NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

Submission to HealthForceOntario (HFO)

Response to HealthForceOntario (HFO) Consultation on Nurse Practitioner Authority to Admit, Transfer and Discharge In-patients

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Response to HealthForceOntario (HFO) Consultation on Nurse Practitioner authority to Admit, Transfer and Discharge In-patients

1. Introduction

The Nurse Practitioners' Association of Ontario (NPAO) is pleased to have this opportunity to provide feedback on the HealthForceOnario (HFO) consultation on amending Reg. 965 under the *Public Hospitals Act* to provide nurse practitioners the authority to admit and discharge hospital in-patients.

NPAO is an interest group of the Registered Nurses' Association of Ontario (RNAO) and represents the professional interests of all Nurse Practitioners in Ontario. Our mission is to achieve full integration of Nurse Practitioners to ensure accessible high quality health care for Ontarians. NPAO represents 1,270 members; about three-quarters of NPAO members are primary health care Nurse Practitioners and the rest are NPs specialized in Adult and Paediatrics care and Registered Nurses enrolled in nurse practitioner programs or who are interested in the role.

NPAO, RNAO and hundreds of Nurse Practitioners have actively participated in the public consultations across Ontario regarding the role and scope of NP practice in recent years. The NPAO has provided submissions and feedback to the Social Policy Committee, Health Minister Caplan and the Health Professions Regulatory Advisory Council (HPRAC)[1]. NPAO has consistently advocated for full integration and utilization of the nurse practitioner role throughout the health care system, to achieve outcomes consistent with government policy agendas.

2. General Comments

The NPAO and its members are encouraged and strongly support the government's efforts to recognize and fully utilize the skills and competencies of Nurse Practitioners (NPs) and support them to work more fully to their scope of practice.

For example, the NPAO welcomes government initiatives to:

- Clarify the controlled acts authorized to Nurse Practitioners (Section 5.1 of the *Nursing Act*).
- Expand NP scope of practice with two new controlled acts:
    1. setting/casting;
    2. dispensing, selling, compounding a drug;
- Remove legislative restrictions on communicating a diagnosis and consultation, prescribing and ordering lab/diagnostic tests and limits on applying forms of energy.
- Enable NPs to treat inpatients (proposed amendments to Reg. 965 under the *Public Hospitals Act*).

[1] http://www.npao.org/statements.aspx

3. Specific Feedback on HFO Consultation on Nurse Practitioner Authority to Admit and Discharge

The NPAO strongly recommends that Reg. 965 under the *Public Hospitals Act* (1990) be amended to provide authority to NPs to admit and discharge hospital in-patients.

It should be noted that while the HFO consultation paper makes reference to the authority to admit, *transfer* and discharge, the *Public Hospitals Act* (PHA) contains sections related to admitting (s.11) and discharge (s.16) only. The PHA does not specifically reference "transfer".

Some of the messages in this NPAO submission refer to "transfer" in order to ensure consistency with the government's consultation questions. In practice, "transfer" is understood to be the discharge of a patient from one health service and admitting to another.

NPAO does not recommend the addition of a new section regarding "transfer" in the *Public Hospitals Act.*

NPAO strongly supports providing NPs authority to admit and discharge hospital in-patients. This submission provides many examples of NP practice experience, in numerous setting across the province, that overwhelming demonstrate that Ontarians will benefit from NPs having the authority admit and discharge. Throughout this submission, stories of their practice experiences underpin and support our position.

Rationale:

These potential amendments to Reg. 965 under the *Public Hospitals Act* are consistent with all key policy agendas of government, including:

- Delivering high quality, safe, patient-centred care;
- Reducing wait times for care;
- Improving access to health care for families;
- Removing barriers to competent practice,
- Promoting the effective and full integration of NPs;
- Optimizing the contribution of all health professionals;
- Supporting effective utilization of health practitioners across the care continuum,
- Supporting innovation and enabling high-functioning, effective interprofessional health care teams;
- Providing access to essential health services in the most cost-effective manner, and
- Using health care resources efficiently.

This authority is also consistent with NPs working to their full scope of practice:

- NPs have the education and competencies to exercise this authority;
- This authority will maximize NPs' contribution to the delivery of accessible, quality health care services to Ontarians.

- NPs are exercising this authority safely in other jurisdictions (some U.S. states, the UK, New Zealand, and Australia).
- In providing authority to NPs to admit and discharge, Ontario would continue to be an innovator and lead Canadian jurisdiction in supporting NPs full integration in the health care system.

NPs not having authority to admit, transfer and discharge restricts their practice and consequently has the following effects on the Ontario healthcare system:

- Fragments the patient experience through the health care system;
- Creates barriers to access and timely treatment for patients;
- Increases wait times for care;
- Creates inefficiencies in patient flow-through and continuity of care;
- Increases length of stay (LOS) in hospitals
- Fails to recognize NP knowledge, skill and judgment to exercise authority to admit, transfer and discharge;
- Reduces effectiveness of interprofessional teams;
- Makes poor use of the services of health care providers ;
- Creates potential legal and risk management concerns within hospital environments;
- Causes unnecessary use of Emergency Department services; and
- Incurs unnecessary costs to the health care system.

4. NPAO Responses to the Consultation Questions

1. Please tell us what you feel are the key issues government should consider regarding NPs admitting, discharging or transferring hospital in-patients. You may wish to comment on each of these activities separately or as a whole.

Providing authority to NPs to admit, transfer and discharge will:

- **Be beneficial to patient care and safety;**
- **Enhance coordination and continuity of health care provided outside the hospital setting (community, long-term care and primary health care settings) and within hospitals;**
- **Make better use the competencies of NPs; and**
- **Promote interprofessional collaboration; and**
- **Make more effective and efficient use of health care resources in Ontario.**

Rationale:

Providing NPs authority to admit, transfer and discharge is consistent with a patient-centred approach to care, will greatly enhance the heath care experience for patients and will make optimal use of health care resources.

Ontario NPs describe current inefficiencies in the Ontario health care system and how authority to admit and discharge would enhance continuity of care and the use of specialists' services:

- *I have an excellent relationship with the doctor that I consult with but we are part of a larger team and 4 different physicians round on my patients. Often, I do not even know when a patient has been admitted, or discharged until days later. This requires me to spend much time tracking down the actual hospital changes/orders. For example, right now I have 2 patients in our 8 bed hospital. One was admitted for a bowel obstruction and one for a GI bleed after being transferred back following treatment in a larger centre. As both are stable, they are being monitored and the bowel obstruction is being assessed by our local surgeon. Thus, their care is really well within my scope but I am unable to provide continuity for my patients.*

Nurse Practitioners also describe how authority to admit and discharge would improve the provision of maternal and newborn care:

- *As an NP providing primary health care in a Family Health Team, I enjoy caring for young families. I frequently provide prenatal care to women during their pregnancy, and then care for their newborn babies. None of the physicians I work with deliver babies, so all of my patients are referred to an obstetrician for care in the 3rd trimester, as well as their intrapartum care. Most of the physicians that I work with do not have hospital privileges, and do not care for their patients in hospital. With the authority to admit and transfer patients I would be able to provide care to my newborn patients in hospital. Because the mothers are under the care of an obstetrician, and because their own family physician does not provide in-hospital care, these healthy babies are being cared for by* paediatricians *while they are in hospital. This is an inappropriate use of resources, and further interrupts the continuity of care that we can provide through primary care*

services. Furthermore, sometimes this even delays discharge, as the paediatrician may not be available to sign-off on the baby's discharge when the mother has been discharged by the obstetrician!

- *I work in a small northern community, population ~ 4,000. As an NP I provide prenatal/ shared care for ~ 40 women a year. Most have to deliver out of town due to lack of MD services but we do provide vaginal delivery service for low risk obstetrics, 10 - 20 a year. I usually attend labour and delivery either as parent support, labour nurse, mentor for new OB nurses or baby attendant depending on staffing. I have hospital privileges and do inpatient rounds but cannot officially admit, write orders or discharge mothers and their babies. I provide follow-up newborn and post partum mother care once they are discharged by the MD. Having the authority to admit, write orders on inpatients and discharge these patients would put the official stamp on services I already provide, would reduce the MD work load and would add to continuity of care.*

An NP providing primary health care to an elderly population describes her experience:

- *I am an NP working in a CCAC and most of my patients are elderly. Hospitals are challenging for these elderly patients who find a sudden move to a new environment difficult. Admission privileges would allow me to facilitate this process to best suit the needs of the client and their family. I could provide a holistic approach to care which consciously considers well established and matured individual patterns of daily living in new and strange accommodations.*

  Being familiar with my patients' habits and complex health histories, I would be a valuable member of the health care team able to offer a unique perspective during periods of deteriorating health. This would aid in early recognition of subtle changes in health status and helping to manage care in a manner that respected the senior's approach to life, health and illness. As a team member in hospital able to actively influence care provision by ordering diagnostics and treatments within my scope, health care would be enhanced. As a team member I would also have an opportunity to learn skills needed to best care for my patients from hospital team members with specialized skills during these required hospitalizations. By discharging appropriately, knowing the home environment, smooth transitions with appropriate follow up could be arranged. The privilege of authority to admit to, order diagnostics and treatments in, and discharge from hospitals facilitates legitimate inclusion of the NP role from the community into hospital and back again and allows for seamless patient centered team building.

Some examples of specific issues regarding authority to admit and discharge government should consider:

<u>Admit</u>

NPs having the authority to admit patients will promote coordinated, continuous care for patients. Currently as NPs must transfer care of the patient to a physician in order for them to be admitted, their admission may be delayed or patients may need to be admitted through Emergency. These processes are cumbersome, inefficient and expensive, disrupt continuity of care and do not make optimal use of health care resources.

An example of how limitations on NP authority may have a negative effect on patient care:

- *Around Christmas last year I unfortunately had to deal with a suicidal patient in my office. This was a patient for whom I was responsible to provide his primary care and that day, while at an appointment with one of our social workers, he divulged suicidal ideation. The social worker then asked me to assess the patient and indeed, he was acutely suicidal and was not able to contract for safety. He was agreeable to hospitalization but given that I cannot complete a form 1, nor admit, I had to transfer this patient to the hospital in the custody of the police to be assessed and admitted by one of my colleagues.*

<u>Discharge</u>:

NPs requiring the signature of a physician to effect transfer (discharge of patient from one health serve and admitting to another) can result in delays in patient care. It does not optimize the skills, knowledge and judgment of NPs to determine appropriate care for their patients and work to their full scope of practice. It is also not an efficient use of NP and physician time and resources.

The requirement for physician sign-off regarding discharge can cause delays that result in longer length of stay (LOS) in hospital than required for patients. This increases costs and may result in beds not being made available to other patients in need. Providing NPs authority to discharge is consistent with and will also optimize recent changes to NP scope of practice regarding prescribing, dispensing and treating.

An NP describes how limitations on authority to discharge may delay transfer of care:

- I work in a hospital managing patients who are medically stable but waiting for transfer to a long term care home. I am unable to directly discharge these patients even though I am fully aware of the comprehensive discharge plan and have actively worked with the patient, family and health care team to develop the plan. When the physician is not available when a bed becomes available, there are unnecessary delays in the transfer.

One member describes how the need for co-signature delayed discharge, blocking a surgery bed:

- *Discharge prescriptions need to be co-signed by the medical director as our limited list does not allow us as NPs to sign off on the scripts. This slows down discharges, one patient on rehab had a discharge delayed last week by 6 hours; this did not allow for a new admission, therefore blocking a surgery bed at the acute care site. In the next few months, there will be change to remove the restrictive drug list that is a barrier to NP practice. Once that change takes place, to truly impact change and address bed wait times NPs need authority to discharge.*

An NP describes current processes that can cause fragmentation of patient care:

- *Based on my current position, once I have been consulted on a medical floor and recommend transfer to our in-patient psychiatry unit, I no longer follow the patient. Often this has led to disruption of care and negative health outcomes. In one case, whereby I had started weaning a patient off a medication (namely, a benzodiazepine which can have negative effects on the elderly), the psychiatrist who took over the care of the*

patient did not continue the weaning process which may have contributed to the patient's subsequent fall. Once consulted, I often follow the patients until they are discharged. I am usually quite involved in the discharge process and often refer to other mental health services. This can help prevent readmission and over- crowding of ER, especially when the family is also provided crisis contact services (often useful in patients with mental health and/or addiction problems).

2. What factors are important for government to think about?

NPs having the authority to admit and discharge will enhance patient care and use of health care resources.

However, in order for NPs to fully exercise the authority to admit and discharge, the government will need to undertake a review of all potentially affected legislation to ensure consistency and avoid unintended barriers to NPs exercising this authority. Hospitals will also need to review and revise policies and by-laws to ensure that there are no impediments to NPs exercising this authority.

This includes but is not limited to:

1. Amending the Schedule of Benefits for Physician Services to recognize the NP as a direct referral source for which specialists can claim a consultation fee[2].(see Appendix 1)

2. Revising related legislation to allow other members of the heath care team (e.g. respiratory therapists, occupational therapists, physiotherapists) to accept direct orders from an NP.

3. Requiring hospitals to review and revise by-laws and/or policies to include NP authority to admit/transfer/discharge and eliminate any unintended barriers to NPs full exercise of the authority.

4. Replace medical advisory committees with interprofessional care committees.

Rationale:

Without specific additional amendments to related legislation and government by-laws and policies, NPs may be unable to fully exercise the authority to admit and transfer hospital in-patients.

Here are specific examples of how facilitating NP referrals to specialists will improve patient care:

- *Presently where I work I have to have a medical directive to refer a patient to the diabetes educator. When I have been between medical directors, I have to discuss this*

[2] See NPAO *Position Statement: Nurse Practitioner Referral to Specialists, attached as Appendix 1 and* recommendations 11 and 12 of the *Report of the Nurse Practitioner Integration Task Team* *http://www.health.gov.on.ca/english/providers/program/nursing_sec/docs/report_task_team_2007.pdf*.

referral with the MD responsible for the ward, request a referral to diabetes educator; only if they agree does the patient get the advantage of an interdisciplinary approach to care. Some physicians do not agree with having patients on the newer insulin regimes and stay with outdated regimes for treating diabetes. We have many patients on our ward with amputations, end stage kidney disease and heart disease, neuropathy and retinopathy due to inadequate treatment and education. They were not treated aggressively to manage their sugars, never sent to a diabetes education team for dietary and medication education. Often they have never seen an endocrinologist. Patients have not been informed of the importance of self management, having the knowledge to care for themselves, understanding the importance of regular blood work, and checkups.

- *Some patients need to see a specialist. One fellow arrived here last week from an acute care site, they were anxious to transfer him here for recovery post Crohn's disease with small bowel perforation, and then he required an ileostomy and a vac dressing (specialized dressing for wounds that are draining copious amounts of discharge). This man did not see a gastroenterologist during his acute stay only the surgeon, I now have to wait to get approval for a referral to a specialist (a gastroenterologist) so we can ensure he is being treated appropriately to heal and not go through the revolving door from sub-acute to home to acute …… this man has not been treated appropriately for years, he needs to see a specialist.*

An NP describes the cumbersome nature of working under medical directives:

- *The process for our patients to be admitted, transferred, and discharged is presently slowed in sub-acute hospital settings as Nurse Practitioners cannot order these acts. Now we need medical directives to be approved by medical director, the medical directors have been changing on a 6-12 month basis. Each time the NP has to wait for the directives to be signed and approved by the medical advisory committee (MAC).*

3. Depending on the competencies of health professionals, activities they may perform may have certain restrictions. Do you have any comments on whether the government should consider any restrictions on NPs admitting, discharging or transferring hospital in-patients?

NPAO does not believe that any restrictions are required to the NP authority to admit, transfer and discharge.

Rationale:

Nursing in Ontario is self-regulated, and governs itself through the College of Nurses of Ontario (CNO). This means that every NP member is responsible for practising in accordance with the standards of the profession, and for keeping current and competent throughout her or his nursing career. The *Regulated Health Professions Act, 1991* and *Nursing Act, 1991*, and their accompanying regulations provide the legislative and regulatory framework for nursing in Ontario[3].

[3] See http://www.cno.org/docs/general/45002_SpectrumService.pdf.

This approach provides the College with the authority to set standards and modify conditions and limitations without requiring legislative change. This will allow Nurse Practitioners to more readily meet patient needs, enable efficiencies in the system and keep pace with changes in the practice environment based on best practices and innovations in science and technology.

An NPAO member reiterates this position:

- *The skills, experience and expertise in practice areas and the standards of practice, (scope of practice) should be the regulating force regarding the ability for NPs to transfer, admit and discharge.*

An NP working in a small town describes how newborn care is within her scope of practice:

- *A premature baby was discharged back to my care from tertiary care centre. I saw her that day and followed her serum bilirubin and weight the next AM. Assessed and determined she required phototherapy. Consulted locum MD on call who agreed to admit her. I wrote up my history including care required in hospital. I had consulted with tertiary care hospital where babe had been discharged from. I visited babe and parents in hospital but could not officially write discharge order. MD did this. I arranged follow up community and in office care with parents. Collaborated with in-hospital care MD. The care of this baby, in and out of hospital, was within my scope as an NP. I can consult with MD as required.*

4. With respect to hospitals, could you tell us what government might need to consider to ensure that NP admit, discharge and transfer runs smoothly? Are there particular areas that need to be considered?

In order for NPs to be able to effectively exercise the authority to admit, transfer and discharge a comprehensive review and revision of related enabling legislation and hospital by-laws and policies will be required. The aim of this should be to identify and eliminate barriers to NPs exercising the new authority and create consistency of practice and policy across the province.

There will need to be communication to and "buy-in" and collaboration from all professions that make up health care teams.

Effective transfer of care will be facilitated when all health organizations and health care professions (including respiratory therapists, occupational therapists, physiotherapists etc.) are able to accept orders from NPs.

Rationale:

There are currently a number of legislative, by-law and policy impediments and inconsistencies that restrict NPs working to their full scope and providing the most efficient and safe client care (see also response to question 3. above).

Nurse Practitioners support promoting and facilitating interprofessional health care:

- *All hospitals in Ontario need to look at their bylaws or regulations and allow interprofessional staff to sit on an interprofessional team, that is the way of the future, the team approach, (family health teams in the community) rather than a one sided look at the issues with medical advisory committees.*

- *Nurse Practitioners need to be able to refer to as well as write orders for the whole interprofessional team including respiratory therapists, occupational therapists, physiotherapists, speech language pathologists, RN, RPNs...as well as diabetes education teams, palliative care teams, pain management teams, geriatric care teams…*

5. What accountability measures should the government consider for NPs with respect to admitting, discharging and transferring hospital in-patients?

No additional accountability measures would be required with respect to NPs admitting, transferring and discharging and hospital in-patients.

Rationale:

NPs are accountable for adhering to the College of Nurses of Ontario's Practice Standards for Nurse Practitioners. If the regulation is amended, the Practice Standards will be revised to reflect the new authority of NPs to admit, transfer and discharge.

It should be noted that providing additional authority to any health professional does not mean that all members of the profession will actually exercise the authority. The Practice Standards for Nurse Practitioners outline professional accountabilities and obligations. As self-regulating professionals, NPs use their knowledge, skills and judgement to exercise authorities within their area of practice.

6. What advice do you have for hospitals and government to help optimize the contribution of NPs to admitting, discharging and transferring hospital in-patients?

Messages:

Amend Reg. 965 under the *Public Hospitals Act* to provide NPs authority to admit and discharge.

Review legislation and hospital by-laws and policies to ensure NPs full and consistent exercise of this authority.

Review the policies of other health care programs and organizations (e.g., CCACs, long term care homes) with regard to barriers that limit the authority of NPs to access service for patients.

Undertake communications to ensure that all members of the interprofessional health-care team are aware of and "buy-in" to the NP authority to admit and discharge to avoid implementation difficulties.

Review and evaluate implementation of new authority to gauge effectiveness, identify challenges, efficiencies achieved and patient outcomes.

Rationale:

NP authority to admit and discharge hospital in-patients will be very beneficial for patients and health care practice settings in Ontario. A coherent, consistent and collaborative approach will ensure that these benefits can be realized.

Review and evaluation of the effects of the exercise of this authority will provide the evidence required for further health care improvements and expansion / full utilization of the NP role.

One Ontario NP who has practised in the U.S. states:

- *I would start my argument by saying that instead of re-inventing the wheel, we can simply look to our neighbours in the U.S. where the evidence is clear in support of the expanded role of the NP which includes the authority to admit, transfer and discharge. It is well documented that NP's decrease LOS, increase access to cost-effective/high quality care, increase medication adherence and patient/family satisfaction, and improve the quality of care in chronic illness management, to name a few. I would propose that if possible, the government support projects implementing these authorities and evaluate their outcomes versus attempting to get approval from all stakeholders.*

7. **What might be the risks and/or benefits for patients of NPs admitting, discharging or transferring hospital in-patients? Could you provide examples?**

There are no risks for patients of NPs admitting, transferring and discharging hospital in-patients.

There are many benefits for patients and the Ontario health care system inherent to NPs admitting, discharging or transferring hospital in-patients.

Rationale:

Ontario patients will derive many benefits from NPs having the authority to admit and discharge. Among these benefits are:

- More efficient use of resources;
- Improved patient access to care;
- Decreased wait times for care;
- Improved coordination of care among community, long-term care, primary care sites and hospitals.
- More efficient in-patient flow-through and continuity of care;

- Better use of physician time and resources (fewer sign-offs required); and
- Reduced costs to the health care system (e.g. less unnecessary use of Emergency Department for admitting, shorter LOS).

NPs have the education, knowledge, skills and judgment to effectively utilize the authority to admit and discharge.

Nurse Practitioners describe the many benefits to patient and the health care system that will result from their authority to admit and discharge under the Public Hospitals Act:

- *Continuity of care: With admission and discharge authority, my patient, who is on multiple medications for heart failure, chronic lung disease and renal failure, will have their health care provider consistently present throughout the care continuum. There will be less medication errors and improved follow up with appropriate care providers, i.e. f/u with chiropodist, or respiratory therapist or an endocrinologist. The NP as most responsible provider will know the patient's whole story and be able to relay appropriate information to the other professionals on the team as well as family members assisting in the care. Less likely for errors and omissions. More patient satisfaction and family too.*

- *Decreased length of stay in acute care beds: I was able to receive with a medical directive a patient from the acute care site with dizziness and early diagnosis of dementia, do a full work up on her, find a proper diagnosis of normal pressure hydrocephalus, get a referral to a neurologist. That is teamwork, it would be even less time consuming of time and energy and use of a hospital bed if I did not need to consult for each step of the process outside the medical directives and my present scope of practice.*

- *Improved coordination of care: Nurse Practitioners working in all settings require the ability to refer, admit, transfer and discharge to assist in the care of their patients in a timely efficient manner. Nurses know how to communicate efficiently and effectively in a manner the patient can understand. Communication with patients, families, and the interprofessional team, is key to a timely treatment plan, discharge or transfer. The health information is transferred effectively to expedite care. This will alleviate many problems for the patient and family and team.*

- *Efficient use of health care resources: We need to use the most appropriate care provider for the most appropriate patients at the most appropriate time to reduce the cost of health care for our ever growing population of patients with chronic diseases.*

- *Improved services to vulnerable elderly population: I have a new job...where I am learning the community sector of the health care system and seeing different clientele - that being "orphaned", frail, house-bound elderly. These are people who disappear from the health care system just when they need it the most. They have a huge variety of chronic diseases which have not been managed. These patients are amongst those that the system has failed...they lack regular primary care providers despite their great vulnerability. So... I spend a fair amount of time organizing their complex medical histories, gathering information from a variety of sources throughout the city and beyond.*

  The primary goals of my involvement are to provide comfort and to maintain function to help these patients maintain their independence and lives in the community as long as

possible. I also want to avoid visits to the Emergency Departments and admissions to hospital as these are difficult both emotionally and physically for those already in fragile states. That being said however, there are times when these patients destabilize and require admissions.

Hospitals are challenging for these elderly patients who find a sudden move to a new environment difficult. Admission privileges would allow me to facilitate this process to best suit the needs of the client and their family. I could provide a holistic approach to care which consciously considers well established and matured individual patterns of daily living in new and strange accommodations. Being familiar with my patient habits and complex health histories, I would be a valuable member of the health care team able to offer a unique perspective during periods of deteriorating health. This would aid in early recognition of subtle changes in health status and helping to manage care in a manner that respected the senior's approach to life, health and illness.

As a team member in hospital able to actively influence care provision by ordering diagnostics and treatments within my scope, health care would be enhanced. As a team member I would also have an opportunity to learn skills needed to best care for my patients from hospital team members with specialized skills during these required hospitalizations.

By discharging appropriately, knowing the home environment, smooth transitions with appropriate follow-up could be arranged. The privilege of authority to admit to, order diagnostics and treatments in, and discharge from hospitals facilitates legitimate inclusion of the NP role from the community into hospital and back again and allows for seamless patient centered team building.

5. Summary of NPAO Recommendations to HFO Regarding Nurse Practitioner Authority to Admit and Discharge Hospital In-patients.

NPAO recommendations:

1. **Amend Reg. 965 under the *Public Hospitals Act* (1990) to provide authority to NPs to admit and discharge hospital in-patients.**
2. **Do not add a section regarding "transfer" to the *Public Hospitals Act.***
3. **Do not impose restrictions or specific additional accountabilities to NP authority to admit and discharge.**
4. **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.**
5. **Revise related legislation to allow other members of the heath care team (e.g. respiratory therapists, occupational therapists, physiotherapists) to accept direct orders from an NP.**
6. **Require hospitals to review and revise by-laws and/or policies to include NP authority to admit and discharge and eliminate any unintended barriers to NPs full exercise of the authority.**
7. **Review the policies of other health care programs and organizations (e.g., CCACs, long term care homes) with regard to barriers that limit the authority of NPs to access service for patients.**
8. **Consider replacing medical advisory committees (MACs) of hospitals with interprofessional care committees.**
9. **Undertake communications to ensure that all members of the interprofessional health-care team are aware of and "buy-in" to the NP authority to admit and discharge to avoid implementation difficulties.**
10. **Review and evaluate implementation of new authority to gauge effectiveness, identify challenges, efficiencies achieved and patient outcomes.**

6. Concluding Remarks

Nurse Practitioners have been the subject of many reports and reviews in recent years. In the first decade since the nurse practitioner was regulated, in addition to HPRAC referrals, there have been many projects commissioned by the Ministry of Health and Long-Term Care specific to Nurse Practitioners and a number of Ministry-funded projects focusing on interprofessional teams with Nurse Practitioners taking integral roles. The multiple reports published through the Canadian Nurse Practitioner Initiative represent further review and analysis of Ontario's Nurse Practitioners at a national level. In addition, numerous federal and provincial health system and health human resource studies have identified multiple health system issues and recommended the need for broad integration of Nurse Practitioners into our health system in order to improve the provision of health care services.

What these reports all have in common is the following:

- A recognition of the added value of the role of Nurse Practitioners in our health care system and the impact the NP role has in addressing multiple health system agendas including reducing wait times, increasing access to care, promoting continuity of care and implementing effective strategies to manage and prevent chronic diseases.

- An identification of legislative, regulatory and policy barriers which limit the scope of NP practice, reduce the effectiveness of interprofessional teams and contribute to fragmentation of patient care and health system inefficiencies.

- Recommendations that call for specific actions to remove barriers to enable more efficient and effective utilization of the NP role, support full scope of practice and integrate the NP role in all settings and sectors of the health care system.

In summary, abundant research supports the position of NPAO and its members regarding NP authority to admit and discharge. Providing NPs authority to admit and discharge is also highly consistent with the vision articulated in the HPRAC *Critical Links*[4] report that sees Ontario:

> "...working toward a regulatory system that enables each of Ontario's thousands of health professionals to contribute to patient care to the full extent of their training and abilities, to collaborate with each other so that the efforts of all are deployed to produce the best possible results for patients, and to respond with up-to-date skills and a deep sensitivity to the rising expectations of today's health care consumers.
>
> ....the maximization of health human resources through increased interprofessional collaboration and enhanced roles for a range of health professionals will contribute significantly to achieving the Minister's vision and priorities. Health professionals, working together and performing the right tasks at the right time will drive efficient and effective care in both hospital and community settings.
>
> ....Collaboration among professionals can ensure that patient needs are met without interruption and that patients are assured that when they receive care, each professional is aware of what, how and when other health services are being provided and for what

[4] http://www.health.gov.on.ca/english/public/pub/ministry_reports/hprac_08/5_critical_links_200900202.pdf

reasons. It is vital that health professionals who have the know-how to safely do so can perform health services in a way that will improve care and enhance service and convenience to the patient."

As mentioned at the beginning of this submission, NPAO supports the initiatives that government has already undertaken to recognize and fully utilize the skills and competencies of NPs and support them to work more fully to their scope of practice. The clarification and expansion of controlled acts authorized to NPs, the lifting of legislative restrictions and enabling NPs to treat hospital in-patients are all appreciated. The government initiative to open more Nurse Practitioner-Led Clinics[5] is enthusiastically welcomed by the NPAO and its many members.

Providing authority to NPs to admit and discharge hospital in-patients is consistent with these recent government actions. Providing NPs this authority will facilitate the provision of accessible, timely, high-quality, seamless health care for Ontarians in many practice setting across the province. The benefits of other recent government initiatives to fully integrate and utilize NPs will be augmented and more fully realized when NPs also have the authority to admit and discharge.

NPAO is committed to continuing dialogue and consultation with the Ontario government regarding all legislative and regulatory changes affecting Nurse Practitioners in the Ontario. If required, NPAO would welcome the opportunity to discuss with HealthForceOntario the recommendations contained in this submission.

[5] http://www.health.gov.on.ca/en/news/release/2010/aug/nr_20100823_1.aspx

Appendix 1

NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

Position Statement
Nurse Practitioner Referral to Specialists

The Nurse Practitioners' Association of Ontario (NPAO) supports the development of a patient-centred health care system where Ontarians have access to care from the provider of their choice. NPAO believes that to achieve the objective of improved and streamlined access to care for patients and full integration of Nurse Practitioners in Ontario's heath care system, full referral to specialists by Nurse Practitioners is necessary and desirable.

In a patient-centred system, the focus is on the needs of the patient and providers work in a coordinated, efficient and effective way to provide value for taxpayer dollars. Nurse Practitioners were introduced into the Ontario health care system to help promote this type of system. In this system, health care professionals value, respect and rely on the expertise of all members of the collaborative team. Also, providers are compensated appropriately and there are no financial penalties to limit collaboration. Removal of barriers to provide safe, effective and optimal care is a goal of all NPs in the province.

To achieve this vision, barriers that limit access for patients or restrict health care professionals from providing effective and efficient care, must be addressed. The *IBM McMaster Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario* (NP Integration Report) specifically identified that physician specialists are deterred from accepting direct referrals from Nurse Practitioners by issues of restrictive remuneration.

Schedule of Benefits for Physician Services for Referrals to Specialists
Changes to the Schedule of Benefits for Physician Services are needed to allow physician specialists to claim a consultation fee when patient referrals are made directly by a nurse practitioner. At present, Ontario's Schedule of Benefits - Physician Services (July 2006) outlines a contractual relationship between a referring physician (commonly the family physician) and a consulting physician (specialist). When a written request is made by a family physician for referral to a specialist, the specialist must render the appropriate assessment and communicate in writing his/her findings to the referring physician. The specialist claims a medical specific assessment fee as well as a consultation fee.

Patients can self refer and other primary health care providers, including NPs, can directly refer to a specialist. Without a request from a physician, the specialist can only claim the medical specific assessment fee, not the consultation fee. Consequently, the remuneration to the specialist physician is 24-39% lower than the comparable fees. Further, without the consultant fee there is no requirement for the specialist to communicate a plan of care in writing to the referring provider.

Nurse Practitioner Referrals to Specialists
According to the standards of practice for Registered Nurses in the Extended Class (commonly referred to as nurse practitioners), the College of Nurses of Ontario states that they offer "the full scope of primary health care practice, including consultation with physicians or other health care professionals when the client requires care beyond the RN(EC)'s scope of practice." Further, they are "accountable for establishing a consultative relationship with a physician" and "consultation occurs with a family physician, however, RN (EC) s may consult with a specialist physician if appropriate to the situation and practice setting." No legislative or regulatory deterrent related to scope of practice exist to Nurse Practitioners to refer to specialist physicians.

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The *NP Integration Report* identified that over 90% of NPs refer their clients to specialists. Eighty-eight percent of those who do refer report they write the consultation note and the collaborating family physician allocates their billing number and simply signs the referral. Less than 10% of NPs reported that they refer the patient to the family physician (who sees the patient and writes the consultation note) or have the family physician write the consult note after discussing the matter with the NP (p. 92). These strategies do not promote streamlined access to care nor contribute to an effective and efficient health care system.

System Inefficiencies of Current Practice Patterns

Delays in access to care, inconvenience for patients, lack of respect for self regulation and scope of practice, increased health system costs and duplication of care are just some of the inefficiencies that result because of this barrier. Real stories frequently cited by Nurse Practitioners and physicians provide evidence of the challenges for patients.

For example, Nurse Practitioners see women who desire sterilization. It is within the nurse practitioner scope of practice to make a referral to a gynecologist. To accomplish this, the nurse practitioner must either circumvent the system as outlined previously or create delays in referral by arranging an appointment to an already overburdened family physician that in turn will refer to the specialist. Nurse Practitioners also care for many patients, individuals and families who do not have a family physician. The only option for the patient who needs a specialist referral is a lengthy visit to a hospital emergency department. This is not only inappropriate care but it results in fragmentation when the NP, as a primary care provider, is not in direct communication with the specialist. Both of these examples result in duplication of assessment, unnecessary system costs, delays in access to care, inconvenience for the patient and additional burden for physicians and/or emergency departments.

There are concerns that by removing the current gatekeeping role of family physicians, Nurse Practitioners will make inappropriate referrals (e.g., specialists will be burdened with unnecessary referrals; expertise of family physicians would not be accessed). There is no evidence that this occurs in the current practice in spite of little oversight from collaborating family physicians. The data in the *NP Integration Report* suggests 89.6% of physicians felt the consultations and referrals were appropriate. There are no data to compare with appropriateness of referrals made from family physicians to specialists.

Another frequently cited rationale for maintaining the status quo arises from a limitation of the scope of practice of the nurse practitioner and the suggestion that continuity of care is better in the existing system. The *NP Integration Report* suggests otherwise. In the current model, physicians receive reports for patients they have not necessarily assessed and there are delays in conveying information to the NP as the primary care provider. Timely follow-up with the patient is not achieved. The notion of coordination of care through restrictive policies is not viable.

Collaboration is not achieved through financial restriction and gatekeeping, particularly when data from physicians and Nurse Practitioners in the *NP Integration Report* suggest the majority of providers choose to circumvent the system in an effort to provide care. Rather than create restrictions, encouraging greater dialogue and communication will be the key to successful partnerships among providers as well as enhance timely care for patients.

Rationale to Improve the Current System

The Nurse Practitioners' Association of Ontario (NPAO) position of promoting patient access to specialists is grounded in the principles of improving timely access to health care, inter-professional collaboration, recognition and respect of scopes of practice, supporting patient choice for primary health care provider, quality patient care, and supporting adequate remuneration for the care provided. Four Canadian provinces, Manitoba, Nova Scotia, British Columbia and Alberta, have not placed financial disincentives

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on nurse practitioner referrals to specialists. There are no reports of inappropriate practices in any of these provinces.

Nurse Practitioners are an essential part of the government's plan to deliver better healthcare to Ontarians. To deliver on this goal, we must create a vibrant health sector that responds to patient and community needs. Accepting the status quo does not meet the commitment from government to find ways to "overcome the barriers to make NPs full participants in the Primary Health Care team" nor does it contribute to a transformed health care system.

Nurse Practitioners support improved access to high quality health care for patients and their families. When NPs make referrals to specialists, it is done in collaboration with the team and is based on an assessment with the patient including knowledge of practice interests, preferences, knowledge, skill and experience of all team members. Nurse Practitioners collaborate and consult with physician team members according to the CNO Standards of Practice, and for the benefit of the patient. The most effective healthcare teams are built on the foundation of trust and respect for each others' skills knowledge and expertise. These effective high-functioning teams use a variety of referral patterns and make choices that best meet the healthcare needs of the patient. Enabling specialists to bill for a referral from a nurse practitioner would not alter the existing respectful, supportive and collaborative relationship NPs currently enjoy with physicians and other members of the interprofessional team and would improve access for patients.

Full integration of Nurse Practitioners is one strategy to achieve the goal of making Ontarians the healthiest Canadians. NPAO supports the removal barriers in order to ensure that patients have access to appropriate and timely specialist services and to improve communications among health care providers for the benefit of the patients we serve.

Implementation Strategy as Proposed by NP Integration Task Team
The report of the NP Integration Task Team (March 2007) reiterates much of the discussion included in this position statement. In addition, this report notes:

- The current system is inconsistent with the government's goals presented in '*Laying the Foundation for Change: A Progress Report on Ontario's Health Human Resources Initiatives.'*
- The *Physician Schedule of Benefits* does not reflect current realities of interprofessional care and collaboration.
- There is great sensitivity on issues of payment, with the Ontario Medical Association clearly stating it will not support NP referrals to specialists. Further consultation is not recommended.

The Task Team advises government to take the necessary action to remove the administrative barriers to NPs being recognized as a referral source. It further proposed two recommendations:

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.
12. That the Ministry review existing accountability mechanisms to ensure appropriate referrals to specialists from all referral sources, including NPs.

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