NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

Submission to Social Policy Committee
Response to Bill 179
Regulated Health Professions Statute Law Amendment Act

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Executive Summary
Response to Regulated Health Professions Statute Law Amendment Act

The Nurse Practitioner's Association of Ontario, the professional voice of almost 1300 nurse practitioners, is pleased to participate in the renewal of the Ontario healthcare system. Nurse practitioners have anticipated many of the legislative changes proposed in Bill 179 for more than a decade. Although many positive changes are proposed, with further amendments Bill 179 will improve and expand access to care for patients and further prepare Ontario's health care system to take full advantage of the knowledge, skill and judgment of regulated health professionals. NPAO's recommendations on the capacity of Bill 179 to fully integrate nurse practitioners into Ontario's healthcare system and to improve access to safe, quality, effective care for patients are summarized here.

Bill 179 meets health care needs of Ontario in these ways

- The proposed structural change to Section 5.1 of the *Nursing Act (1991)* provides role clarity and supports the effectiveness of interprofessional teams.

- The proposed change to Section 5.1 (1) 4, 5 and 8 of the *Nursing Act (1991)* adds three new controlled acts for nurse practitioners. This expanded scope will reduce patient wait times and recognizes the knowledge, skill and judgment of nurse practitioners in providing safe, effective care.

- The proposed change to Section 14 (1) (f) of the *Nursing Act (1991)* removes restrictions on communicating a diagnosis and will enable the College of Nurses of Ontario to better regulate the role and enable effective interprofessional teams.

Bill 179 falls short of meeting health care needs of Ontario in these ways

- The proposed legislative and regulatory changes to expand nurse practitioner scope of practice and support increased access to care for patients, are incomplete and both legislative and regulatory amendments are required to several different Acts.

- The new authority for nurse practitioners to dispense, sell and compound drugs, will be severely restricted in the absence of open prescribing.

- Changes in Bill 179 to legislation governing other health care providers, specifically the Medical Radiation Technology Act, fails to recognize the expanded scope of practice for nurse practitioners to order diagnostic tests and forms of energy and must be amended.

Bill 179 fails to meet the health care needs of Ontario in these ways

- The absence of open prescribing for nurse practitioners does not enable timely, effective care for Ontarians and does not recognize nurse practitioner competencies.

- Restrictions on nurse practitioner authority to administer a substance by inhalation or injection have not been removed which limits patient access to care and restricts nurse practitioner practice.

- The absence of changes to authorize nurse practitioners to order oxygen and prescribe blood and blood products limits patient access to care and restricts nurse practitioner practice.

- The absence of an amendment to the *Nursing Act (1991),* to add an additional member to the College of Nurses of Ontario who will be a nurse practitioner elected by eligible nurse practitioners, may restrict the ability of the College to fully engage in debates on issues related to nurse practitioners.

The Nurse Practitioners' Association of Ontario believes every Ontarian deserves quality health care. With further amendments as recommended, Bill 179 will result in significant changes that will enable Ontario's health care system and health care providers to more effectively and efficiently meet the health care needs of Ontario.

Submission to Social Policy Committee
Bill 179 – The Regulated Health Professions Statute Law Amendment Act

The Nurse Practitioners' Association of Ontario (NPAO), an interest group of the Registered Nurses' Association of Ontario (RNAO), represents the professional interests of all nurse practitioners (NPs) in Ontario. Our mission is to achieve full integration of NPs to ensure accessible high quality health care for Ontarians. NPAO represents almost 1300 members including adult, paediatrics and primary health care NPs as well as students in NP education programs and advanced practice nurses who are preparing to write the NP registration examinations.

NPAO commends government for addressing many legislative barriers to NP practice through *The Regulated Health Professions Statute Law Amendment Act (2009)*. For over a decade, NPAO and Ontario's NPs have anticipated the legislative changes proposed in Bill 179. Bill 179 proposes many legislative changes that will improve and expand access to care for patients and further prepares Ontario's health care system to take full advantage of the knowledge, skill and judgment of regulated health professionals. However, as this submission will illustrate, there are many legislative issues that remain to be addressed to ensure NPs are able to fully contribute to improving access to safe, quality care for patients. Bill 179 does not address three critical issues: open prescribing of medications within NP competencies, NP authority to order oxygen and prescribe blood and blood products and a wide range of necessary legislative and regulatory amendments; in particular regulations under the Public Hospitals Act. With further amendments, Bill 179 has the potential to enable Ontario's health care system to significantly improve access to safe, effective, evidence-based, quality care by allowing NPs to practice to full scope.

In 1998, Ontario demonstrated leadership to other Canadian jurisdictions by establishing NP education programs, proclaiming legislation, funding the integration of primary health care nurse practitioners in practices across the province and registering over 300 members in the extended class. Since that time NPs, the Ministry of Health and Long Term Care (MOHLTC), the College of Nurses of Ontario (CNO), RNAO and NPAO have worked together to address numerous challenges to the implementation and integration of the role. Ontario's leadership in advancing NP practice is also evident in the government's commitment to establish twenty-six NP-Led Clinics. Despite these initiatives, the legislative and regulatory framework for NPs in Ontario has not kept pace with evolving health system needs, new and emerging technologies, NP capabilities and education, or patient care needs and expectations.

No other health professional group in Ontario, regulated or unregulated, has been the subject of as many reviews and studies as NPs. Prior to the 1997 legislation to regulate the role, government commissioned three major papers.[1] In this decade, there have been three additional reviews examining role integration in primary health care,[2] as well as two reports on role integration in specific settings (e.g., long term care and emergency departments) and finally the prescribing review by the Health Professions Regulatory Advisory Council (HPRAC).[3]

[1] Utilization of Nurse Practitioners in Ontario (1993); The Clinical Nurse Specialist, Clinical Nurse Specialist/Nurse Practitioner and Other Titled Nurse in Ontario (1994), Assessment of the Need for Nurse Practitioners in Ontario (1994)
[2] HPRAC's Report to the Minister of Health and Long-Term Care on the Review of the Scope of Practice of Registered Nurses in the Extended Class (2008); Report of the PHCNP Integration Task Team (2007); IBM McMaster University Report on the Integration of Primary Health Care Nurse Practitioners in Ontario (2005)
[3] HPRAC's Critical Links (2009); The Integration of Acute Care Nurse Specialists, Primary Care Nurse Practitioners and Physician Assistants in Ontario Emergency Department Teams - Final Report (2008); The Ontario Nurse Practitioner in Long-Term Care Facilities Pilot Project in Ontario. Interim Evaluation, Final Report, aestima research (2005)

Recommendations in these reports regarding the many legislative, regulatory and policy barriers that limit the full contribution of the NP are reflected in our comments.

This submission addresses only those issues specific to the role of NPs. Each issue is structured with the following components: NPAO's request to HPRAC; Bill 179's capacity to address NPAO's request; NPAO's position and recommendation to the Social Policy Committee and additional comments/rationale.

Provide Open Prescribing for Nurse Practitioners and Remove Limitations on Administering a Substance by Injection or Inhalation

Request to HPRAC: To remove limitations on the authorized act of prescribing and the authorized act of administering a substance by injection or inhalation from the *Nursing Act (1991)*. Further, any conditions necessary to protect the public should be placed in the RN(EC) Practice Standard rather than in legislation.

Capacity within proposed Bill 179: The legislation fails to provide NPs authority for open prescribing within their competencies and retains a list based approach in regulation. The legislation fails to address any change to administering a substance by injection or inhalation.

NPAO Position: NPAO strongly recommends NPs be granted open prescribing and that government enact the necessary legislative and regulatory changes without further delay. This recommendation is not innovative or ground-breaking and in fact, would simply bring Ontario in line with a national standard of care in Canada. Intricately linked to the authorization for open prescribing is removal of the limitations on the authorized act of administering a substance by injection or inhalation for NPs.

Additional Comment/Rationale: Open prescribing is the critical and necessary change needed to remove inefficient processes and increase patient access to timely health care across all health care settings. To continue a list based model for NP prescribing is a timid and insufficient response to the real problems of access to health care for Ontarians.

The expansion of authority to open prescribing for NPs is not leading edge. NPAO has based this recommendation on solid evidence, national NP standards, existing regulatory approaches and almost 30 years of Canadian experience. Government commissioned reviews and research findings provide strong evidence of safety and efficacy with NP provided health care. The following key points summarize the rationale for NPAO's recommendation.

> <u>Safe NP Practice</u>
> NPs are the most extensively researched health care profession in history. The published literature of more than 1200 papers includes numerous descriptive studies and randomized controlled trials all describing safe and efficient practice.[4] Several of these studies were conducted by Dr. Alba DiCenso, CHSRF/CIHR Chair in Advanced Practice Nursing and Professor, Faculty of Nursing, McMaster University. For most researchers, one randomized controlled trial is sufficiently strong evidence to support practice change. This research provides an overwhelming body of evidence describing safe practice in numerous different clinical settings. No studies have demonstrated

[4] HPRAC Scope of Practice Review for RN(EC)s: A brief note and high level review of literature. November 2007 retrieved from http://hprac.org/en/projects/resources/hprac-nursing.LitReviewNovember2007.final.pdf retrieved February 25, 2009

harm. No other professional group can claim such a strong body of evidence of safety and efficacy.

The Canadian Nurses Protective Society (CNPS), the provider of malpractice coverage for nurses and NPs informs that NPs currently carry the appropriate amount of liability insurance according to trends of legal cases in North America. To date, no claims have been paid for an NP in Canada.

Diverse Patient Needs in Diverse Practice Settings

Collectively NPs manage care for patients across all ages in a wide variety of settings. To provide timely, effective and efficient care NPs require a broad and flexible prescribing approach with a comprehensive range of drugs to manage overall health care needs of patients. When medications are required as part of the treatment plan, patients deserve access to the best available choice.

Nurse practitioners have been prescribing medications to patients in community and specialized settings for many years. Each NP gains an expertise in prescribing medications that meet the health care needs of the specialty population they provide care for. Specialty NP practice exists in cardiology, oncology, neonatology, neurology and critical care to name a few. Only a broad prescriptive authority will support NPs in providing evidence-based care to patients through all patients' needs and practice settings. The list based approach is restrictive in responding to the needs of Ontarians in two ways: many of the drugs are limited to renewal only and the process to review and update the list is slow and does not respond to the rapid pace of technological change in pharmaceuticals.

Trends in Other Jurisdictions – The Case for National Scope of Practice

Since HPRAC's initial review of NP prescribing practice in other jurisdictions, considerable change in the prescribing environment in Canada and elsewhere has occurred. The trend across Canada is for NPs to be authorized open prescribing. British Columbia, Alberta, Saskatchewan, Manitoba, Nova Scotia, New Brunswick and Newfoundland and Labrador all have moved to enable open prescribing for NPs. The American Academy of Nurse Practitioners recently published the annual state-by-state review of nurse practitioner legislation and healthcare issues. Forty-eight states in USA currently support full prescriptive authority for NPs in every category of scheduled drugs.[5] In Great Britain where significant advances in prescribing are underway, general class nurses – not nurse practitioners – can take additional education and be regulated as "prescribers" with access to the entire National Health Service formulary.

Canada has a national set of core competencies for NP practice. These competencies are the foundation for NP education across the country. There is one national standard for NP entry to practice examinations based on these competencies. Under legislation currently being considered in Ontario (i.e., Bill 175) and the federal Agreement on Internal Trade, NPs can move from province to province without additional requirements for registration. Without amendments to Bill 179 to provide open prescribing for NPs, when a qualified, competent NP moves from Alberta or Nova Scotia to Ontario, her/his ability to prescribe would be dramatically decreased. This may impact recruitment and retention of NPs to Ontario.

[5] The Pearson Report: The annual state-by-state national overview of nurse practitioner legislation and health care issues retrieved on February 26, 2009 http://www.webnp.net/downloads/pearson_report09/ajnp_pearson09.pdf

Current NP Competencies, Education and Practice

Today, NPs have a minimum of six years of education. As graduates of four year baccalaureate programs in nursing, they have a solid education in both the biological and sociological basis of healthcare management. Entry requirements for the NP education program include a minimum of two years of practice, at least one in an advanced practice role; most NP students have ten years experience prior to entering the program. Most NP programs are two year programs at the masters level.

Healthcare renewal with effective use of health human resources is necessary to sustain Ontario's healthcare system. Expanding non-physician providers prescribing authority along with ensuring the right number and mix of healthcare providers is a step in right direction. To move healthcare renewal forward today, methods of prescribing for each profession must reflect current competencies, education, regulation and practice of each provider. For NPs, the evidence supports safety and efficacy of open prescribing by NPs without further education.

Regulated lists do not allow for full utilization of nurse practitioner knowledge, skill and expertise – the very thing the Premier and Minister stated their government intends to take advantage of. It is also inconsistent with the government's objectives for HealthForceOntario to ensure that Ontario is a leader in enabling health professionals to work to the full extent of their knowledge and expertise.

Physician Support

The submission of the College of Physicians and Surgeons to HPRAC states, "The CPSO feels that the current method of regulating RN(EC) prescribing and diagnostic/laboratory privileges inhibits the ability of RN(EC)s to readily adapt to changes in viable treatment options, and may constrain nurse practitioners in providing the most effective care to their patients. Ideally, RN(EC)s should be permitted to prescribe all the treatment options that fall within their scope of practice. Where patient safety or resource availability is of concern, then specific exceptions can be made excluding those options from RN(EC) practice."[6]

Individual physicians, especially those who work directly with NPs, report that they value the knowledge, skill and judgment of NPs and recognize they deliver safe, effective, quality care to patients. Many also express frustration with the limits of NP scope of practice and support expanded scope of practice including prescribing.[7, 8, 9, 10]

Decreased Reliance on Medical Directives

Nurse practitioner practice has responded to population needs within the healthcare system. NPs work in community settings, ambulatory care clinics, long term care and acute care specialty settings. The list approach to prescribing has limited NPs in all

[6] Submission by College of Physicians and Surgeons of Ontario to HPRAC retrieved on February 26 at http://hprac.org/en/projects/resources/hprac-nursingresponse_CNOCPSOnew2.pdf
[7] Submission by Dr. Peter Bell to HPRAC as retrieved on February 26 at http://hprac.org/en/projects/resources/hprac-nursing.response_CNO.PeterBellfinal.pdf
[8] Submission by Dr. Angus Daniel to HPRAC as retrieved on February 25 at http://hprac.org/en/projects/resources/hprac-nursing.response_CNO.AngusDanielnew.pdf
[9] Submission by Dr. Stephan Ragaz to HPRAC retrieved on February 26 at http://hprac.org/en/projects/resources/hprac-nursingresponse_CNORagaz-PNFHT.pdf
[10] Submission by Dr. Zahir Poonja to HPRAC retrieved on February 25 at http://hprac.org/en/projects/resources/hprac-nursing.response_CNO.ZahirPoonjanew1218.pdf

these settings. As a result medical directive documents have been developed providing NPs some authority through physicians to prescribe necessary drugs to patients. HPRAC acknowledged that medical directives are cumbersome and ineffective and have a negative impact on both system efficiency and interprofessional teams. Both CNO and NPAO have consistently indicated that reliance on medical directives over time is an implicit recognition that delegated activities need to be subsumed by the receiving profession. Through open prescribing the need to continually rely on medical directives is removed, thus enabling NPs to take full accountability for their activity in prescribing.

Limitations of List Based Models (including by category) for Prescribing

As already discussed above, a list approach to prescribing for NPs is not supportive of effective, safe, high quality care for the diverse populations that NPs care for nor does it recognize NP competency.

Several practical implementation issues have emerged in NPAO's analysis and review of lists based on categories including: prescribing combination drugs and prescribing drugs with multiple therapeutic uses. The NP Task Team report findings clearly indicate that adapting to the rapid changes in preferred prescribing as new drugs and therapies emerge is virtually impossible in list based models. Access to combination drugs and drugs with multiple therapeutic indications are particularly problematic in a list based approach where single drugs are approved for single indications. In the current regulatory framework, specific drugs are approved for one specified indication. NPs are not allowed to prescribe combination drugs even though each substance may be on their approved list nor are they allowed to prescribe for an alternate use. It is unclear how combination drugs, and drugs with multiple indications will be managed in the future.

There is increasing reliance on combination drugs to ease administrative burden for patients and enhance patient adherence to medication treatment plans as demonstrated in the following example:

> *NPs play a strong role in chronic disease management. Patients with chronic diseases are often on multiple medications. In fact, patients discharged after an acute myocardial infarction may be on as many as 5 new medications. It is much simpler for the patient to manage and has been shown to improve compliance and reduce the number of medication errors (which in turn reduces re-hospitalizations), to limit the number of pills a patient must take each day. New combination formulations are introduced on a regular basis. Even though NPs can prescribe an antilipemic and a calcium channel blocker, NPs cannot prescribe the combination drug Caduet. As a result, NPs are unable to provide evidence-based care to patients without investing extra time in writing medical directives or having to unnecessarily consult with a physician.*

If NP prescribing is limited to one purpose or application of a drug which falls within a category, this may preclude NPs from addressing patient needs and meeting best practice prescribing as demonstrated in the following examples.

> *Viagra is commonly prescribed for erectile dysfunction. In critical care and acute care respirology this drug is commonly used in patients with pulmonary hypertension to reduce the hypertension and reduce cardiac/respiratory effects thus enable weaning from mechanical ventilation. In fact, pulmonary hypertension was the original research for the drug, the effect on erectile dysfunction was a serendipitous finding from that research. It is certainly within nurse practitioner scope to prescribe under both therapeutic uses.*

Gabapentin is used as an adjuvant for pain management. Gabapentin is listed in the anticonvulsant drug category so would seem not to be relevant for orthopaedic practice. In fact, gabapentin is effective in reducing pain after joint replacement, managing phantom pain after amputation and is routinely used by pain management specialists for both chronic and acute pain.

Impacting Health System Policy Agendas

Nurse practitioners provided many stories, such as the one below, demonstrating barriers negatively impacting NPs ability to contribute to current health policy agendas such as reducing wait times, increasing access to safe high quality patient centred care and maximizing the knowledge and skills of Ontario's health human resources.

I assess and manage patients with anxiety and depression on almost a daily basis. Cipralex is a new medication but is not on our list. It is the drug of choice for a subset of my patients and because I cannot prescribe it my choices are as follows:

- *asking the patient to return when there is a physician available to prescribe;*
- *ask the patient to wait while I track down a physician who will sanction the prescription;*
- *prescribe a potentially less effective drug;*
- *take time from patient care to create a medical directive that subsumes my knowledge, skill and judgment and places accountability for my prescribing on the authorizing physician.*

None of these options are particularly effective / efficient or patient-centred.

Full Support of Self-Regulating Professions

Self-regulation, a process government and HPRAC are committed to, is the concept that members of a profession are in the best position to determine entry-to-practice and ongoing competencies, establishing and enforcing standards of practice for the profession and having appropriate quality assurance programs to ensure ongoing competence. A list based approach to prescribing with oversight and vetting to an external Expert Panel is inconsistent with this commitment.

Taking Action on Recommendations in Government Commissioned Reports

In November 2004, then Minister of Health George Smitherman established the NP Integration Task Team comprised of nursing, medicine and public representatives. Their mandate was to review, prioritize, implement or advise on the implementation of the recommendations of the report "The Integration of Primary Health Care Nurse Practitioners into the Province of Ontario". Dr. Alba DiCenso, BScN, MSc, PhD, CHSRF/CIHR Chair in Advanced Practice Nursing and Sue Matthews, RN, BA, MHScN, PhD, then Provincial Chief Nursing Officer, were appointed as co-chairs. Nurse practitioners, physicians and representatives from the Ministry of Health and Long-Term Care, NPAO, OMA and CNO chaired and/or participated in working groups to achieve this mandate.

The key findings of the Task Team in relation to NP prescribing included:

- Ontario's legal framework for NPs is the most restrictive in Canada (This assessment was made in early 2007.)
- Regulated lists are inconsistent with self-regulation.
- Regulated lists do not fully utilize NP knowledge and skills.

- Regulated lists are not responsive to patient needs, delay access to care and result in system inefficiencies.
- The lengthy process to review and update lists delays the ability of NPs to comply with best practices.
- CNO received overall positive feedback to their consultation and proposal to remove the drug list from regulation, with the exception of the Ontario Medical Association.

The Task Team's conclusion in regard to NP prescribing was that further consultation on this issue as it would be unlikely to generate new findings. The Task Team recommended, consistent with the accountability of regulated health professionals to practice within their individual scope and area of competence, that government should immediately draft legislation that provides NPs with the authority to prescribe drugs approved in Ontario and specific drugs should no longer be listed in regulation and/or legislation."[11] This recommendation was based on the government's objectives to improve access to care for patients, enable NPs to work to full scope and maintain public safety. Despite this strong recommendation to government, HPRAC was directed to undertake yet another study of NP prescribing.

Authority to Order Oxygen and Prescribe Blood and Blood Products

Request to HPRAC: That NPs be authorized to prescribe blood and blood products and order oxygen.

Capacity within proposed Bill 179: The authority to prescribe oxygen, blood and blood products is not addressed in the legislation.

NPAO Position: NPAO recommends that the Minister of Health and Long Term Care immediately consult with the College of Nurses of Ontario and implement the necessary legislative or regulatory changes required to provide the authority to nurse practitioners to provide patients with oxygen, blood and blood products.

Additional Comments/Rationale: NPAO's submission to HPRAC noted the following:

- NPs prescribe oxygen, blood and blood products under delegation and medical directives authorized by physicians on a regular basis and in many different health care sectors.
- Oxygen, blood and blood products do not fit in the controlled acts model. Previous attempts to provide NPs with this authority through CNO's annual review of the drug list were not successful.
- Therapeutic oxygen is listed as a drug that midwives may order and administer under the *Midwifery Act (1991) Designated Drugs Regulation,* setting precedent for this recommendation.
- NPs in other jurisdictions (e.g., Alberta, Nova Scotia, British Columbia) have authority to order oxygen and prescribe blood and blood products.

NPAO specifically identified the issue of oxygen, blood and blood products at HPRAC's round table sessions. HPRAC acknowledged the specific challenges related to these substances and indicated a preference to include them as part of the prescribing review. Despite these highlighted aspects, HPRAC did not address these substances in relation to NP practice and consequently Bill 179 also fails to address these issues. It was interesting to note that HPRAC

[11] Report of the NP Integration Task Team to the Minister of Health and Long-Term Care. March 2007. P. 18

did recommend, and Bill 179 has implemented, that Respiratory Therapists have the authority to order oxygen. Based on the experience of other jurisdictions and discussions during the HPRAC consultations, it is essential that these issues be resolved to support efficient patient access to oxygen, blood and blood products when required as part of the treatment plan for patients being care for by NPs.

The following story illustrates the need for nurse practitioners to have authority to order oxygen and prescribe blood and blood products:

> *I am caring for a 53 year old woman with Behcet's disease who regularly travels from Sault Ste. Marie to Toronto to see a Gastroenterologist (GI). The GI specialist recommended occasional blood transfusions due to severe chronic anemia. I am unable to order the blood transfusions when they are required and have to go to my collaborating physician to authorize this needed treatment every time. This additional and unnecessary step delays access to care for the patient and unnecessarily interrupts the physician to provide care that I have assessed the need for and am capable of providing. The patient doesn't understand why I can't provide the care she needs.*
>
> *I was providing care to a very elderly patient with several co-morbidities, including congestive heart failure. His was failing, weak, short-of-breath and hypoxic (low oxygen level). He refused hospital care but agreed to home-oxygen treatment. I arranged for the local company who administers home-oxygen to meet him at his home that same day, assess his oxygen needs and get him started on a home program for palliation. To do this, I had to interrupt my physician partner several times to sign forms, etc. while he was seeing other patients. It would have been more efficient, if I could have provided the prescription for home oxygen and completed the forms independently within my competency – saving the patient and his wife, my physician partner, and myself considerable time and effort.*

Ancillary Amendments to Legislation and Regulation

Requests to HPRAC: NPAO identified that, in addition to the *Nursing Act (1991),* government needs to amend the following legislation and regulations:

- *Healing Arts and Radiation Protection Act (1990)* to provide NPs with broad diagnostic authority for x-rays and CT scans.
- *Drug and Pharmacies Regulation Act (1990)* to remove restrictions pertaining to the controlled act of dispensing, selling and compounding.
- *Immunization of School Pupils Act (1990)* to allow NPs to sign exemption forms.
- *Patient Restraints Minimization Act (2001)* to enable NPs to order restraints.
- *Highway Traffic Act (1990)* to require NPs to report patients who are unfit to drive and provide NPs with protection from civil suits.
- *Mental Health Act (1990)* to provide NPs with authority to order and complete Form 1.
- *Health Promotion and Protection Act (1990)* to require NPs to report patients with communicable diseases who refuse or neglect treatment.
- *Medical Radiation Technology Act (1991) to* authorize NPs to order certain procedures by Medical Radiation Technologists. [12]
- *Ontario Drug Benefits Act (1990)* to ensure costs of ODB eligible substances are covered for eligible clients when ordered by a NP; allow NPs to submit special case referrals and ensure

[12] This request was not previously submitted to HPRAC because the issue was identified based on the specific changes proposed in Bill 179.

that pharmacists can dispense them; and various changes related to language of physician prescribing.
- *Regulation 965* of the *Public Hospitals Act (1990)* to enable NPs to admit, treat and discharge patients; to enable NPs to sign certificates of death in prescribed circumstances and to authorize NPs to provide notification of patients being admitted with an infectious disease or who are a danger to themselves or others.
- *Regulation 1094* of the *Vital Statistics Act (1990)* to enable NPs to sign certificates of death in prescribed circumstances.
- *Regulation 682* of the *Laboratory and Specimens Collection Centres Licensing Act (1990)* to allow NPs broad diagnostic authority to order laboratory tests by deleting Appendix C and provide NPs authority to perform simple diagnostic lab tests in the office (e.g., Urine dipstick analysis).
- *Regulation 340* of the *Highway Traffic Act (1990)* to enable NPs to sign seatbelt exemptions.
- *Regulation 552* of the *Health Insurance Act (1990)* to enable payment to hospitals, provide payment for broader NP authority pertaining to laboratory and other services and provide consultation payments to specialist physicians for patient referrals from NPs.
- *Regulation 107* of the *Regulated Health Professions Act (1990)* to specify forms of energy that a NP can prescribe and order.

Capacity within Bill 179 and Legislative Changes: Bill 179 makes the necessary changes to some but not all of the legislative changes requested by NPAO. The following chart indicates which changes are addressed in the Bill and which are not.

Legislation	**Status**
Healing Arts and Radiation Protection Act	Achieved in Bill 179
Drug and Pharmacies Regulation Act	Partially achieved in Bill 179 As presented NPs would be limited to only those substances that they can prescribe
Immunization of School Pupils Act	Not achieved in Bill 179
Patients Restraints Minimization Act	
Highway Traffic Act	
Mental Health Act	
Health Promotion and Protection Act	
Medical Radiation Technology Act	
Ontario Drug Benefit Act	

Minister Caplan's Regulatory Proposals: The Minister recently provided information on regulatory changes related to Bill 179. The proposed changes are categorized into two groups: those that may be made if Bill 179 is passed in its current form and those that may be made regardless of whether or not Bill 179 is passed. The proposed changes indicate that the Minister will respond to some but not all of the regulatory changes requested by NPAO. The following chart indicates which changes are addressed in the Bill and which are not.

Regulation		Status
Regulation 965 Public Hospitals Act	Enable NPs to admit, treat and discharge patients	Change partially addressed in Minister's notice. The proposal indicates NPs will be able to treat but not admit or discharge patients.
	Enable NPs to sign certificates of death in prescribed circumstances	Change included in Minister's notice
	Authorize NPs to provide notification of patients being admitted with an infectious disease or who are a danger to themselves or others	Change not included in Minister's notice
Regulation 1094 Vital Statistics Act	Enable NPs to sign certificates of death in prescribed circumstances	Change included in Minister's notice
Regulation 682 Laboratory and Specimens Collection Centres Licensing Act	Allow NPs broad diagnostic authority to order laboratory tests	Change included in Minister's notice
	Provide NPs authority to perform simple diagnostic lab tests in the office (e.g., urine dipstick analysis).	Change not included in Minister's notice
Regulation 340 Highway Traffic Act	Enable NPs to sign seatbelt exemptions.	Change not included in Minister's notice
Regulation 552 Health Insurance Act	Enable payment to hospitals	Change not included in Minister's notice
	Provide consultation payments to specialist physicians for patient referrals from NPs.	Change not included in Minister's notice
Regulation 107 Regulated Health Professions Act	Specify forms of energy that a NP can prescribe and order.	Change included in Minister's notice

NPAO Position: NPAO supports all of the proposed legislative and regulatory changes in order to increase access to care for patients. NPAO strongly encourages government to act on all of the other proposed changes without delay.
Proviso to NPAO Position: Changes in Bill 179 to the Medical Radiation Technology Act, fails to recognize the expanded scope of practice for nurse practitioners to order diagnostic tests and forms of energy and must be amended.

Additional Comment/Rationale: Since regulation of the NP role in 1998, NPAO together with CNO and RNAO, has repeatedly advocated for changes to legislation, regulation and policy to enable NPs to work to full scope of practice. As noted previously, there are multiple studies that

have identified legislative and regulatory barriers and proposed recommendations that would improve patient access to care through enabling NPs to work to their full scope of practice. In addition, such changes would address inefficient practices that have developed over time to "work around" these practice challenges. Bill 179 and the related regulatory development process provide government with a unique opportunity to enable NPs as an effective health human resource for a renewed healthcare system.

Two of the proposed regulatory proposals have historically been viewed as controversial recommendations and deserve additional comment. These are admitting/treating/discharging inpatients and referrals to specialists.

Authority to Admit, Treat and Discharge Inpatients

Regulation 965, under the Public Hospitals Act, limits the ability of NPs to work to their full scope of practice in the hospital in-patient setting. Amendments in 2003 to Regulation 965, NPs are limited to admit, treat and discharge in outpatient clinics and emergency departments and similar regulatory changes to various long term care legislation enabled NPs to admit, treat and discharge in long term care homes.

With the introduction in 2007 of additional NP specialties - adult, paediatrics and anaesthesia, who work primarily in acute care settings, it is imperative to remove this regulatory barrier. Recent research has determined that over 500 NPs currently practice in hospitals addressing population based needs and identified gaps in health care.[13] There are also NPs who practice in community settings whose patients would benefit from the ability for their primary care provider to have an active role in their care in the hospital setting.

In the absence of changes to Regulation 965, NPs who practice in public hospitals and care for in-patients, will continue to rely on medical directives to communicate diagnoses, initiate interventions, prescribe drugs and order diagnostics and treatments. As noted earlier, medical directives are a cumbersome, time consuming and ineffective process. The following story outlines key problems NPs struggle with under this regulation:

> *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.*
>
> *With the advent of electronic health records comes a safe and effective method of prescribing on discharge. The system generates one document that is considered a prescription thus ensuring all medications the patient is taking in hospital are listed. The prescriber reviews the list, selects the appropriate medications for going home, writes in the quantity required and signs the document. This is the prescription. If all the medications on the prescription are not on the NP prescribing "list" then I cannot prescribe any of the medications and the patient must wait for the physician. Being unable to provide this care delays patient discharge, forces patients and families to wait and slows the flow of patients out of the hospital.*

[13] Van Soeren, M., et al. The Integration of Specialty Nurse Practitioners into the Ontario Healthcare System. August 2009.

Appropriate Funding to Specialists for Nurse Practitioner Referrals

NPAO believes that specialists deserve appropriate compensation and that economic disincentives are not acceptable rationale for limiting access to care for patients of NPs. The issue of referral to specialists was reviewed in detail in two government commissioned reports (i.e., PHCNP Integration Report,[14] NP Task Team Report[15]). The key findings in these reports are similar as follows:

- It is within the scope of practice and consistent with the standards of practice for NPs to refer to specialists. There are no legislative or regulatory deterrents related to scope of practice that limit NP referrals to specialists.
- Arguments that NPs refer inappropriately or that NP referrals will increase system costs are without merit.
- Over 90% of NPs refer to specialists and with their consulting physicians have developed "work arounds" to enable access to care for patients.
- In four other Canadian jurisdictions, Manitoba, Alberta, Saskatchewan and Nova Scotia, specialists receive the same payment for a referral from a NP as from a family physician.

For example, NPs see women who desire sterilization. It is within the NP scope of practice to make a referral to a gynecologist. To accomplish this, the NP must either circumvent the system as outlined previously or create delays in referral by arranging an appointment to an already overburdened family physician who in turn will refer to the specialist.

As with prescribing, in 2007, the NP Task Team Report recommended that further consultation on this issue would not result in new findings. The report recommended "That the Minister take action to amend the Schedule of Benefits for Physician Services [Regulation 552 Health Insurance Act] to recognize the NP as a direct referral source for which specialists can claim a consultation fee from the Ministry."[16] NPAO's position paper on referrals to specialists is attached.

Expand Nurse Practitioner Scope of Practice with Three Additional Controlled Acts

Request to HPRAC: To amend the *Nursing Act (1991)* to authorize three new controlled to nurse practitioners including:

- setting or casting a fracture of a bone or a dislocation of a joint;
- dispensing, selling or compounding a drug; and
- applying a form of energy prescribed in regulation.

Capacity within Bill 179: Bill 179 proposes amendments to the *Nursing Act (1991)* to authorize three additional controlled acts to NPs.

NPAO Position: NPAO commends government for the changes in Section 5.1 (1) 4, 5 and 8 of the *Nursing Act (1991)* to add three new controlled acts for NPs.

[14] IBM McMaster University Report on the Integration of Primary Health Care Nurse Practitioners in Ontario (2005)
[15] Report of the PHCNP Integration Task Team (2007)
[16] Ibid p. 16

Proviso to NPAO Position: NPAO notes that in the absence of open prescribing, NPs will be restricted in their ability to dispense/sell/compound to the list of drugs they can prescribe. NPAO does not support this restriction.

Additional Comments/Rationale: These proposed new acts for nurse practitioners represent significant changes that will improve access to care for patients and more fully utilize the knowledge, skill and judgment of NPs. In authorizing these acts to NPs, there will be a positive impact on the health care system by improving timely access to care and reducing the "leave without treatment" rate. NPAO looks forward to working with CNO on the development of standards and processes that will ensure the necessary quality of practice while granting access to patients who require this service.

In the absence of open prescribing, the following story demonstrates the continuing restrictions that will limit NP practice and access to timely care for patients.

> *A newly diagnosed patient with Type 2 Diabetes can easily need up to five medications at a cost of hundreds of dollars per month. The ability to dispense samples for a trial of a medication before investing in a particular medication that may have intolerable side effects is an important aspect of care that can increase a patient's confidence in a prescribed treatment before investing large amounts in medications that may need to be changed.*

NPAO recognizes that the ability to dispense samples would also require authorization through amendments to federal legislation (Food and Drug Act) and is working with CNO, RNAO and the Canadian Nurses Association to effect that change.

Nurse practitioners already have the authority to order a form of energy. The expansion of scope to include the authority to apply a form of energy is a natural progression directly related to nurse practitioner competency. These changes will streamline access to diagnostic tests for patients. Nurse practitioners will be able to order screening and prevention tests such as bone mineral density tests for patients at risk of osteoporosis and provide a broader range of diagnostic tests such as x-rays of the spine, hip or shoulder. Without this authority patients are often required to visit another health care professional or an emergency room or urgent care centre for unnecessary duplication of care. With the introduction of the NP-Anaesthesia role, a broader range of access to controlled acts, building upon the experiences of advance practice nurses and NPs who practice in critical care areas, will be critical to enable the role to work effectively in anesthesia care teams.

Strengthening Self-regulation

Request to HPRAC: To amend the *Nursing Act (1991)* to specifically reference NPs as members of the CNO Council.

Capacity within Bill 179: This issue is not addressed in Bill 179.

NPAO Position: NPAO recommends an amendment to the *Nursing Act (1991)* to add an additional member to CNO who will be a NP elected by eligible NPs.

Additional Comments/Rationale: A NP position on CNO Council will ensure the NP practice perspective is well represented in discussions concerning NP scope of practice issues, legislative and regulatory changes, as well as patient safety and quality of care requirements

that are unique to the NP role. Although from time to time there have been NPs elected to Council, there is no specific requirement in the *Nursing Act (1991)* to ensure that at least one member of Council is a NP.

Clarification of Nurse Practitioner Scope of Practice

Request to HPRAC: To consolidate the list of controlled acts for NPs in the *Nursing Act (1991).*

Capacity within Bill 179: Section 5.1 of the *Nursing Act (1991)* is amended to consolidate the listing of all controlled acts for NPs in one section and separates them from the acts authorized to other nurses (i.e., general class RNs and RPNs).

NPAO Position: NPAO supports the proposed structural change to Section 5.1 of the *Nursing Act (1991)* to provide clarity and support the effectiveness of interprofessional teams.

Additional Comments/Rationale: This change will minimize confusion and enhance clarity respecting NP authority to order others to perform controlled acts, in particular registered nurses and registered practical nurses. This change will also facilitate the effectiveness of interprofessional teams.

Remove Restrictions to Controlled Act of Communicating a Diagnosis

Request to HPRAC: To remove restrictions in the *Nursing Act (1991)* pertaining to the existing NP controlled act of communicating a diagnosis.

Capacity within Bill 179: Section 14 (1) (f) is amended to enable CNO to develop standards respecting consultation with other health professions.

NPAO Position: NPAO supports the proposed change to Section 14 (1) (f) to enable the College of Nurses of Ontario to better regulate the role and enable effective interprofessional teams. As noted previously under ancillary legislative and regulatory changes, Regulation 682 Lab Specimens Act and Regulation 552 HIA will need to be changed to reflect the removal of restrictions to laboratory and other tests that NPs will have the authority to order.

Additional Comments/Rationale: NPs are competent to communicate a diagnosis consistent with their competencies and to consult and collaborate with other health care providers when appropriate as are all regulated health professionals. NPs are the only health care profession to have a requirement for consultation included in their professional legislation. It is the assessment of NPAO that this is not necessary as it is inconsistent with interprofessional collaboration. Removing restrictions from regulation/legislation and placing consultation requirements in practice standards is consistent with self regulation and will allow CNO to better monitor practice.

Conclusion

NPAO's approach to our analysis of the Bill and our recommendations to the Social Policy Committee are consistent with the government's intent for this legislation, namely, that it is designed to "improve access to health care for Ontarians by enabling a number of health

professions to provide more services and improve patient safety." [17] Our submission also speaks to other key agendas for Ontario's health care system including to deliver high quality, patient-centred care; to maintain safety for both patients and providers; to support innovation and value leadership; to reduce waiting lists; to maximize use of health human resources; and to enable high-functioning, effective interprofessional health care teams.

The Nurse Practitioners' Association of Ontario believes every Ontarian deserves quality health care. With further amendments as recommended, Bill 179 will result in significant changes that will enable Ontario's health care system and health care providers to more effectively and efficiently meet the health care needs of Ontario.

[17] Ontario Ministry of Health and Long-Term Care, retrieved May 23, 2009 from http://www.health.gov.on.ca/english/public/legislation/regulated/regulated_health_professions.html

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.

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 who 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 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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