anne Resnick

Director of Professional Practice
Ontario College of Pharmacists

Ms. Marilyn Fender

Chair of Practice
Nurse Practitioner Association of Ontario

Ms. Shenda Tanchak

Manager, Policy
College of Physicians & Surgeons of Ontario

Dr. Daniel Way

Physician Consultant
College of Physicians & Surgeons of Ontario

Ms. Allison Henry

Acting Manager
Health Professions Regulatory Policy and
Programs Branch
Ministry of Health & Long Term Care

Ms. Gwen Gignac

Regulatory Policy Analyst
Health Professions Regulatory Policy and
Programs Branch
Ministry of Health & Long Term Care

Ms. Leela Prasaud

Manager, Quality Management, Laboratories
Branch
Ministry of Health & Long Term Care

Ms. Karen Parsons

Senior Policy Consultant, Interdisciplinary
Practitioner Program
Ministry of Health & Long Term Care

Funding Working Group

Mandate

The Funding WG will develop options and strategies to address the following recommendations:

- #13. MoHLTC and hospitals to review the impact of NPs on emergency department volumes and the associated impact on MD positions funded through Alternate Payment Plans.
- #20. MoHLTC to consult with medical and nursing associations in relation to billing rules within Ontario's Schedule of Benefits related to the issue of allowing a specialist to be paid when a referral comes from an NP.

Membership

Ms. Suzanne McGurn (Co-Chair)

Acting Director, Provider Services Branch
Ministry of Health & Long Term Care

Ms. Willi Kirenko (Co-Chair)

President and Board Chair
Nurse Practitioner Association of Ontario

Ms. Joanne Opsteen

Nurse Practitioner
Primary Health Care Nurse Practitioner Program

Mr. Ken Tremblay

President & CEO, Chatham-Kent Health Alliance
Ontario Hospital Association

Dr. Ted Boadway

Executive Director, Health Policy
Ontario Medical Association

Ms. Julie Ingo

Senior Consultant, Provider Services Branch
Ministry of Health & Long Term Care

Ms. Carol Jacobson

Director, Health Policy
Ontario Medical Association

Ms. Laura Offord

Acting Manager
Interdisciplinary Practitioner Program

Communications & Public Education Working Group

Mandate

The Communications and Public Education WG will develop options and strategies to support implementation of the following recommendations:

- #26 MoHLTC, in collaboration with NP stakeholder groups, to develop a public education program about NPs and their role in primary health care. This program will include guidelines and best practices for community education programs about the NP role.

- #27 MoHLTC and NP stakeholder groups to facilitate the development of a best practices information clearing house related to community/organization/health setting education and/or orientation to the NP role. This information should be integrated with other initiatives related to best practices for primary health care delivery.

Membership

Ms. Michelle Clifford-Middel (Chair)

Chair, Political Action
Nurse Practitioner Association of Ontario

Ms. Carol Jacobson

Director, Health Policy
Ontario Medical Association

Ms. Kavita Mehta

Project Analyst, Primary Health Care Policy Development & Program Design

Ms. Sharon Balsys

Senior Communications Advisor
Ministry of Health & Long Term Care

Jane Sanders

Executive Director
Nurse Practitioner Association of Ontario

Appendix C

Nurse Practitioner (NP) Task Team

RECOMMENDATION	DISCUSSION
<p>The Nursing Secretariat to be accountable for facilitating an evaluation in two years time to examine the extent to which the recommendations in this report are implemented and the impact of that implementation.</p>	<p>A PhD student will be commissioned to work with the Nursing Secretariat in developing an evaluation strategy. The Nursing Secretariat will continue to monitor progress on NP related initiatives, including those relevant to the recommendations herein. The Task Team will re-convene in two years to assess progress.</p>
<p>MoHLTC, Council of Ontario University Programs in Nursing (COUPN), stakeholder organizations and associations to develop a joint statement related to the vision for NPs in the province. This vision statement should be broadly disseminated to health organizations, providers and the public.</p>	<p>In <i>“Laying the Foundation for Change: A Progress Report on Ontario’s Health Human Resources Initiative”</i> the Ontario government articulates its vision for health care, which is a “system that helps people stay healthy, delivers good care when people need it and will be there for our children and grandchildren”. Within this vision, the goal for health human resources is to have the “right number and mix of appropriately prepared health care providers, where and when they are needed”.</p> <p>Related to this recommendation, the Ministry provided \$247,200 under the <i>Ontario Primary Health Care Transition Fund</i> to the Nurse Practitioners’ Association of Ontario to develop an “accord” on the NP role in Ontario. This project resulted in a high level “blue print” for the NP role in Ontario – and allowed for visioning around how NPs will contribute to the future vision of health care in Ontario. This group identified a number of characteristics important for a transformed health system of the future, including a focus on: person-centred care; collaborative teams; patient safety; wellness/population health; integration; science and technology; evidence-based care.</p> <p>The blueprint was developed in consultation with key stakeholders – including those from other professional groups. There are clear similarities between the blueprint developed by this group and the government’s vision for health care and HHR.</p> <p>Early in its mandate, the Task Team developed a draft vision statement for NPs and requested feedback from members of each working group, the Joint Provincial Nursing Committee (JPNC), and the Ontario College of Family Physicians (OCFP). Feedback was received from OCFP, JPNC, and some Ministry divisions - and was discussed at length by the Task Team.</p> <p>Ontario’s current emphasis is on integrated HHR initiatives and interprofessional health service delivery – both viewed to be positive developments by Task Team members. There was some concern that an NP specific vision statement, in the absence of such statements for other providers, is inconsistent with this current context. Task Team members also felt confident that current government support for the NP role is self-evident, which was not the case when the recommendations were first written.</p> <p>Instead of an NP vision statement, the Task Team advises the Ministry to continue to include NPs as part of the government’s broader vision for health care in Ontario. This means allowing NPs the opportunity to participate in shaping HHR strategies, such as the blueprint for interprofessional practice, and to ensure that such strategies continue to include NPs.</p>
<p>MoHLTC to encourage organizations with funded NP positions to articulate their mission, vision and team strategy. This could be a requirement in the proposal process for sites to have a funded NP.</p>	<p>The Ministry currently funds over 400 NP positions through a variety of program areas. The Task Team discussed the option of requiring organizations that have been funded for several years to now develop a mission/vision statement. It was determined that this would create administrative burden for sites. Rather, the Task Team preferred this be considered a requirement on a go forward basis. The NP Task Team advises the Ministry to make this a mandatory requirement in the application process for organizations seeking NP funding in the future.</p>

RECOMMENDATION	DISCUSSION
<p>Educational institutions, with the support of MoHLTC, to plan opportunities for NPs, physicians and other allied health care professionals to learn about respective roles during professional training.</p>	<p>The NP Task Team is pleased to see that the integration report was ahead of its time, recommending strategies regarding interprofessional education, which has since become a priority for all providers. This recommendation, along with key strategies for its implementation, are discussed fully in the main report.</p> <p>More broadly, in 2003, Health Canada established the <i>Interprofessional Education for Collaborative Patient Centred Practice</i> initiative. This program has resulted in a \$3.6 million investment in Ontario to start building the foundation for true interprofessional education in the province. Ontario projects are listed below.</p> <p><i>Queen's University Interprofessional Patient-Centred Education Direction (QUIPPED)</i> The QUIPPED project seeks to create an inter-professional educational (IPE) environment at Queen's that enhances the ability of learners and faculty to provide patient-centred care, while recognizing the contribution of the health care team within a respectful and collaborative framework. Specifically, the project aims to demonstrate and promote the benefits of IPE for collaborative patient-centred practice, increase the number of faculty prepared to teach from an inter-professional patient-centred perspective and expand the number of health professionals trained for collaborative practice, among other things, with a view to forming an academy of interprofessionalism. NPs are included in the QUIPPED project</p> <p><i>The Institute of Interprofessional Health Sciences Education.</i> This project's goal is to facilitate interprofessional collaboration in educational and practice settings through the use of web and team based learning activities. It is anticipated that the project will build a network of expertise to develop knowledge, skills, and attitudes and promote cultural change in students and clinicians. Project deliverables will include trained faculty to deliver interprofessional education and students who will attain the capacity and skills to practice collaboratively in academic and clinical settings.</p> <p><i>Structuring Communication Relationships for Interprofessional Teamwork (SCRIPT)</i> The SCRIPT program is designed to create a shift in the way health professionals collaborate, by transforming units in hospitals affiliated with the university into interprofessional, collaborative patient-centred practice settings. The program has three integrated components: 1) partnership with health professional leaders; 2) creation of structured communications tools to improve collaborative practice; and 3) professional development of multi-professional faculty teams to promote team building and implementation of communication tools in their clinical teaching units. This project is expected to lay the groundwork for transformational change.</p> <p>Other Investments: <i>Working Together in Long-Term Care Project</i> Funds the development of resources aimed at helping teams work together to improve long-term care for the elderly. Among its resources, the team developed a learning module on collaboration for pharmacists, nurses, NPs, and physicians in long-term care. This project was funded through the <i>Ontario Primary Health Care Transition Fund</i>.</p>

RECOMMENDATION	DISCUSSION
<p>Council of Ontario University Programs in Nursing (COUPN), with the support of MoHLTC, to plan for internship opportunities for NPs that build on the basic NP education and recognize the transition from novice to expert. These opportunities should also recognize the differences in skills and experiences across practice settings</p>	<p>This recommendation, along with key strategies for its implementation, are discussed fully in the main report.</p> <p>In addition, in March 2006, the Nursing Secretariat funded the Council of Ontario University Programs in Nursing (COUPN) to conduct a stakeholder forum to discuss this recommendation. The initiative was led by the NP Education Working Group. COUPN convened two forums to discuss interprofessional clinical practice opportunities for NP learners and the development of a mentorship resource to address the needs of novice NPs beginning clinical practice. Stakeholders included representatives of: nursing, medicine, employers and educators. The sessions produced a range of strategies to help address NP preceptorship and mentorship issues, including:</p> <ul style="list-style-type: none"> - increase emphasis on mentorship as a professional responsibility for all nurses (e.g., include concepts of mentorship in the curricula for NPs); - offer preceptor/mentor recognition (e.g. professional development opportunities, access to library / reference materials, etc); - identify NP champions and leaders for mentorship; - develop a mentorship “toolkit” and clearinghouse of mentorship resources. <p>The Supporting Interdisciplinary Practice (SIP) project is designed for collaborating NPs and family physician partners to support successful development of collaborative NP/FP practices. The project received \$1,635,600 under the <i>Ontario Primary Health Care Transition Fund</i> to support inter-professional collaboration between NPs and physicians working in the 117 NP sites announced in 2003. The project is overseen by five partner organizations comprised of medical and nursing stakeholder groups, post-secondary educators, and experts on collaborative practice. The project is designed to create a mentoring support system for family physicians and NPs; it includes the development of mentor training and orientation workshops and tools to name a few. The materials are based on the structured collaborative practice model developed by L. Jones and D. Way. The project was completed in 2006.</p>
<p>MoHLTC to require that funding proposals for NP positions include a needs assessment and clear definition and description of the proposed NP role at that site.</p>	<p>As discussed in the main report, Health Canada provided \$8.9 million under the <i>National Primary Health Care Transition Fund</i> to the Canadian Nurses’ Association to fund the Canadian Nurse Practitioner Initiative (CNPI). One outcome of CNPI was the development of an evidence-based, NP Integration Toolkit, which provides step by step guidelines to support successful implementation of the NP role. Its design was based on the framework for a Participatory, Evidence-based, Patient-focused Process for Advanced practice nursing (PEPPA framework), developed by D. Bryant-Lukosius and A. DiCenso, as well as on a Results-Based Logic Model for Primary Health Care developed by D. Watson, A.M. Broemeling, R. Reid, and C. Black for the Centre of Health Services and Policy Research. The Toolkit provides practical advice, and starts with a comprehensive needs assessment to guide organizations through determining whether they in fact require an NP to meet their population health and practice needs, or if perhaps another type of provider is required. It also includes an evaluation framework that has undergone some preliminary testing.</p>
<p>MoHLTC, in collaboration with stakeholder groups, to develop an orientation package for sites funded for an NP. The package could include specific information about NP skill sets and guidelines for education and orientation to the NP role for all members of the health care team.</p>	
<p>NPs to be included by the funded sites in defining their role and level of autonomy, taking into consideration their skills and experience as part of the introduction of the NP into the practice setting.</p>	
<p>NP role definition to be reviewed and updated by sites funded for an NP on an annual basis or as needed to ensure patient needs, other team members’ roles and practice focus are aligned.</p>	

RECOMMENDATION	DISCUSSION
<p>Practices creating an NP role for the first time to be given one-time funding from the MoHLTC to support the costs associated with orientation, role definition, team building exercises and conflict resolution. Knowledge created through this process should be transferred when other NPs/team members join the practice.</p>	
<p>MoHLTC to work with stakeholders to create a venue/forum for sharing best practices related to team collaboration in sites funded for a NP.</p>	<p>The Supporting Interdisciplinary Practice (SIP) project mentioned above also established a forum for sharing best practices.</p> <p>The Task Team believes that the SIP project provides valuable contributions to collaborative practice in Ontario – and although focused on physician – NP collaboration, could be expanded to include other providers. The SIP project materials could also serve as prototypes for collaborative relationships between other professionals.</p> <p>Strategies for implementing this recommendation are outlined in the main report.</p>

RECOMMENDATION	DISCUSSION
<p>MoHLTC to remunerate MDs for consultation and collaboration with the NP unless the funding mechanism of a setting (e.g., CHC) already includes this remuneration. The MoHLTC and OMA should work to determine the most appropriate rate to be paid to physicians for formal and informal collaboration and consultation with the NP.</p>	<p>As discussed in the report, the 2004 Physician Services Agreement included a new pilot project which outlines monthly payments for physician time spent in consultation and collaboration with certain ministry-funded positions for Registered Nurses in the Extended Class [RN (EC)s]. These funds are to reimburse physicians for the provision of consultative services to a RN(EC)s, with whom the physician has established a formal collaborative relationship.</p> <p>Where the physician practices in a Fee-For-Service or Family Health Group (FHG) setting, or where the physician works in certain primary care models and consults with NPs about patients who are not the physician's or group's rostered patients, a payment of \$800 per month per NP position will be paid to the organization.</p> <p>Where the physician practices in certain primary care models and consults with NPs about the physician's or group's rostered patients, a payment of \$150 per month per NP position will be paid to the organization.</p> <p>The NP Consultation Fee Pilot Project will assess how much time NPs and collaborating physicians spend in consultation and collaboration. The data collected will assist MoHLTC to determine the appropriate level of remuneration for physician consultation and collaboration services provided to NPs. It will also recognize the important contribution of collaborating physicians to the participation of NPs in primary health care delivery.</p> <p>The project will run until October 2007. An external evaluation will be conducted to examine the amount of time that NPs and physicians are spending in consultation and collaboration as well as the associated benefits of this collaboration, using data from the pilot.</p> <p>Some Task Team members express concern that there has been no direct NP involvement in the pilot project. They also express concern in situations where physicians receive a collaboration fee while also receiving capitation payments – particularly in situations where the NP is the primary provider for the patient.</p> <p>Although there have been steps towards implementing this recommendation, the NP Task Team is concerned about newer physician remuneration models. These concerns, and associated strategies are fully discussed in the report.</p>
<p>MoHLTC and hospitals to review the impact of NPs on emergency department volumes and the associated impact on MD positions funded through Alternate Payment Plans.</p>	<p>To date approximately 10-15 NPs are working in EDs across the province. There is preliminary evidence from these sites to suggest that NPs reduce the number of patients who leave the ED without being seen and this may offset their impact on ED volumes. The working group deferred activity on this recommendation because the ministry has since initiated a pilot project to integrate NPs and physician assistants into hospital EDs. This pilot will analyze the existing status of NPs in EDs – including their existing contributions and funding mechanisms. The pilot is expected to end in April 2007, and will provide recommendations for sustainable funding mechanisms for these roles in the EDs on a go forward basis.</p>

RECOMMENDATION	DISCUSSION
<p>To facilitate planning and monitoring, the MoHLTC to develop with the program areas and selected stakeholders, standard information collection and reporting mechanisms regarding NP human resources and activity. This information could be used to facilitate planning for resource allocation, NP education and to support the development of performance measures.</p>	<p>There has been progress in improving the availability of NP information over the past few years. Under the <i>Ontario Primary Health Care Transition Fund</i>, the Ministry provided \$130,600 to the Nurse Practitioners' Association of Ontario to fund the development of an electronic NP registry, the purpose of which is to enable members of the public to search for an NP in their community, as well as to educate the public on the NP role. The registry contains a voluntary listing of 336 NPs (includes acute care NPs) and is currently housed on NPAO's website (www.npao.org). It includes a link to the College of Nurses of Ontario's (CNO) website for verification of current registration with the College. CNO also reports aggregate data for all nurses that may be used to support planning, including demographic data, regional distribution, and practice settings.</p>
<p>MoHLTC to develop a centralized process to maintain current information about funded NP positions.</p>	<p>Health information management plays a key role in the overall governance and administration of the health system. Through the Health Results Team – Information Management (HRT-IM) the Ministry has begun to articulate its health information strategy. In addition, information and data management to support HHR planning will play a key role in the <i>HealthForceOntario</i> strategy. In addition, the Health Professions Advisory Council (HPRAC) has made recommendations to the Minister regarding the data that regulatory Colleges should be authorized to collect from their members, including data that would support HHR planning.</p> <p>The Scope & Accountability Working Group completed an inventory of patient encounter data collected across government funded NP positions. Data are typically collected quarterly. In some cases, reporting tools were developed in consultation with NPs. Patient encounter data typically includes:</p> <ul style="list-style-type: none"> – Number of patient encounters (includes regular clinic hours, extended hours, home visits, visits to patients in LTC homes, hospital visits, phone calls) – Number of patients on waiting list – Average time to appointment (business days) – Immunizations given (number & type) – Screening (e.g. 18th month assessment, routine prenatal/antenatal, etc) (number & type) – Curative diagnosis and treatment visit (number & type) – Rehabilitative care (number & type) – Supportive care (number & type) – Number of consultations with collaborating physician & details (e.g. purpose, outcome) – Number of referrals to: family physicians, rehab professionals, specialists, lab tests, etc (total of 18 categories across all program areas) – Number of referrals from: family physicians, etc.

RECOMMENDATION	DISCUSSION
<p>MoHLTC and selected partners to develop NP activity benchmarking and disseminate this information to sites with funded NP positions.</p>	<ul style="list-style-type: none"> – Details about the nature of consultation – Type of visit (prenatal, well baby, mental health, etc) – Continuing education attended (workshops, seminars) <p>NPs employed by community health centres (CHCs) report differently, according to employer requirements.</p> <p>Specific strategies for implementing these recommendations are outlined in the report.</p>
<p>MoHLTC to identify a co-ordinating body for NP human resources planning and monitoring.</p>	<p>This recommendation, along with key strategies for its implementation, are discussed fully in the main report.</p>
<p>In relation to NP salary and benefits:</p> <ol style="list-style-type: none"> a. MoHLTC to oversee the development of a policy for a stable funding mechanism for NP positions. b. In conjunction with selected stakeholders, MoHLTC to develop guidelines for sites to use in relation to salary equity. c. MoHLTC to develop a plan to align salaries between newly funded positions and current positions. d. MoHLTC to develop a long-term plan for funding to account for cost of living and other increases. e. MoHLTC to re-examine the amount allocated to sites for overhead costs to ensure comprehensive and appropriate coverage. 	<p>As noted in the report, the Task Team identifies the funding alignment initiative as a positive first step. Strategies for implementing the remainder of these recommendations are identified in the report.</p>
<p>MoHLTC to consult with medical and nursing associations in relation to billing rules within Ontario’s Schedule of Benefits related to the issue of allowing a specialist to be paid when a referral comes from an NP.</p>	<p>In the “integration report”, NPs identified factors in their practice setting that facilitate and/or create barriers to their ability to fulfill their role. The issue of health care financing was identified as a key issue. The Task Team’s recommendations are identified in the main report.</p> <p>The multidisciplinary working group of the Task Team charged with developing a strategy to address this issue was unable to reach consensus – a clear indication of the sensitivity that surrounds payment matters. An overview of stakeholder perspectives discussed at the working group table is provided below.</p> <p>NP participants on the working group and Nurse Practitioners’ Association of Ontario (NPAO) report that NPs continue to refer patients to specialists using similar processes identified in the integration report. They also indicate that NPs continue to cite this issue as a barrier in their ability to provide their patients with timely access to health care services.</p>

RECOMMENDATION	DISCUSSION
	<p>The Ontario Medical Association (OMA) does not believe that referral to specialists is the answer to access as we have noted before. The OMA indicates that this continued inference seems to run counter to an interprofessional approach to care.</p> <p>The OMA, represented by an OMA Board member and an OMA staff person suggest that NPs and collaborating physicians can develop local solutions to the issues identified in the study. The OMA also indicates that the physician sample included in the IBM study is not representative of organized medicine. Rather, these physicians have chosen a different style of practice and have a different philosophical approach to the delivery of care, and thus their perspectives and attitudes are often at odds with those of the rest of their medical colleagues.</p> <p>NPAO highlights that there is nothing within the NP scope of practice that prohibits them from making referrals to physicians. According to the College of Nurses of Ontario, “consultation occurs with a family physician, however, RN(EC)s may consult with a specialist physician if appropriate to the situation and practice setting” (RN(EC) Practice Standard, p. 6).</p> <p>The OMA has noted that there is nothing in the College of Physicians and Surgeons that obligates a specialist to taking a referral from a non-physician.</p> <p>The OMA expresses concern about the appropriateness of referrals made by NPs, particularly if referrals are made for problems that could have been treated by the collaborating physician. The association states that this results in the inappropriate use of specialist time, an overall increase in wait times for patients to see a specialist. Bypassing the collaborating family physician will not allow the family physician to work to his/her full scope of practice, and it will result in an increase in cost to the healthcare system. The OMA has adopted a policy that non-physician referrals to specialists should not be permitted.</p> <p>OMA also expresses concern for situations in which the collaborative physician has not been involved in the patient’s care and the NP does not consult him/her in making the specific patient referral, and the specialist may determine a course of treatment for patient care which is within the realm of the primary care but outside of the NP’s scope of practice. Once seen by the specialist, follow up care will be carried out by the provider with the appropriate scope of practice. The OMA is concerned that a specialist may have to continue to provide care for the patient if the referral is directly from the NP.</p> <p>The Ontario Hospital Association (OHA) representative indicates that the status quo is untenable and supports the notion of NP to specialist referrals.</p> <p>All participants emphasize the need for appropriate communication among all three parties involved in the patient’s care: the NP, the primary care collaborating physician and the specialist - at all stages of the referral and subsequent follow-up care.</p> <p>In general, the concerns raised above signal that further information and clarity may be required about:</p> <ul style="list-style-type: none"> • NP practice, including scope of practice and consultation requirements as outlined by CNO; and • the nature of NP-Family Physician collaborative practice, and how this collaborative relationship works – including responsibilities and obligations of the respective partners.

RECOMMENDATION	DISCUSSION
<p>Consistent with the RHPA, MoHLTC to consult with nursing and medical associations and regulatory bodies to develop a review process related to approved drugs NPs can prescribe and laboratory tests that NPs can order. This is intended to improve and streamline the process and ensure inclusion of tests and drugs to manage conditions within the NP's scope of practice.</p>	<p>As noted, changes to the NP drug and lab list require Cabinet approval. Changes to lists of some other diagnostic tests, for example x-rays, require Royal Assent.</p> <p>The College of Nurses of Ontario (CNO) oversees a process through which new drugs and diagnostic tests may be added to the list. The process is outlined below.</p> <ol style="list-style-type: none"> 1. RN(EC)s (sometimes in collaboration with physician partners) and/or the Nurse Practitioner Association of Ontario may submit a change request form to the CNO. They must provide a rationale for the proposed change and a summary of the evidence/best practice guidelines. 2. An expert panel of RN(EC)s, physicians, pharmacists, and educators review the list of proposed amendments in light of current evidence, best practice, and applicability to RN(EC) practice realities and settings. 3. The CNO circulates the expert panel approved list to a broad range of stakeholders (listed below), for feedback. In addition to receiving written responses, the CNO hosts a stakeholder consultation session to discuss the proposed changes. A summary of decisions and discussion points are sent back to stakeholders for validation. 4. Proposed amendments are published on the CNO website and quarterly journal and members are given 60 days to submit feedback before the list is sent to Council for approval (the 60-day circulation period is required by the <i>Regulated Health Professions Act, 1991</i> for regulatory amendments proposed under the <i>Nursing Act, 1991</i>, such as proposed drug amendments; this process is also used by the CNO to obtain feedback for other proposals concerning prescribing/diagnostic authority). 5. Feedback is collated and reviewed by the expert panel. This may result in changes to the list. Final recommendations are proposed to the CNO Council for approval. 6. The CNO submits Council approved proposals to the Ministry. <p>The overall approval process takes more than one year from the compilation of submissions made by RN(EC)s to government approval. The regulation process within government is very complex. The ministry undertakes a broad review of the proposed regulation to ensure it is consistent with the policy principles and authority set out in legislation. The ministry process usually includes consultation within the ministry or other ministries to ensure that a proposed regulation is aligned with the government's health care agenda or other government commitments.</p> <p>The ministry evaluates a proposed regulation to ensure that the request is within the scope of practice of the profession and the professions' authorized controlled acts, does not establish unintended barriers to registration or professional practice, and most importantly that there are appropriate mechanisms in place to protect patient safety. The ministry also determines what fiscal or other impacts the request may have on publicly funded programs and government services.</p>

RECOMMENDATION	DISCUSSION
	<p data-bbox="1067 207 2548 302">During the review process, requests for additional information or clarification regarding the proposal may take place between the College and the ministry particularly where there is stakeholder disagreement or the proposal negatively impacts on government programs or services.</p> <p data-bbox="1067 337 2502 431">The process includes a full legal analysis and drafting by legislative counsel of the proposed regulation. A proposed regulation must satisfy the legal requirements of the RHPA, the profession specific Act and other statutes depending on the type of regulation.</p> <p data-bbox="1067 467 2540 626">Once all the policy, legal and legislative drafting concerns are addressed, the regulation is then reviewed by the minister and approved by the Lieutenant Governor in Council. The timing of the approval is dependent on the availability of dates to place an item on the government’s agenda for review. A regulation usually comes into force once it has been approved by the Lieutenant Governor in Council and filed with the Registrar of Regulations. All regulations are posted on the government’s website www.e-laws.gov.on.ca within a few days of filing and must be published within one month in the <i>Ontario Gazette</i>.</p> <p data-bbox="1067 662 2403 724">The Task Team notes that the process involves extensive stakeholder consultation, which in the past has lent itself to inappropriate stakeholder influence on NP practice.</p>

RECOMMENDATION	DISCUSSION
<p>Nursing associations to develop a process to ensure the timely dissemination of information to NPs about updates to the list of approved drugs. This list to categorize drugs by name and classification.</p>	<p>Until the issues identified in recommendation 21 have been resolved, there are comprehensive processes in place to disseminate information regarding updates to the drug list that include:</p> <ol style="list-style-type: none"> 1. Upon notification of proclamation of an amendment to the Ontario Regulation 275/94, the College of Nurses of Ontario (CNO) posts revisions of the RN(EC) Drug and Lab List on their website http://www.cno.org/. The CNO notifies the Chair of the Nurse Practitioner Association of Ontario (NPAO) of these revisions. The revisions are published in the CNO's quarterly journal (The Standard), which is received by all nurses who are registered with the CNO. 2. The chair of the NPAO notifies the membership by: <ul style="list-style-type: none"> • posting a message on the NPAO web site message board http://www.npao.org/ with a link to the CNO web site • activating the NPAO email tree which notifies approximately 75% of NPAO members • including a notification in the quarterly NPAO Newsletter (if timely). <p>In the past, NPAO has commissioned the Ontario Pharmacists' Association's Drug Information and Research Centre (DIRC) to develop an information package on new drugs proposed by NPAO and approved to be included on the revised RN(EC) Drug List. This package has included: monographs for news drugs added to the RN(EC) Drug list. DIRC web site: http://www.dirc-canada.org/.</p> <p>The Task Team notes that this is an onerous and time consuming process, made necessary to mitigate the patient safety risks inherent in the current "list-based" system.</p>

RECOMMENDATION	DISCUSSION
<p>MoHLTC, with the appropriate stakeholders and institutions, to develop a process that facilitates the flow of information between care sectors (e.g., hospital, long-term care facility) and allows for NP involvement in patient care as it relates to continuity.</p>	<p>In the “integration report” NPs raised issues during site visits regarding inconsistent access to information about their patients who had been admitted to hospital. Specifically, these limitations were identified where NPs were the main health care provider and were providing essential care to patients who would otherwise not have appropriate access to primary health care. These NPs described barriers associated with not being authorized to admit patients to hospital and with not routinely receiving information about their patients who had been admitted to hospital.</p> <p>The Task Team notes that the latter issue, information sharing across sectors, is not unique to NPs as family physicians also report difficulty in accessing information about their patients following hospitalizations. A number of system changes are underway that may help to address this at local levels within communities – specifically once LHINs are established and operational – they can be charged with ensuring appropriate flow of patient information across sectors and to ensure broad stakeholder input, including NPs, within their planning regions. The Task Team advises that as part of their community integration planning, LHINs take the lead to address cross-sectoral integration.</p> <p>The fact that NPs are not authorized to admit or attend to their patients who are hospitalized continues to pose issues in communities where they are the main primary health care provider and access to the consulting physician is limited. Although the NP is the health provider most familiar with the patient’s health and social history, they are prohibited from contributing to the patient’s care when in hospital. The Task Team recommends that the Ministry amend Regulation 961 under the <i>Public Hospitals Act</i> to permit NPs to admit and treat in-patients.</p>
<p>Nursing and medical associations to disseminate information to NPs, physicians and interested stakeholders about current NP liability coverage and implications for each professional group.</p> <p>In the Fall of 2002, relevant stakeholders, including nursing and medical associations, respective protective agencies and MoHLTC began a collaborative review of the restrictions related to NP liability protection that was resolved in June 2003. It is recommended that the implementation of the outcomes of this review be monitored by the involved stakeholders.</p>	<p>In January 2004, the Canadian Nurse Protective Society (CNPS) voted to increase NPs’ personal, occurrence based (protection extends from date of incident to date of claim), professional liability protection from \$2M to \$5M. This coverage is available to NPs who are members of the Registered Nurses Association of Ontario.</p> <p>In March 2005, the CNPS and Canadian Medical Protective Association issued a joint statement on liability protection for NPs. This statement informs physicians and NPs of their various liability risks.</p> <p>The Task Team believes that these recommendations have been met, and no further action is required.</p>

RECOMMENDATION	DISCUSSION
<p>MoHLTC, in collaboration with NP stakeholder groups, to develop a public education program about NPs and their role in primary health care. This program will include guidelines and best practices for community education programs about the NP role. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 101 and 102, Site Visit Summary, Chapter 6.)</p>	<p>The Public Education & Communication Working Group completed an extensive audit of media campaigns related to the NP role. Over the past several years, there has been substantial investment at both the national and provincial levels to raise public awareness of governments' priorities for the health system. Several of these initiatives include reference to NP contributions to primary health care. CNPI presented the most specific example of a media and public awareness campaign geared specifically to the NP role.</p> <p>The Task Team has identified strategies for addressing this recommendation in the main report.</p>
<p>MoHLTC and NP stakeholder groups to facilitate the development of a best practices information clearing house related to community/organization/health setting education and/or orientation to the NP role. This information should be integrated with other initiatives related to best practices for primary health care delivery. (See Key Findings of Analysis of NP and MD Surveys, Site Visit Summary, Chapter 6.)</p>	<p>This recommendation, along with key strategies for its implementation, are discussed fully in the main report.</p>

RECOMMENDATION	DISCUSSION
<p>MoHLTC and COUPN to review strategies for increasing the educational preparedness of the NPs including longer clinical practica, addition of an internship year, raising the level of the PHCNP educational program to a Master's level, increasing the length of the educational program, and increasing the emphasis on and access to continuing education.</p>	<p>Strategies for implementing this recommendation, as it pertains to basic NP education, are outlined in the report.</p> <p>Consistent with the need for post-graduate supports to assist transition to practice for new graduate NPs, continuing education is also key to support mobility of NPs within Ontario (i.e. across sectors) and is a necessary part of the professional practice development of any health professional. MoHLTC has provided one time funding in previous years to support development and delivery of NP continuing education courses. In 2005/06, COUPN received approximately \$400,000 to administer five courses:</p> <ul style="list-style-type: none"> • Fundamentals in Primary Health Care • Pharmacotherapeutics • Rural and Remote Health • Mental Health • Care of the Older Adult. <p>NPs are also eligible for up to \$1500 tuition reimbursement each year through the Nursing Education Initiative.</p> <p>COUPN also conducted a consultation on the continuing education needs of NPs; key findings included the need for a comprehensive needs assessment of the workforce and environmental scan of existing offerings.</p> <p>The Task Team believes that ongoing support for NP continuing education geared to meeting current and evolving needs of the workforce is required, and advises that the Nursing Secretariat be responsible for working with COUPN to ensure continuing education priorities for NPs are addressed.</p>
<p>MoHLTC and COUPN, in consultation with nursing associations, to develop an educational strategy that would respond to the basic and on-going education needs of NPs related to specific primary health care clinical practice areas.</p>	