RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Health System Improvements

1. **RNs, NPs and nursing students know that the health system can be improved through:**

- Expanding the mandate of Local Health Integration Networks (LHIN) to include local health system planning, funding allocation, monitoring, accountability and evaluation for all sectors.
- Ensuring that service delivery and service management is a function of service provider organizations - not the LHINs.

Are you on the same page as us?

2. **Research and international reports show that the hallmark of a high performing health system is a robust primary care sector. Ontario lags behind. Do you support the following improvements to build Ontario's primary care sector?**

- Locating the 3,500 CCAC care co-ordinators in primary care.
- Eliminating the compensation gap for primary care NPs.
- Expanding the scope of practice of the RN to include the independent authority to prescribe medications, order diagnostic tests and communicate a diagnosis.
- Expanding the scope of practice of the NP to include prescribing controlled substances, the authority to order all diagnostic imaging (MRI, CT and X-Rays) and initiate an application for psychiatric assessment under the *Mental Health Act*.

Health System Restructuring:

RNAO applauds Ontario's Minister of Health and Long Term Care -- Dr. Eric Hoskins -- for his bold and visionary ideas to change the way health services are delivered.[1] RNAO is also pleased that it was given credit in the minister's blueprint for system change. We are delighted that many of the ideas in RNAO's *Enhancing Community Care for Ontarians* (ECCO),[2] are reflected in the Minister's discussion paper: *Putting Patients First*. The context underpinning the minister's proposals are clear: inadequate access to services, duplication, lower than expected outcomes, inefficiencies, and rising health expenditures. These are challenges that RNAO has been highlighting for years and we are pleased the minister is listening to our call for action.

The minister wants to extend the reach of the Local Health Integration Networks (LHIN) to incorporate all local health service planning and performance management. His proposal also includes the creation of sub-LHIN regions. This proposal is consistent with RNAO's position regarding LHINs in ECCO[3] by placing greater emphasis on integration across all sectors according to population needs and context. Some of the current limitations of LHINs stem from their inability to plan for an entire regional health system, which is similar to an airplane flying with a single wing. One crucial element missing from the

minister's proposal is positioning the LHINs as the single health system funder. To effectively plan and manage performance that produces meaningful integration across the system, LHINs must be able to enter into service agreements with providers across sectors.

RNAO is gravely concerned with reference to the involvement of LHINs with service delivery. It would be inappropriate for LHINs to engage in direct service provision and it is unclear what the proposal's definition of "service management" entails. RNAO urges the ministry not to perpetuate the existing limitations of the CCAC model, which acts as a case management brokerage that allocates hours of service to people in need of care. This type of command and control approach isn't effective. RNAO believes service provision and the management of service, including decisions surrounding service provision at the patient level, should be the focus of provider organizations that have the best understanding of patient need.

Improving Primary Care Capacity:

An effective health system has a strong primary care system as its foundation. Strides have been made to improve primary care capacity, such as attaching Ontarians with primary care providers. However, timely access to primary care services, care co-ordination and health system navigation remain deficient. RNAO believes that the following strategies must be implemented to improve primary care capacity:

1) **Care Co-ordinators in Primary Care**

This ministry is proposing to eliminate the boards of Community Care Access Centres (CCAC) and transition of its functions to the LHINs. RNAO supports this proposal, provided that it entails elimination of the CCAC as a structural entity. RNAO urges the minister to ensure meaningful change takes place and that CCACs are not just re-positioned under LHINs. This is the only way to reduce duplication, improve the integration of services, enhance efficacy and cost-effectiveness.

RNAO also strongly urges that current CCAC care co-ordinators, of which approximately 3,000 are RNs, be located in primary care, with their salary and benefits intact. RNs possess a comprehensive understanding of the health system and a persons' holistic health status, including physical, mental, social, emotional and spiritual needs. Their competencies, knowledge and skill mean they are uniquely suited to lead care co-ordination and health system navigation.

2) **Primary Care NP Compensation Gap**

Primary care NPs have had their compensation frozen for almost a decade. This has created a discrepancy of as much as $20,000 between NPs working in hospitals and CCACs and those in primary care. Nearly 20 per cent of primary care NP positions are vacant. This results in a de-stabilized workforce and limits access to timely, quality primary care for Ontarians.

To achieve the government's goals of putting patients first and improving community care, RNAO is calling on the Ministry of Health and Long-Term Care to make follow through with its commitment made at RNAO's 2015 QP Day to ensure that all NPs receive equitable compensation and benefits.

3) **NP Scope of Practice**

The growth of the NP role in Ontario's health system, including serving as the lead primary care provider for thousands of Ontarians, most responsible provider (MRP) in hospitals, and attending NPs in long-term care homes, demands action when it comes to remaining scope of practice gaps. This will ensure that NPs can continue to deliver safe, timely and effective care. Necessary regulatory changes are urgently needed to authorize NPs to prescribe controlled substances, including methadone and suboxone (harm reduction) and testosterone (support transgendered persons). RNAO is also urging the government to lift restrictions that currently prevent NPs from ordering all x-rays and CT/MRI scans. Lastly, amendments are needed to the *Mental Health Act* to authorize NPs to initiate an application for psychiatric assessment when a person is at risk of harming themselves or others and is suffering from mental/emotional distress.

4) **Independent RN Prescribing**

Compared to other international jurisdictions, RNs in Ontario have in-depth educational preparation (four years) and yet, have not had a formal scope expansion since the entry to practice requirement was changed in 2005. Independent RN prescribing will increase timely access to health services throughout the system. Although the government has committed to making RN prescribing a reality, it is now seeking implementation advice from the Health Professions Regulatory Advisory Council (HPRAC). Independent prescribing refers to a regulation model that is defined by HPRAC as "... [prescribing] medications, under [one's] own authority, without restrictions or from a limited or pre-defined formulary within a regulated scope of practice. Independent prescribers are allowed to prescribe any licensed or unlicensed drugs that are within their clinical competency area. As an independent prescriber the RN would be fully responsible for the assessment of the patient's needs and prescription of medication."

There are over 96,000+ RNs practising in all areas of the health system in the province. An enabling framework is needed to build an expanded scope that will meet current and future health needs of Ontarians. RNs already practise in expanded roles through protocols and medical directives. Coupled with independent prescribing, formally enabling RNs to order diagnostic testing and communicate diagnoses gives them the authority to deliver person-centred care and maintain clear lines of accountability that are not possible through protocols or collaborative practice agreements.

RNAO is proposing that the scope expansion be voluntary for current RNs who choose to pursue a continuing education program that ensures they have the necessary knowledge, skills and competencies. We call for the expanded scope to be integrated within baccalaureate programs by 2020. Independent RN prescribing would allow employers and RNs to define the specific parameters of an expanded RN scope given the RNs' knowledge, competencies and skills; the population(s) being served and access gaps that need to be remedied.

Independent RN prescribing will enable RNs to provide preventative care (e.g. vaccines, foot care, and hormonal contraception), chronic disease management (e.g. adjusting established medications, wound care) and treatment for episodic illnesses (e.g. dermatological conditions, uncomplicated urinary tract infections, otitis media). Independent RN prescribing will improve chronic disease management by delaying the progression of illnesses and improve the response to episodic illnesses by providing timely access to care.[4] Studies conducted in other jurisdictions that have independent RN prescribing have demonstrated an increase in patients' ability to receive prompt care,[5] longer consultations[6] and timely follow-up.[7]

References

[1] Registered Nurses' Association of Ontario (2015). *RNAO praises Ontario's blueprint to reform home and community care and achieve greater health system integration.* Retrieved from: http://rnao.ca/news/media-releases/2015/12/17/rnao-praises-ontarios-blueprint-reform-home-and-community-care-and-ac

[2] Registered Nurses' Association of Ontario (2014). *Enhancing Community Care for Ontarians (ECCO) v. 2.0* and (2012) *Enhancing Community Care for Ontarians (ECCO) v. 1.0*. Retrieved from http://www.rnao.ca/ecco

[3] Registered Nurses' Association of Ontario (2014). *Enhancing Community Care for Ontarians (ECCO) v. 2.0* (see page 25). Retrieved from: http://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf

[4] Carey, N., K. Stenner, and M. Courtenay, *Stakeholder views on the impact of nurse prescribing on dermatology services.* Journal of Clinical Nursing. 19(3-4): p. 498-506.

[5] Carey, N., Stenner, K., Courtenay, M. (2009). Stakeholder views on the impact of nurse prescribing on dermatology services. *Journal of Clinical Nursing, 19*(3-4), 498-506.

[6] Courtenay, M., Carey, N., Gage, H., Stenner, K., Williams, P. (2015). A comparison of prescribing and non-prescribing nurses in the management of people with diabetes. *Journal of Advanced Nursing, 71*(12), 2950-2964.

[7] Courtenay, M., Stenner, K., Carey, N. (2010). The views of patients with diabetes about nurse prescribing*. Diabetic Medicine. 27*(9), 1049-54.