



RNAO

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

Increase access to care by fully utilizing NPs

Do you support changes in provincial policy that would enable nurse practitioners (NP) to work to their full scope of practice, thereby increasing access to health care in Ontario?

Time and again we hear that people across Ontario have limited access to health services. One key way to increase access to care is to enable NPs to work to their full scope of practice and to ensure all health sectors are adequately staffed with the appropriate level of NPs who are receiving fair compensation.

What is an NP?

NPs are registered nurses who have advanced knowledge and education, and a broader scope of practice.¹ NPs are registered with the College of Nurses of Ontario (CNO) under four specialty categories: primary care; adult; paediatric; and anaesthesia.^{2 3} NPs work in all health-care settings, including: public health, primary care, hospitals, rehabilitation, home care, and long-term care.

For more than four decades, NPs have delivered high quality patient care to meet the needs of Ontarians.⁴ Evidence collected over the last 40 years conclusively shows the positive value and impact NPs have on patient care and health system outcomes.^{5 6 7 8}

The evolving role of NPs in Ontario

Driven by RNAO's evidence-based advocacy, our province has been a trailblazer in developing and expanding the NP role. We have achieved tremendous advances for NPs in Ontario.

- There are 24 NP-led clinics – with 7 additional satellite locations – providing primary care in Ontario⁹
- NPs in Ontario were the first in Canada to be granted the authority to admit, treat, transfer, and discharge hospital in-patients¹⁰
- The province committed to funding 75 *Attending NPs* in long-term care homes, of which 60 positions have been funded¹¹
- NPs were given federal authority to prescribe controlled drugs and substances in 2012, and provincial authority in Ontario followed in 2017¹²

These are important advances for NPs in Ontario. However, several barriers remain that hinder access and prevent NPs from providing comprehensive care to their full potential.

NP compensation

NPs practise in all areas of the health system, but the majority of NPs practise in community settings.¹³ NPs substantively improve access to comprehensive primary care for Ontarians. A recent review of evidence shows that in primary care, appropriately trained nurses “probably provide equal or possibly even better quality of care compared to primary care doctors, and probably achieve equal or better health outcomes for patients.”¹⁴ Despite this evidence, there are persistent inequalities in NP compensation – both salaries and benefits – when compared to other members of the interdisciplinary team, and compared to NPs across different health sectors.

While recent Ontario budgets earmarked more funding for primary care, little of that was spent on NPs. That needs to change. The ministry-funded rate continues to put NP compensation well below market rates.¹⁵ A recommended salary structure for primary care has been developed to provide guidance for recruitment and retention in Ontario’s interprofessional primary care organizations.¹⁶ And although the Ministry of Health and Long-Term Care (MOHLTC) has identified NPs as a priority group, a guideline document prepared by the ministry for the primary care team recruitment and retention funding gives employers “flexibility to approve a compensation plan that best addresses the need of the recipient.”¹⁷ Employers are not held to account for how the funding is distributed. We have heard from our members that NPs are leaving the community practice setting because of inadequate compensation. Members are reporting little or no increase in NP compensation despite the existence of government funding. The health ministry must designate extra funding specifically for NPs to ensure they are compensated adequately and equitably, based on their role regardless of which sector they work in.

RNAO calls on the government to dedicate additional funds to ensure new and existing NPs in primary care receive compensation equivalent to that received by NPs in hospitals.

Untapped potential of *Attending NPs* in long-term care (LTC)

All LTC homes must ensure that either a physician or NP “attend regularly at the home” to provide assessment and other clinical services, and to be on-call.¹⁸ RNAO successfully advocated for the creation of the *Attending NP* role in LTC to ensure resident care needs are met on-site in a timely manner, and to advance continuity of care by allowing NPs and residents to develop long-term therapeutic relationships. Unlike attending physicians who typically visit LTC homes on a weekly or bi-weekly basis, *Attending NPs* are based in their respective LTC homes full-time. The *Attending NP* has the overall responsibility for managing and co-ordinating resident care in their respective LTC home. NPs also play an important role in LTC through early detection and treatment of medical complications, treating chronic conditions, and dedicating time for health promotion and evaluation, thereby reducing the need for hospitalization of LTC residents.^{19 20 21}

MOHLTC announced in 2015 the creation of 75 *Attending NP* in LTC positions, to be funded in three phases.²² To date, 60 positions have been funded through phases one and two. Phase three has not been funded, and thus, 15 *Attending NP* positions are owed to Ontarians who live in nursing homes. LTC homes and their residents are in desperate need to have all 75 *Attending NP* positions be funded, hired, and working full time – on-site – as per the role description.

According to the MOHLTC's role description, 70 per cent of an *Attending NP's* time is to be spent on direct resident care, and the other 30 per cent in clinical mentorship and research.^{23 24} Unfortunately, the intended goals of *Attending NPs* in LTC have not been realized. NPs are not being used to their full scope, as outlined by the MOHLTC initiative. For instance, NPs are being used for administrative tasks instead of patient care. Many NPs hired into these roles act as independent contractors instead of employees. Consequently, they receive lower salaries than specified in the ministry's funding policy. This has resulted in difficulty attracting qualified candidates for the role.

RNAO calls on the government to release funding and fill the 'phase three' outstanding *Attending NP* in LTC positions. RNAO also wants LTC homes to be held accountable for hiring *Attending NPs* in the manner specified by the MOHLTC role description and funding policy.

Legislative, regulatory, and organizational barriers to NP practice

Patients and Ontario's health-care system have much to gain by enabling NPs to practise to their full scope. NPs have demonstrated competency to perform advanced assessment, order and interpret diagnostic tests, make differential diagnoses, prescribe medications, and perform procedures within their legislated scope of practice based on their additional education and experience.²⁵ Yet, persisting barriers to NP scope of practice hinder NPs from providing the full continuum of care to patients, and from being fully utilized as vital members of our health system. The government must implement legislative and regulatory changes and direct health-care institutions to remove organizational barriers that prevent those changes from taking effect.

Removing legislative and regulatory barriers

In 2009, the *Regulated Health Professions Statute Law Amendment Act* amended several health related statutes significantly expanding NP scope of practice.²⁶ It has been a long and unfinished process to see the changes outlined in this legislation become fully implemented in practice. There remain several outstanding amendments yet to be proclaimed.²⁷

1. Permit NPs to perform point-of-care testing

NPs are authorized to order laboratory tests as appropriate for patient care since July 2011 when restrictive lists in regulations were removed.²⁸ Yet, NPs are not authorized to perform point-of-care tests, such as a urinalysis dip or pregnancy test. NPs must use medical directives to perform these tests, which are restrictive and time consuming.²⁹ It is more efficient and cost-effective to perform point-of-care testing that produces test results on-the-spot. Furthermore, it is well within NP competency to order, perform, and interpret point-of-care testing.

The story of Raymond demonstrates the importance of NP point-of-care testing.

Raymond is an NP in a busy urban family health team. His patient – a 15-year-old teenage girl – has come to see him to get a pregnancy test. After performing the procedure herself, she hands the urine sample to Raymond and asks him for the results. Although Raymond is capable of testing the urine via dip stick and interpreting the results, he has to send the sample to the lab to be tested. His patient anxiously waits for hours for the results. If Raymond and other NPs are able to perform point-of-care testing, patients will get timely results and interventions without having to wait unnecessarily.

2. Permit NPs to order and apply additional forms of energy

In the past year, progress has been made in terms of the authority of NPs to order and apply forms of energy without the restrictive lists previously in place. Following legislative amendments, regulatory changes were made on Jan. 1, 2018 authorizing NPs to apply and order all ultrasounds.³⁰ Further regulatory changes were made on April 1, 2018 authorized NPs to order all x-rays.^{31,32} RNAO applauds the regulatory changes. Ontario must continue eliminating barriers for NPs to order necessary tests and procedures.

NPs need the authority to order additional forms of energy to maximize NP utilization and its positive effects on the health-care system. This includes expanding NP authority to order computed tomography (CT) scans, magnetic resonance imaging (MRI), nuclear medicine procedures, and non-invasive electroencephalogram (EEG). Restricting NPs' authority to order diagnostic tests impedes timely diagnosis and management of care.

In addition, NPs are only authorized to order an electrocardiogram (ECGs) in non-urgent situations. This distinction between urgent and non-urgent situations is irresponsible. In order to increase timely access to necessary care, NPs should be given authority to order this test in all situations, *especially* those that are urgent. The current gap decreases access to a necessary test for clients in critical situations, and creates the need for inefficient medical directives that delay urgently needed client care. The government should remove this senseless restriction.

Further, it is essential to ensure diagnostic tests ordered by NPs are insured services for patients. Thus amendments to the *Health Insurance Act*, 1990 are necessary to reflect any changes made to NP scope of practice.

3. Expand NPs' authority to certify a death

RNAO continues to advocate for expanding NPs' authority to certify a death beyond the current eligibility criteria, and calls for corresponding changes to Regulation 1094 (General) under the *Vital Statistics Act, 1990* to include NPs. This will ensure the dignity of deceased persons and support the well-being of their loved ones. It also ensures that the regulation keeps pace with the significant evolution in NP utilization in Ontario, as NPs now serve as most responsible providers across all sectors.

4. Authorize NPs to complete legal forms for mental health services

At present, Section 15 of the *Mental Health Act* authorizes a physician to complete seven forms related to mental health services.³³ Forms one through five are related to bringing someone to a psychiatric facility, keeping them there, and discharging them. There are also two forms that control access to a patient's clinical records.

Given that NPs often serve as entry points to the health system, restricting the ability to initiate legal forms for mental health services presents a significant safety hazard. For example, at present, if a client who appears to be suffering from a mental illness presents to an NP indicating

they are at risk of self-harm or harming someone else, the NP is severely limited in their response: a physician would have to be located to initiate a *Form 1 – Application for Psychiatric Assessment*, which may not be possible and would certainly cause delay, leading to undue risk. While waiting for a physician, the patient – who may be in a compromised state of mind – is able to leave on their own free will. As an alternative, an NP could appear before a justice of the peace to seek a Form 2; but again, this takes too much time and ignores a patient’s distress.

Authorizing NPs to initiate legal forms for mental health services aligns with the evolution of the health system and the NP role. It promotes the public interest, improves access to needed care and is consistent with the scope of practice NPs already have. It also increases safety for individuals, families, and communities.

Removing practice environment barriers

Regulatory changes to Ontario’s *Public Hospitals Act* in 2012 authorized NPs to admit and discharge patients. These regulatory changes enable NPs to act as Most Responsible Provider (MRP) in hospital settings. This term refers to the healthcare provider who has primary responsibility and accountability for a patient across their care trajectory, throughout admission, treatment, and discharge.³⁴ An RNAO-led survey of senior nurse leaders in Ontario’s hospitals found that while 70 per cent of responding organizations had NPs treating patients, only 41 per cent had NPs discharging patients and just four per cent had NPs admitting patients. Nurse leaders who responded to the survey cited physician concerns, budget limitations, and organizational policies as the main barriers to fully utilizing NPs. Limiting NPs’ duties by not enabling their role as MRP also occurs in some primary care settings. Regardless of sector, this negatively impacts timely access to quality care. Extensive evidence on the value of NPs demonstrates that fully utilizing NPs improves the quality of care, patient outcomes, patient experience, and cost-effectiveness.³⁵ RNAO’s *Nurse Practitioner Utilization Toolkit* is a key resource to assist organizations in optimizing NP utilization.³⁶

RNAO calls on the government to remove legislative and regulatory barriers so that NPs are authorized to:

- **Perform point-of-care testing.**
- **Order additional forms of energy (e.g., CT, MRI, nuclear medicine procedures, non-invasive EEGs, and ECGs in all situations).**
- **Apply specified forms of energy (e.g., defibrillation).**
- **Complete Forms 1, 2, 3, 4, 5, 14 and 28 for mental health services.**

RNAO also calls on government to remove practice environment barriers so that NPs can

- **Act as most responsible providers in hospital.**
- **Expand their authority to certify a death**

RNAO's NP PRACTICE ASKS

- Dedicate additional funds to ensure new and existing NPs in primary care receive compensation equivalent to that received by NPs in hospitals.
- Release funding for the outstanding *Attending NP* in LTC positions. Develop and implement a framework to hold LTC homes accountable for hiring *Attending NPs* in the manner specified by the MOHLTC role description and funding policy.
- Remove legislative, regulatory, and practice environment barriers to NP scope of practice, as follows:
 - a. Authorize NPs to perform point-of-care testing.
 - b. Authorize NPs to order additional forms of energy (e.g., CT, MRI, nuclear medicine procedures, non-invasive EEGs, and ECGs in all situations).
 - c. Authorize NPs to apply specified forms of energy (e.g., defibrillation).
 - d. Expand NPs' authority to certify a death.
 - e. Authorize NPs to complete Forms 1, 2, 3, 4, 5, 14 and 28 for mental health services.
 - f. Ensure NPs are enabled to act as most responsible providers in hospital.

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