

**Consultation on Hospital Admit/Discharge/Transfer by Nurse Practitioners
NPAO - December 16, 2010**

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| Evidence & Need | <p>1. Outside the hospital setting, what are the specific patient populations that would benefit from NPs being authorized to admit/transfer/ discharge hospital in-patients?</p> <p>What is the estimated size of this 'need'?</p> | <p>A diversity of patient populations, requiring care in many areas and across the age spectrum, would benefit from NPs being authorized to admit and transfer¹. This would include all the populations served by NPs outside the hospital setting.</p> <p>Statistics from the College of Nurses of Ontario (CNO), 2009, indicate that, in addition to employment in Acute Care Hospitals (25.5%), NPs were employed in:</p> <ul style="list-style-type: none"> • Community Health Centres (21.1%); • Physician's Office/Family Practice Units (19%); • Public Health (3.7%); • Colleges/Universities (3.5%); and • a broad range of other employment settings (25.4%). <p>These statistics indicate that all patients cared for by NPs, from neonates to seniors, could benefit from NP authority to admit and discharge.</p> <p>With the planned established of 26 NP-led clinics by 2012 NPs will be the primary care providers for an even greater number of patients across Ontario.</p> <p>In a 2006 survey of primary health care NPs, the vast</p> | <p>CNO Membership Statistics Report 2009. http://www.cno.org/Global/docs/general/43069_stats/43069_MemberStats2009.pdf</p> <p>Nurse Practitioner Workforce</p> |

¹ 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". 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*.

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| | | <p>majority (almost 92%) reported having a practice focus of health promotion and disease prevention.</p> <p>Given the demographic shift to an aging population, many requiring care for chronic disease management, the senior population of patients, in particular, may derive very specific benefits from the continuity and coordination of care between community and hospital enabled by NPs having authority to admit and discharge.</p> <p>It should be noted that for patients outside of the hospital setting, admission to hospital needs may be to acute care hospital beds, rehab beds, or complex continuing care beds and discharge may be to a variety of community settings, such as the home, other hospital closer to home, rehab, complex continuing care or LTC.</p> <p>In summary, all patient populations receiving NP care outside of hospital settings could potentially benefit from the continuity of care enabled by NP authority to admit and discharge.</p> | <p>Survey and NPAO Electronic Registry Project Report, http://www.npao.org/Uploads/members/NP%20Workplace%20Survey%20and%20Registry%20Report.pdf</p> <p>NPAO, "NP Roles in Ontario: Looking to the Future The Accord Project - Briefing Paper" April 2007. http://www.npao.org/Uploads/Accord%20Project%20Briefing%20Paper.pdf</p> <p>Velji, Karima. "Nurse Practitioners Optimizing Our Future" Keynote presentation at the NPAO Annual Conference, November 5, 2010. (see attachment)</p> |
| | <p>2. Within the ED or hospital setting, what are the specific patient populations that would benefit from NP's ability to admit/transfer/ discharge?</p> <p>What is the volume of patients that would be affected?</p> | <p>Increasingly we know that NPs are working in acute care environments including ED. In fact 30% of NPs currently work in these areas that encompass the following groups of patients.</p> <p>Within the ED/hospital setting, a diversity of patients across the age spectrum, receiving care in the following specialty areas would benefit from NPs authority to admit or discharge:</p> <ol style="list-style-type: none"> 1. General cardiology 2. Cardiac surgery 3. Neurology 4. Neurosurgery | <p>CNO Membership Statistics Report 2009: http://www.cno.org/Global/docs/general/43069_stats/43069_MemberStats2009.pdf</p> |

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| | | <ol style="list-style-type: none"> 5. Nephrology 6. Organ transplant 7. Adult Critical care (general and specialized) 8. General surgery 9. Pediatric critical care 10. Orthopedic surgery 11. Neonatal intensive care 12. Plastic surgery 13. Trauma 14. Vascular surgery 15. Rehabilitation medicine 16. Acute and chronic pain teams 17. General medicine 18. Wound management teams 19. Palliative care teams 20. Respiriology 21. Gerontology/seniors' health teams 22. Mental health 23. Oncology 24. Rheumatology 25. Gastroenterology <p>For hospital-based NPs who see patients in both ambulatory settings and as in-patients, access to both admission and discharge is needed. Admission would mean that the patient's care can't be managed in the ambulatory setting. This could be for any patient with a medical diagnosis (heart failure or other cardiac problem, oncology patients etc.). It could also apply to postoperative patients being followed in clinics who develop complications necessitating admission to hospital to be managed.</p> <p>From the 2009 study of specialty NPs, team members working with NPs in cardiology, pediatrics, LTC,</p> | <p>van Soeren, M., Hurlock-</p> |

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| | | <p>neurology, wound management, pain management, oncology and critical care all suggested that it would be an advantage to have NPs able to discharge patients. The specific advantages noted by these team members (who included physicians, nurses, pharmacists and other team members) were: 1. Increases role clarity when the NPs scope of practice is not fragmented around some aspects of care and not others and 2) Ready access to the NP allows safer and faster assessments of the patients prior to discharge and 3) Greater consultation among team members with the NP versus the physician allows for more accurate assessments of readiness for patients to be safe to discharge and finally 4) Earlier discharges based on ongoing assessment by the NP in collaboration with the team.</p> <p>In summary, all patient populations receiving NP care in hospital could potentially benefit from the continuity of care enabled by NP authority to admit and discharge.</p> | <p>Chorostecki, C., Kenaszchuk, C. Abramovich, I., & Reeves, S. (2009) <i>Report to Ontario Ministry of Health and Long-Term Care On Research Project: The Integration of Specialty Nurse Practitioners into the Ontario Healthcare System</i> . http://www.npao.org/Uploads/SNP%20report%202009.pdf</p> |
| | <p>3. How does the geographic location, health human resource capacity, primary care practitioner model impact the 'need' for NPs to have hospital admission/ discharge privileges?</p> | <p>As indicated in NPAO's September 1, 2010 submission to HFO, NPs in a variety of practice settings currently experience barriers to providing continuous, high-quality care due to the inability for NPs to admit and discharge.</p> <p>For community NPs, in particular, there are significant geographic differences. In teaching hospitals in Toronto as well as large community hospitals in the GTA, many family physicians do not have admission or discharge privileges. If the patient of a community-based NP in these geographic areas requires hospitalization for any reason the admission process is normally through Emergency.</p> <p>Once in ED there are variable processes involving ED</p> | <p>NPAO <i>Response to HealthForceOntario (HFO) Consultation on Nurse Practitioner authority to Admit, Transfer and Discharge In-patients</i>, September 1, 2010. (see attached)</p> |

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| | | <p>physicians and specialists (potentially including NPs of different certifications as part of the assessment process). The decision to admit is currently made by the specialist referred to or the ED physician.</p> <p>However, in rural areas the role of the family physician may be very different where they as the primary care provider may have admission and discharge privileges and care for their patients once in hospital. This may apply to acute care, transitional / rehabilitative care and complex continuing care units. This type of care model may also apply to select units within larger community hospitals for transitional care units, and rehabilitation units and possibly complex continuing care.</p> <p><u>There is a particular need to enable the NP to admit and discharge in hospitals and on units where primary care providers already admit, provide care to, and discharge hospital in-patients.</u> It is inefficient for the NP to require the physician to admit and discharge in these situations.</p> <p>In northern, remote and/or under-served communities, NPs having the authority to admit and discharge will ensure that patients do not experience delays in care due to the need to obtain a physician's authorization to admit and may decrease the unnecessary use Emergency Department services for admitting.</p> <p>A closer collaboration between the hospital and community care will be fostered by NPs having the authority to discharge and this will smooth this process and may lessen lengths of stay in hospital.</p> <p>In areas where few family doctors have hospital</p> | |

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| | <p>4. Are you aware of any data / information relating to NP costs, service utilization, or quality of care findings in relation to hospital in-patient admission /transfer/ discharge?</p> | <p>privileges, NPs having authority to admit and discharge will help to ensure more effective chronic disease stabilization and coordination and continuity of care between community, hospital, and long-term care.</p> <p>There is a vast amount of data that supports the benefits of integration of NPs in terms of patient satisfaction, preventing unnecessary hospital admissions, decreasing length of stay and promoting early hospital discharge. However, there is a lack of quality Canadian research quantifying the cost-effectiveness of NP care.</p> <p>A cost analysis paper from Holland, "Economic evaluation of nurse practitioners versus GPs in treating common conditions" indicates that 19 million euros per year could be realised by one NP.</p> <p>A study of NPs in long-term care in Ontario (McAiney et al.) indicated that hospital admissions were prevented in 39–43% of cases. Such outcomes should represent significant cost saving to the Ontario health-care system.</p> | <p>van Soeren, M., Hurlock-Chorostecki, C., Kenaszchuk, C. Abramovich, I., & Reeves, S. (2009) <i>Report to Ontario Ministry of Health and Long-Term Care On Research Project: The Integration of Specialty Nurse Practitioners into the Ontario Healthcare System</i> . http://www.npao.org/Uploads/SNP%20report%202009.pdf</p> <p>Dale, A., Steuten, L., Metsemakers, J., Derkx, E., Spreeuwenberg, C., & Vrijhoef, H. (2010) <i>Economic evaluation of nurse practitioners versus GPs in treating common conditions</i>". British Journal of General Practice. http://www.ncbi.nlm.nih.gov/pubmed/20040165</p> <p>McAiney Carrie. A. et. al. "A unique practice model for Nurse Practitioners in long-term care homes" Journal of</p> |

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| | | <p>The capacity to influence care was also seen in the role the NP played in development and dissemination in evidence based practices. This was seen by many team members as a key role; in particular, administrators and physicians found this to be an important role for NPs.</p> <p>St. Michael's Hospital has reduced its ED wait times significantly thanks largely to a designated "fast-track" area where patients without life-threatening injuries receive treatment quickly from dedicated nurse practitioners. The area helped reduce the hospital's wait times by 16.7 hours (61%) for patients who require complex medical care or admission to hospital and by 4.6 hours (45%) for patients with minor conditions. Enabling NPs to admit and discharge in-patients would further allow them to contribute to efficient through-times in this busy downtown ED.</p> | <p>Advanced Nursing Volume 62, Issue 5, June 2008. http://www.ncbi.nlm.nih.gov/pubmed/18489449</p> <p>van Soeren, M., Hurlock-Chorostecki, C., Reeves, S. (2011). The role of nurse practitioners in hospital settings: Implications for interprofessional practice. <i>Journal of Interprofessional Care</i>. In press.</p> <p>Ruffell, Brett, "Hospital's NP-led 'fast track' area aids ER wait-time improvement" Canadian Healthcare Network, July 10, 2010. http://www.npcanada.ca/portal/index.php?option=com_content&task=view&id=88&Itemid=9</p> |

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| <p>NP Role & Practice Models</p> | <p>1. If NPs are authorized to admit/discharge/transfer hospital in-patients</p> <p>a) What are the practice models/roles of greatest benefit to patients, to the hospital, and to the system?</p> | <p>An important concept is to think of admission and discharge as processes of providing care rather than single acts as they may once have been years ago in much less complex health-care systems. Admission and discharge processes in hospitals are increasingly a focus for quality improvement and an area where the patient experience is continually being evaluated and improvements made based on continuous evaluation.</p> <p>Healthcare models where NPs practice on inter-professional teams are of greatest benefit to patients, hospitals, and the healthcare system. Collaboration with a team, however needs to have capacity to enact the whole plan of care. Currently, the team member who is least accessible (the physician) is the only one able to complete the entire plan. This gate keeping role is at odds with timely team based actions. Therefore any models that are developed require the NP to be an equal partner in a team with physicians and other professionals as indicated by the patients' condition.</p> <p>Some Ontario examples of innovative models utilizing NPs include: 1. the Central East LHIN's GAIN Geriatric Clinic (Geriatric Assessment and Intervention Network), which establishes the admission from urgent/ emergent clinics for seniors at four hospitals (Lakeridge, Rouge Valley, Scarborough & Peterborough) to ACE (Acute Care of the Elderly in-patient units. 2.The NP-led C.A.R.E. model of Lakeridge Health where the NP has been the MRP for complex continuing care patients. 3. the NP-led Transitional Care model of Parkwood Hospital where patients are transitioned from acute care to home effectively reducing ALC in acute care.</p> | <p>"Shorter Wait Times and More Healthcare Access for Seniors in the Central East LHIN", December 13, 2010. http://www.northumberlandvie.w.ca/index.php?module=news&func=display&sid=5660</p> <p>Acorn, Michelle, <i>"Innovative Models of Care: Utilizing Nurse Practitioners"</i>, February 11, 2008.</p> <p>(see attached)</p> |

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| | b) Are there unique competencies required? | <p>No. CNO's <i>Practice Standard</i> outlines the competencies specific to the NP scope of practice and no other unique competencies are required.</p> <p>NPs are accountable for adhering to the CNO's standards. If the regulation is amended, the Practice Standards will be revised to reflect the new authority of NPs to admit, transfer and discharge.</p> <p>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.</p> | <p>College of Nurses of Ontario, <i>Practice Standard, Nurse Practitioner</i>, June 2009 http://www.cno.org/Global/docs/prac/41038_StrdRnec.pdf</p> |
| | c) Are specific credentials beyond NP needed? | <p>No. CNO outlines the entry to practice requirements for nurse practitioners and no credentials other than those indicated by the College should be required.</p> <p>As self-regulating professionals, every NP is responsible for practising in accordance with the standards of the profession, and for keeping current and competent throughout her or his nursing career.</p> | <p>See College of Nurses of Ontario, <i>Fact Sheet, Registration, Nurse Practitioners</i>, December 2009: http://www.cno.org/Global/docs/reg/45025_fsExtendedclass.pdf</p> |
| | d) Are there differences between NP specialty certificates that need to be considered (Primary Health Care, Paediatrics, Adult, and Anasthesia)? | <p>No – as indicated in a previous section, as self-regulating professionals, NPs use their knowledge, skills and judgement to exercise authorities within their area of practice.</p> <p>NPs in all areas would be expected to exercise their authority to admit and discharge within their specialty and scope of practice.</p> | <p>College of Nurses of Ontario, <i>Practice Standard, Nurse Practitioner</i>, June 2009 http://www.cno.org/Global/docs/prac/41038_StrdRnec.pdf</p> |

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| | <p>e) Are there in-patient units or patient populations where role restrictions are needed?</p> | <p>No – NPs have the knowledge, skills and judgement to exercise the authority to admit and discharge within their scope of practice. No restrictions are required.</p> | <p>College of Nurses of Ontario, Practice Standard, Nurse Practitioner, June 2009: http://www.cno.org/Global/docs/prac/41038_StrdRnec.pdf</p> |
| | <p>f) Does the accountability of MRP change? How?</p> | <p>Yes – it is important in the renewal of our healthcare system to move away from the terminology that enables a single access to the system. We need to consider team based decisions around care. To enable this change the Most Responsible Physician needs to become Most Responsible Provider to reflect authority of more than physicians to admit and discharge.</p> <p>Midwives' <i>Indications for Mandatory Discussion, Consultation and Transfer of Care</i>, 2000 outlines when midwives need to discuss, consult, or transfer primary care responsibility so that another care provider becomes the MRP. This process has been working well for more than a decade and may serve as a model as NPs gain authority to admit and transfer.</p> <p>When NPs are provided authority to admit and discharge, similar guidelines for NPs should be developed by CNO to guide MRP processes and accountability.</p> | <p>See College of Ontario Midwives document: <i>Indications for Mandatory Discussion, Consultation and Transfer of Care</i>, 2000. http://www.cmo.on.ca/downloads/communications/standards/G04-Indications%20for%20Mandatory%20Discussion%20Consultation%20and%20Transfer%20Jun00.pdf</p> |

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| | g) Which RHPA professions, beyond nursing, would require the ability to accept an 'order' from a NP? Under what conditions? | All health professions that make up health-care teams should require the ability to accept an order from an NP. In some cases, this will require an amendment to the legislation and/or regulations governing these professions. | |
| | <p>2. To what extent is a pre-defined, consistent collaborative practice model needed across hospital sites / practice settings?</p> <p>What are the key features/ requirements that should be considered in any Collaborative Practice Model?</p> <p>What are the models that currently exist?</p> | <p>NPAO supports interprofessional collaborative practice models and believe that these are necessary to implement the changes required to enable NPs to exercise the authority to admit and discharge.</p> <p>Key features that should be included in such a model have been articulated in the NPAO Project "Development of an Accord on the Nurse Practitioner Role in Ontario: Developing Models of Interdisciplinary Practice that Enhance Patient Care (The Accord Project). Funded by the Primary Health Care Transition Fund (PHCTF) of the Ontario Ministry of Health and Long-Term Care, the project was proposed to be a vehicle for advancing a proactive, planned change process targeting the NP role within the Ontario health care system.</p> <p>Key features that should be considered in a collaborative Practice Model include:</p> <ul style="list-style-type: none"> • attention to unmet patient needs within the current health care climate; • creation, acknowledgement and promotion of high-energy, team based practices (therapeutic microcultures) that seek to promote interprofessional practice and patient-centred care through understanding of the cultural assumptions within all professional disciplines; • development of the relational infrastructure that | <p>NPAO, "NP Roles in Ontario: Looking to the Future The Accord Project - Briefing Paper", April 2007. http://www.npao.org/Uploads/Accord%20Project%20Briefing%20Paper.pdf</p> |

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| | | <p>supports effective interprofessional collaboration;</p> <ul style="list-style-type: none"> • promoting and sustaining highly reliable team practices that support patients and families to have intact, meaningful lives; • role positioning and championing of the NP role at leadership levels; and, • applying existing research on NP outcomes and interprofessional role effectiveness. <p>Examples of successful interprofessional practice models include the GAIN model mentioned previously.</p> | |
| Implementation Topics | <p>1. Do hospital admission/transfer/discharge criteria currently exist?</p> <p>Are they consistent across hospital sites?</p> | <p>There is variability in the existence of admission and discharge policies among hospitals and programs across Ontario. Where such policies have been established, they are usually outlined in by-laws and policies.</p> <p>If NPs are provided the authority to admit and discharge, individual hospital by-laws would require revisions to allow NPs to fully exercise this authority within the interprofessional team and the practice setting. It would be helpful to have templates created that would address key points for standardization across hospitals in Ontario, rather than individual practices that may not completely enable the full scope of practice for the NP.</p> | |
| | <p>2. To what extent are credentialing practices and 'privilege' granting practices similar across hospitals?</p> | <p>Credentialing and privileging practices for physicians, dentists, and midwives are similar across hospital settings in Ontario. Few hospitals have credentialing and privileging processes for other health professions such as NPs.</p> <p>For non-hospital employed practitioners there is a fairly</p> | <p>Acorn, Michelle and Colleen Dooks, "Credentialing and Privileging For NPs" presentation to the Annual Nurse Practitioner Conference, November 13, 2004. (see attached)</p> |

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| | | <p>standard process. For those employed by the hospital credentialing is not required.</p> <p>The general process is:</p> <ol style="list-style-type: none"> 1. Data is collated for the Credentialing Committee (re. the NP's proof of registration, certification, educational preparation, proof of malpractice insurance; proof of skill performance) and approved; 2. The Privileging Committee grants privileges to the practitioner; 3. The Medical Advisory Committee approves; 4. The Hospital Board approves; and 5. A letter is sent to the NP from the CEO of the hospital, the Program Leader and the Physician Leader which outlines the scope and limitation of the privileges granted. <p>The goal of privileging is to :</p> <ul style="list-style-type: none"> • Assure high quality of patient care • Mitigate hospital & partnership risks • Provide a clear, standardized process to ensure consistency across the sites & corporation • Privileges may expand based on evolving clinical mastery, advanced training, and increased services required • Acts may be closely supervised initially and then expand to a more autonomous level of performance as efficacy & safety is proven. | |
| | <p>3. <u>If</u> NPs are authorized to admit/discharge/transfer hospital in-patients -</p> <p>a) What are the factors that</p> | <p>The main factors to consider are that providing authority to NPs to admit, transfer and discharge will:</p> <ul style="list-style-type: none"> • Be beneficial to patient care and safety; • Enhance coordination and continuity of health care provided outside the hospital setting | <p>NPAO "Response to HealthForceOntario (HFO) Consultation on Nurse Practitioner authority to Admit, Transfer and Discharge In-</p> |

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| | <p>should be considered and who should make decisions about determining the need for this practice role at a specific hospital?</p> | <p>(community, long-term care and primary health care settings) and within hospitals;</p> <ul style="list-style-type: none"> • Make better use the competencies of NPs; and • Promote interprofessional collaboration; and • Make more effective and efficient use of health care resources in Ontario. <p>The provincial government should take the lead by amending the <i>Public Hospital Act</i> to provide NPs authority to admit, transfer, and discharge. Hospital senior leadership should make decisions regarding the implementing the changes in their practice settings to optimize NPs exercise of this authority.</p> | <p><i>patients</i>", September 1, 2010. (see attached)</p> |
| | <p>b) Who would oversee granting NP admission /discharge 'privileges'?</p> | <p>Hospital Credentialing and Privileging Committees, which should include representation from an NP for non hospital employed NPs. For hospital employed NPs this would be overseen by the Chief Nursing Executive.</p> | |
| | <p>c) Which hospital bylaws or policies are absolutely critical to revise and why? How difficult is it to make changes to these bylaws or policies?</p> | <p>Amendments to hospital by-laws and policies that would be critical to revise would include all those that would affect the authority or potentially create barriers to NP exercising full authority to admit/discharge. These would include, but are not limited to:</p> <ul style="list-style-type: none"> • Revising Privileged Staff by-laws; • Including NPs in Most Responsible Provider (or Physician) policies; • Replacing medical advisory committees (MACs) with Interprofessional Advisory Committees (IACs) and ensuring NP representation on the IACs; • Allowing all other health professionals to receive orders from NPs; and | <p>NPAO, "Position Statement Nurse Practitioner Referral to Specialists" March 2008.</p> <p>http://www.npao.org/Uploads/members/Position%20Statement%20Referrals%20to%20Spe</p> |

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| | | <ul style="list-style-type: none"> • Allowing NPs to make referrals to specialists, and 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. <p>In order to enact a smooth transition and effect the changes needed to provide NPs authority to admit and discharge, hospitals must lead, embrace and manage the changes required throughout their organizations.</p> <p>While it is not difficult to enact changes to policy, gaps can exist between legislation, provincial policy directives and on-the-job practice. These gaps may occur when changes are not effectively communicated and/or practice settings are resistant to change. For example, even though midwives are primary health care providers with authority to admit and discharge in Ontario, a 2007 survey found that 48% of midwives experiences barriers to their working to their full scope of practice.</p> | <p>cialists%20March08.pdf</p> <p>Association of Ontario Midwives, “NP Admit/Discharge/Transfer Submission to HealthForceOntario”, September 3, 2010.</p> |
| | <p>d) What are the benefits to the patients if NPs serve on the MAC?</p> | <p>NPAO recommends that medical advisory committees (MACs) of hospitals should be replaced with interprofessional advisory committees (IACs).</p> <p>This would be an important step in allowing such committees to evolve to keep pace with changes in the health care system, to reflect the expanded roles of NPs and the growing importance of interprofessional care in Ontario for the oversight of quality of patient care.</p> <p>Whether MAC or IAC, either type of committee would benefit from the inclusion of NP representation in order to provide an interprofessional perspective and input specific to the role, scope and competencies of NPs as</p> | <p>See NPAO’s and Association of Ontario Midwives’ submissions to HFO regarding admit/transfer and discharge, September 2010.</p> |

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| | | <p>part of the healthcare team contributing to achieving a high quality of care.</p> <p>Data from the Specialty NP study indicates the NP informs physician practices by inclusion of specialized evidence, greater understanding of team roles and hospital processes. Therefore, having this knowledge available to a decisional body would provide a greater capacity for decisions that are not based on one professional perspective.</p> | <p>van Soeren, M., Hurlock-Chorostecki, C., Reeves, S. (2011). The role of nurse practitioners in hospital settings: Implications for interprofessional practice. <i>Journal of Interprofessional Care</i>. In press.</p> |
| | <p>e) Should there be one or more NP compensation models?</p> | <p>No – there should be one salary-based model, consistent with the current compensation model for NPs in hospital settings.</p> <p>NPAO strongly supports that there should be sustained, dedicated funding for hospital-based NP positions. When NPs are funded largely from global hospital budgets this threatens their positions in times of fiscal change.</p> <p>All referrals to specialists, including those from NPs, should be compensated at the same rate.</p> | <p>van Soeren, M., Hurlock-Chorostecki, C., Kenaszchuk, C. Abramovich, I., & Reeves, S. (2009) <i>Report to Ontario Ministry of Health and Long-Term Care On Research Project: The Integration of Specialty Nurse Practitioners into the Ontario Healthcare System</i> . http://www.npao.org/Uploads/SNP%20report%202009.pdf</p> |
| | <p>f) What models should be considered and why?</p> | <p>This should include:</p> <ol style="list-style-type: none"> 1. Salary; 2. team-based incentives; and 3. on-call stipends (if applicable). <p>Team-based incentives are seen as a fair and equitable way to foster and reward inter-professional team</p> | <p>NPAO <i>Position Statement "Team-related bonuses is the correct way to go"</i> March 2008 http://www.npao.org/Uploads/members/Position%20Statement%20Team%20Based%20Bo</p> |

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| | | <p>collaboration and provide an opportunity for all team members to share in the benefit of quality improvement.</p> <p>Similarly, in an equitable fashion, if on-call stipends are provided to other on-call health care staff, NPs should also receive this compensation.</p> | <p>nuses%20Correct%20Way%20to%20Go%20Mar%20.pdf</p> |
| | g) How would 'on-call' coverage be addressed? | If on-call service is required by NPs, they should be provided an on-call stipend. | |
| | h) What liability coverage is essential? | <p>NPAO does not believe that any additional liability insurance would be required when NPs gain authority to admit and discharge.</p> <p>Currently, most NPs in Ontario hold professional liability insurance obtained through the Canadian Nurses Protective Society, which automatically provides \$5M occurrence-based professional liability coverage to NPs in Ontario who are members of the RNAO and registered with the College of Nurses of Ontario (CNO) as an RN(EC).</p> <p>Under the <i>Regulated Health Professions Statute Law Amendment Act, 2009</i> (Bill 179) all health professionals in Ontario will be required to hold professional liability insurance.</p> <p>In response to this requirement, CNO has introduced amendments to its General By-Laws (article 44.4) to require all members to hold Professional Liability Protection (PLP); RN(EC) members would be required to hold \$5 million per claim and these were considered by Council December 1, 2010.</p> <p>This By-Law would come into effect only if and when the</p> | <p>See NPAO Member Benefits and Other Background Information. http://www.npao.org/mem_benefits.aspx</p> <p>See: http://www.e-laws.gov.on.ca/html/source/statutes/english/2009/elaws_src_s09026_e.htm</p> <p>See: http://www.cno.org/en/news/2010/12/council-decisions-regarding-proposed-registration-regulation-and-related-by-law-amendments/</p> |

**Consultation on Hospital Admit/Discharge/Transfer by Nurse Practitioners
NPAO - December 16, 2010**

| Topic | Specific Questions | NPAO Response | References |
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| | | <p>government proclaims new provisions in the <i>Health Professions Procedural Code</i> related to professional liability protection. Since those provisions have not yet been proclaimed, Council has deferred decision on the proposed new Article 44.4.</p> | |
| | <p>i) What are the implementation responsibilities of the hospital, the NPs, the physicians and others in successfully enacting the role / model</p> | <p>Every hospital will need to have an implementation plan. NPAO would welcome working with the Ontario Hospital Association and Chief Nursing Executives to develop a framework for implementing and evaluating the changes required to enable NPs to fully exercise the authority to admit and discharge.</p> <p>Elements of the implementation framework should include:</p> <ul style="list-style-type: none"> • a comprehensive review and revision of related enabling legislation and hospital by-laws and policies. 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. • A communications plan to inform and promote “buy-in” and collaboration from all professions that make up health care teams. • Enabling all health care professionals (including respiratory therapists, occupational therapists, physiotherapists etc.) to accept orders from NPs. • As part of the development of electronic health record processes, ensure that mechanisms are in place for NPs to be registered as the Most Responsible Provider. | <p>van Soeren, M., Hurlock-Chorostecki, C., Kenaszchuk, C. Abramovich, I., & Reeves, S. (2009) <i>Report to Ontario Ministry of Health and Long-Term Care On Research Project: The Integration of Specialty Nurse Practitioners into the Ontario Healthcare System</i>. http://www.npao.org/Uploads/SNP%20report%202009.pdf</p> |