NPAO’s Response to *Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario*,
Released December 17, 2015

NPAO’s Vision for a Healthy Ontario

NPAO supports a strong, efficient health care system that provides “the right care at the right time in the right place by the right provider”.

Nurse Practitioners, by virtue of their nursing education, place an emphasis on promoting health, preventing illness and injury, and reducing complications. With this patient-centered focus, NPs aim to reduce unnecessary emergency room visits, reduce the length of stay for hospital patients, and ensure that people are well cared as close to home as possible.

Foreword

NPAO applauds Minister Hoskins, the Wynne government, and the Minister’s team for developing *Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario (Dec. 17, 2015)*. We were honoured to be invited to the initial briefing session as well as the official release. Subsequently, NPAO sent the document to all of our 2,100 members and included the feedback URL so that individuals could submit feedback individually. Since the release, the proposal paper has been the subject of three NPAO Board meetings, one of which we had the privilege of hosting senior members of the MOHLTC. In addition, we have held two webinars that many of our members have participated in. We appreciate very much the consultation sessions that have been held across the province and the fact that Ministry staff has been available and accessible for questions, clarification and feedback. We thank the Minister for this fulsome consultation process and the opportunity to provide input in order to improve Ontario’s world-class health care system.

The primary values and principles set out in *Patients First* reflect many of the values and goals that NPAO members cherish as articulated in *Better Value. Better Care (NPAO, 2014)*. NPAO endorses the key directions that *Patients First* is proposing. In the discussion paper, the Ministry has chosen to use the term “Patients”. Respectfully, NPAO puts forth that a patient is somebody requiring health care for a
disease, illness or injury. Throughout this response, we will interchange the words patients, clients, and people. In addition, within our frame of reference, a “patient” will always refer to a patient/client and their family or caregiver(s).

In the response to Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario (hereinafter called “Patients First”), NPAO has chosen to ask the following questions: What does this proposal mean for patients? What does this mean for citizens and communities? What is working well and what needs improvement from a patient/citizen perspective? What does this mean for the future of health care in Ontario? What does Patients First propose as different than the status quo? These questions will guide our response.

1. Improve Access to Timely Primary Care

Primary Care is the entry point to the health care system when and where needed. Primary care is where the vast majority of healthcare happens across the lifespan from “womb to tomb”. Particularly with the goals of reducing ER visits and hospital length of stay, in addition to supporting aging-at-home, more care is provided in the community by Primary Care Providers (PCP) and inter-professional teams than ever before.

Today more than 94% of Ontarians report having a regular primary care provider (HCES, MOHLTC, 2015). More specifically, approximately 94% of Ontarians report that they have a Family Doctor, General Practitioner, or Nurse Practitioner that they see regularly for check-ups or when they are sick (HCES 2015 phone questionnaire). Despite having a good overall attachment rate, the variability across the province is disturbing. Attachment rates go from a high of 97% in the South East to a low of 87.3% in the North West. This same phone survey has found that approximately 2% to 3% of Ontarians do not wish to have a regular PCP even if one were available.

The term Primary Care Provider is akin to the concept of Most Responsible Practitioner/Provider (MRP). MRP is more of a legal construct rather than a tenet enshrined in regulation and legislation. Essentially, MRP refers to “the main practitioner directing the care and ordering therapies most of the time for a client” even when the plan of care is carried out by many members of a team. The concept of MRP helps to make accountability and responsibility more transparent. When things go wrong and there are errors or omissions, the identified MRP often bears the brunt of the liability (OHA, 2012). The Ontario Primary Care Council has arrived at a consensus that MRPs are physicians or Nurse Practitioners (OPCC, 2016).

Unfortunately, having a Primary Care Provider (PCP) does not necessarily mean that people can get in to see that person in a timely fashion. Patients First states that 57% of Ontarians cannot see their primary care provider the same day or next day when they are sick and 52% report having difficulty accessing care in the evenings or on
weekends. In fact, only 44% of Ontarians report being able to access their PCP same day or next day when sick, with a range of 30% in the North West to a high of 53.5% in the Central West (HQO, 2015).

What do patients want? Patients want to make sure that their primary care provider is available when and where needed. This means that, when somebody thinks they have a chest infection or they think they have a laceration that may require sutures, that person has somebody to talk to who may be available to assess and/or treat them that day or the next day. At the very least, patients want to be triaged by someone who knows them. This includes having access to weekends and after-hours care. In addition, home-bound clients should be able to expect that their primary care provider or inter-professional team-member (someone who knows them) would be able to make a home visit. This does not mean that primary care providers should be available to do a periodic health exam at 3 a.m. on a Sunday. But it does mean that a person might be able to avoid going to the Emergency Department on the Friday night of a long weekend with a urinary tract infection or an exacerbation of bronchitis.

How would this be accomplished? Firstly, patients should be able to contact their primary care provider or an alternate provider on the team who has access to their electronic health record 24/7. Patients should be able to expect that their diagnostic imaging results, hospital discharge notes, and/or lab results would be available to that provider. In addition, the utilization of e-mail and other electronic communication (using a secure portal) should be enabled to communicate with patients and other providers in the circle of care. E-Prescribing, E-referral, e-consults, telemedicine, tele-derm and also electronic monitoring should be promoted and enabled.

*Patients First* endorses the concept that existing relationships between patients and their care providers would continue. The paper also states: “Patients will always have the right to choose their primary care provider, and the sub-regions would help patients change physicians or nurse practitioners to get care closer to home.” This concept supports patient choice and care closer to home, both of which NPAO heartily endorse. But the document also states that: “...clinicians would retain choice for what patients they care for within their sub-region.” This is a troubling concept for NPAO. It means that patients may be rejected by primary care providers for any one of a variety of reasons.

In the Price-Baker report (2015), the concept that people ought to be able to receive care as close to home is set out fairly clearly. This concept is endorsed by NPAO. The same way that Ontario ensures that every child will be placed in a local school when their family moves, so too should the health care system provide that no person will be turned away because they have moved or because of the number of medications they are on. There will be situations where a local provider cannot provide the best care for the client. We strongly encourage the Minister to adopt a more equitable and inclusive way of ensuring that the entire population has a Family Physician or
Nurse Practitioner. This is a true guarantee of a Primary Care Provider as set out by Premier Wynne (2014).

Nurse Practitioners are proud of the fact that they provide care to many clients who are marginalized and under-served within our current health care system. As part of inter-professional teams within CHCs, AHACs, FHTs and NPLCs, hospitals, and Long-Term Care Homes, Nurse Practitioners serve many of the most vulnerable people within our society. Nurse Practitioners have developed expertise in the care of people with addiction and mental health issues. They serve refugees, new immigrants, and those whose first language is not English. NPs serve people with numerous co-morbidities and complexities, many of whom experience material deprivation and social isolation.

Currently there are 25 Nurse Practitioner Led Clinics (NPLCs) in Ontario serving approximately 54,000 previously orphaned patients in areas that were historically under-served. These clinics typically have 4 Nurse Practitioners (one of whom is the Lead NP) along with social workers, physiotherapists, RPNs, a part-time physician and pharmacist. The NPLCs epitomize the concept of “disruptive innovation” in that they are serving a segment of the population previously underserved (www.christenseninstitute.org). Nurse Practitioner Led Clinics provide high quality health care at a lower cost than other models. This innovative and groundbreaking model has extended primary care services to many people who were turned away from other providers (personal communication with the Director of Health Care Connect, 2015).

The concept of rejecting or abandoning a client because they are too complex is foreign to the ethos of a Nurse Practitioner. On occasion, clients are transferred to another care provider if they move or if their therapeutic goals are not being met within that team. But NPs and NPLCs do not screen patients in an effort to roster healthy patients or those who may not require as much care. All Nurse Practitioners are paid a salary; as such, there is no funding incentive either to “cherry pick” or to reject potential clients.

NPAO firmly asserts that Primary Care is best provided in the context of a co-located inter-professional team that works collaboratively to meet the goals of the client. Patients First states that “planning would include improving access to inter-professional teams for those who need it most, facilitating care plans and supporting an integrated, coordinated patient-centered experience” (p 16).

Currently inter-professional primary care teams funded by the MOHLTC provide comprehensive primary care services to approximately 25% of Ontarians. We call these models Inter-Professionals Care Organizations or IPCOs; they include CHCs, FHTs, NPLCs and AHACs. Additionally, some Ontarians also have access to inter-professional providers as enrolled patients of FHGs or FHOs. Communities, such as Guelph, Collingwood and Chatham-Kent, that have the highest attachment rates to
inter-professional teams (i.e., where 80% or more of the community belong to an IPCO), also have some of the best health indices.

What does the phrase mean: “for those who need it most”? When does an individual need a Registered Dietitian: after they are diagnosed with Type 2 Diabetes Mellitus or before they are diagnosed, but when they have risk factors? When does a couple need access to a social worker for marital counseling: when they are going through a divorce or when they are experiencing discord in their marriage? When does an adolescent need the help of a Clinical Psychologist: after they have attempted suicide or when they are showing signs of depression and social isolation?

NPAO challenges the Ministry to use an up-stream approach that focuses on prevention and health promotion with respect to the allocation and utilization of inter-professional health teams rather than a “down-stream” approach that focuses on responding to people in crisis. The right to an inter-professional health team with providers such as Registered Dietitians, Clinical Psychologists, Social Workers, Podiatrists and care-navigators should neither be the exclusive privilege of the rich nor a “search and rescue team” for those who have fallen overboard.

NPAO also challenges the Ministry to orient services toward a Health care system rather than an Illness-care system. At one of the roundtable discussions on Patients First, an ADM revealed that approximately 700,000 people each year receive home care services and approximately 900,000 people are admitted to hospital in Ontario. Logically, some of the ones who receive home care are the same people who were hospitalized. Either way, that still leaves approximately 12 Million Ontarians in neither group. How can we best orient our system to keeping people healthy and well? How can we best ensure that people don’t become Patients?

“Those who need it most” certainly include: people from low socio-economic groups; Indigenous, Inuit and First Nations peoples; refugees and new immigrants; as well as other marginalized communities. “Those who need it most” also include people with mental health and addiction issues, people with complex health conditions and numerous co-morbidities.

These are exactly the populations that NPLCs serve as well as Nurse Practitioners across the health care system. As a proportion, more Nurse Practitioners work in northern, remote and underserved areas; this is partly because this is where the MOHLTC has historically funded their positions. According to the College of Nurses of Ontario (2015), 9.2% of Ontario Nurse Practitioners work in the Northeast LHIN and 4.4% of Ontario Nurse Practitioners work in the Northwest LHIN. So, approximately 13.6% of Ontario Nurse Practitioners work in the northern LHINs. Approximately 6.1% of the population of Ontario lives in these two LHINs. This is clear evidence that policies set by the MOHLTC can result in the equitable distribution of health human resources to meet the needs of all Ontarians. Having said that, there needs to be more incentives to attract health care providers to rural, remote, and underserviced areas.
Nurse Practitioners have more than 50 years of experience serving the most vulnerable people within our society. Nurse Practitioners always work within a team. NPAO would be happy to share this experience and expertise with others.

We applaud the Minister’s efforts to ensure the full utilization of the teams by ensuring every team member is working to their optimal scope of practice (Canadian Academy of Health Sciences, 2014). Working to one’s “optimal” scope of practice is different than working to one’s “full” scope of practice. For example MDs, as part of their “full” scope of practice, are authorized to prescribe chemotherapy agents and do surgical procedures. However, this does not necessarily mean that all physicians should or would do this in every setting. We urge the Ministry to expedite the removal of barriers to the current scope of practice for Nurse Practitioners in order to achieve better efficiencies. Removing barriers to the current scope of practice for NPs by enabling them to prescribe controlled drugs and substances, complete a Form 1, and order all diagnostic imaging tests, would enable the optimal scope of practice and provide efficient and timely care to patients.

An equitable compensation policy would also help to ensure a return on the investments in Nurse-Practitioner Led Clinics and community-based health care that the province has already made and pledges to make. Low turnover of NPs in IPCOs improves patient safety and continuity of care. The province has committed to a further investment of $85 Million over 3 years for IPCO team members. This is a great first step and we applaud the government but much more work needs to be done to ensure predictability and stability of essential health human resources.

NPAO endorses the concept that every Ontarian should have a patient-centered primary care home. A Patient-Centered Primary Care Home (PCPCH) will ensure that patients have a personal family physician or nurse practitioner as their primary care provider (OPCC, 2015). A PCPCH will provide a broad scope of services carried out by teams of providers and will provide comprehensive primary care across the lifespan. Team members will utilize and maintain electronic health records for their practice population. It will commit to carrying out ongoing evaluation of effectiveness and the patient experience through CQI. The PCPCH will ensure timely access to appointments in the practice and help with coordination of timely referrals.

The CCFP challenges its members, family physicians across Canada, to adopt the tenets of this model and move toward accomplishing these goals by 2022 (CCFP, 2011). This is a laudable goal.

NPAO would suggest that these goals are currently being accomplished by nurse practitioners working within CHCS, FHTs, NPLCS and AHACs. All of these models currently utilize an EMR. All of them provide extended hours of service and after-hours triage. All of these models have submitted Quality Improvement Plans and are
currently tracking performance measures. All provide clients with an inter-
professional, team-based primary care home.

NPLCs currently provide all of the expectations of the Patient-Centered Primary Care Home at the lowest cost per case within the health care system. For example, each FTE Nurse Practitioner working in an NPLC is contractually obliged to work 37.5 hours per week. Utilizing flexible scheduling ensures the clinic is always staffed and the NPLC also provides after-hours care such as evening clinic hours. Expanding the number of NPLCs and the capacity of NPLCs would enable them to register more clients and take call as needed. Increasing the number of NPLCs would also provide more people in the province with a patient-centered primary care home. This could be done easily and in a cost-effective way thereby providing better value to taxpayers.

2. Improve Access to Specialist Care

There can be no discussion of improving primary care and system integration without touching upon the need to improve timely access to specialist care. A finding from the Health Analytics Branch HCES demonstrates that 50% of Ontarians wait more than a month for an appointment with a specialist. As well, 18.4% of Ontarians wait more than 90 days. Residents in the northwest LHIN have the longest wait times with almost 70% waiting for more than 30 days and 29% waiting more than 90 days.

When patients wait too long, they become anxious and occasionally skip the queue and go through ER where they might see a specialist on the same day or in an expedited period of time. Invariably, this is associated with the duplication of diagnostic tests. It also circumvents normal channels of communication between the primary care provider and the specialist thus undermining care coordination.

NPAO is strongly in support of the expansion of the E-Consult pilot and the E-Referral pilot. Provincial or LHIN access to virtual consults through OTN and telederm needs to be put in place. The ECHO model of mentorship and case-consultation is a great idea whose time has come. Programs, such as the ISAEC model of assessing and managing lower back pain, need to be scaled up. Finally, and most importantly, the MOHLTC needs to enable Nurse Practitioner-to-Nurse Practitioner referrals. At this point in time, there are only mechanisms for Nurse Practitioners to refer directly to a physician. A Nurse Practitioner in the community may know a colleague with expertise in the care of people with tuberculosis or tracheostomies but often she/he cannot refer directly to her/his colleague.

Furthermore, clinical integration cannot happen absent a secure, inter-connected and fully operational electronic health record, which would include a connection to hospital data, OLIS, PACS, and pharmacies. Evidence-based practice tools such as Choosing Wisely, Up-to-date, and the Canadian Task Force Clinical Guidelines would be imbedded into the EHR.
3. Enhance the Roles of LHINs

*Patient First* proposes enhancing the authority of LHINs; NPAO supports this in principle. The LHINs currently plan and monitor the performance of hospitals, long-term care homes, community mental health and addiction services, and home care. Many of these organizations continue to have their own Board of Directors; therefore, governance structures are replicated at a provincial, regional and organizational level. Maintaining numerous Boards may help to provide enhanced opportunities for public engagement but it makes accountability more cumbersome and ambiguous.

*Patients First* talks about “integrated funding” but until this integration happens at all levels, the province’s plan to revamp, renew and improve the health care system will be thwarted. The paper states that, “While LHINs would play a greater role in primary care health human resource planning, physician compensation and primary care contracts would continue to be negotiated by the government and administered centrally” (p.16). According to ICES, this means that the government would continue to negotiate more than 300 different types of contracts. In addition, the discussion paper states that: “Ontario Medical Association (OMA) representation rights would continue to be respected” (*Patients First*, p.16). Does this mean that all other collective bargaining organizations, other than the OMA, would undertake collective bargaining LHIN by LHIN?

As long as there is a dedicated envelope of funding for physicians and physician services that is separate from the rest of health care funding, there will not be “integrated funding” in Ontario (NPAO Pre-Budget Submission, 2016). Furthermore, LHINs are undermined from achieving their mandate as they lack the fiscal levers to create meaningful change. If the LHIN mandate is to expand to include performance management for primary care and home and community care, they should have the tools that will enable success, not set them up for failure.

As an example, four Public Health Units (PHUs) in Ontario recently laid off all of the Nurse Practitioners in their sexual health clinics. These Nurse Practitioners had been providing high quality health services for many years and were greatly appreciated by clients. The Public Health Units replaced the Nurse Practitioners with physicians. Why? Because Nurse Practitioners were paid a salary out of the global budget of the PHU whereas the physicians are able to bill fee-for-service through OHIP. Would this cost taxpayers less? No, in fact it would likely cost taxpayers more.

NPAO recommends that the Ministry take bold and decisive action to implement a fully integrated health care system. Funding for all health care organizations should flow through the LHINs. Funding should wrap around the patient and family, not the provider. Following on the recommendations of the Drummond report (2012), the
province should continue to move from a fee-for-service payment model for physicians to paying for performance.

In addition, bonuses and incentives should align to produce the best outcomes. In Family Health Teams, individual physicians are provided incentives for the work done by other team members. Physicians are incented to directly provide well baby care, prenatal care, and smoking cessation counseling. It would be more cost-effective and efficacious to have these services provided by Nurse Practitioners and Registered Nurses. In the current fiscal environment, which demands efficiencies and cost savings, these incentives seem counterproductive.

Health human resource planning needs to occur in a deliberate, evidenced-based way and not as an unintended consequence of misaligned incentives compelling CEOs to “follow the money”. The work of the team as a synergistic whole needs to be rewarded with incentives and bonuses; currently these incentives and bonuses go only to one member of the team.

If LHINs are to have the accountability and enhanced authority they must also have the power to allocate funding and resources and hold recipients accountable for performance. In turn, the compensation of LHIN leaders should be tied to their performance.

At a LHIN and Sub-LHIN level, the LHINs could optimize their collective purchasing power by pooling extended health benefits across organizations and sharing back office resources. The LHINs could also set up “My CART” which would provide a virtual procurement network with the goal of sourcing competitive prices for supplies and equipment by taking advantage of economies of scale.

Further reforms to the health care system must go hand-in-hand with reforms to social assistance. Funding and allowances for those on a fixed income have undermined many of the goals that the health care system is attempting to achieve. As an example, the transportation allowance (e.g., public transit allowance) for an ODSP recipient increases commensurate with the number of appointments one has with physicians, specialists, and social service agencies. However, ODSP recipients do not receive a transportation allowance to attend yoga classes or to swim at the YMCA. The special diet allowance for social assistance recipients increases with diagnoses such as hypertension and obesity, allowing people to buy more food or better food. Why would it not also provide the allowance for those who choose more fish, fruits and vegetables or for those who choose to participate in “the good food box” or field-to-table programs? Why not pay people to go to smoking cessation groups or exercise classes? A program that enables the working-poor to access medications and dental care is also essential for the health of the population.

Although Patients First articulates an enhanced role for LHINs, the paper does not clearly articulate the relative role of the Ministry of Health vis-a-vis the LHINs. The Ministry of Health is the steward of the health care system. Through strategic policy-
making, including funding policies, the Ministry sets the strategic directions for the health care system (based on the mandate provided by the electorate) and holds funding recipients to account. The role of the Ministry of Health needs to continue to be two-fold: the Ministry needs to continue to ensure that necessary insured health services are provided equitably while also minding the public purse so that these services are available for future generations.

NPAO believes that laboratory services and drug programs should remain under the direct purview of the MOHLTC as both of these programs require significant review and reform.

Exceptions for LHIN integration would include specialized facilities such as the Hospital for Sick Children and CAMH, but even these institutions should be supported to develop more satellite clinics and virtual clinics. A Nurse Practitioner who had recently graduated with a Pediatric specialty certificate wanted to work in Barrie rather than commute to Toronto. Her expertise would have been well-positioned serving children with complex health needs in her own area but there was no funding mechanism available for a local clinic. Ironically, she now commutes to Sick Kids where many of the families she cares for are also commuting there from the same community.

The discussion paper also suggests that LHINs would need to be augmented. LHINs will need to be augmented with more access to leaders in epidemiology, biostatics, health performance management, along with ICES and academic-affiliated research teams. Given an increased role for home and community care, LHINs would benefit from the experience and expertise of the leadership of CCACs. This would be a good place to recruit needed talent.

In anticipation of proposed changes, NPAO re-organized its Board in 2015. Traditionally, NPAO had 7 Regional Representatives on its Board of Directors. NPAO changed the boundaries of these regions to align with the LHINs. Initially this meant that there was one rep for approximately two LHINs, but the intention is to have an NPAO rep for each and every LHIN. NPAO respectfully suggests that these reps be incorporated onto the LHIN Boards and/or senior LHIN committees. To date, LHIN engagement strategies have focused primarily on physicians and/or hospital leadership. The Primary Care Physician LHIN Lead model has excluded Nurse Practitioners. Future engagement strategies need to purposefully engage all key providers in a fulsome relationship, not as an after thought or tokenism. The Nurse Practitioners’ Association of Ontario is happy to facilitate the development of these important relationships.

More than 2,800 Nurse Practitioners work across the health care system in hospitals, long-term care homes, CHCs, FHTs, NPLCs and AHACs. Nurse Practitioners are involved in the care of more than 4 million primary care patients and millions more in hospitals and long-term care homes across the province. And yet engagement between Nurse Practitioners and the LHINs has been at times sporadic.
and notional. It would help to have a consistent plan of engagement and communication across all LHINs. The NPAO LHIN representatives are there to help. The Ministry needs to oversee and ensure a consistent engagement and a formal plan reflective of regional and local characteristics but not so diverse as to dilute what we want to accomplish as a society.

NPAO is fully supportive of the recommendations set out in the Donner Report (2015) *Bringing Care Home*. It is essential that families and caregivers understand the basket of home care services available to them... as well as those not available. There should be improved consistency of services across LHINs but also across settings. Currently, patients may be eligible for certain medications and better supplies if they are in hospital, but not if they are in the community. As per the Donner Report, NPAO advocates for allocating funding directly to some families to manage (e.g., families whose children have medically complex and long-term needs). Funds need to be available for emergency respite care, transportation, housekeeping services, and home renovations to accommodate special needs.

NPAO does not support a model whereby the LHINs would deliver services such as home and community care. There is an inherent conflict of interest in suggesting that LHINs could plan, fund and monitor all health care services at a regional level and also act as a service delivery agency. NPAO recommends that the Ministry transition CCAC care navigators as well as Nurse Practitioners currently providing direct care (including palliative care) from CCACs to Primary Care Teams. Embedding NPs and RNs within inter-professional teams enhances the ability of those teams to respond to the needs of their clients across the care continuum. Care coordination is the domain of primary care providers as clients journey through various parts of the health care system (OPCC, 2015).

**4. Establish Stronger Links between Population Health, Public Health and other Health Care Services**

NPAO recommends that Public Health should maintain the following roles: health promotion and protection (e.g., conducting restaurant inspections and ensuring safe drinking water); infectious disease surveillance; and emergency preparedness. The modernization of Public Health Units as well as the *Health Promotion and Protection Act* should reflect the fact that 89% of deaths in Canada are now the result of chronic, non-communicable diseases such as cardiovascular disease, cancer, COPD and Diabetes rather than communicable infections (CNA, 2014).

In order to work more collaboratively with LHINs, the boundaries of Public Health Units should be changed to conform to the boundaries of the LHINs. The amalgamation of 36 PHUs into 14 could create efficiencies and cost-savings. In addition, in order to ensure consistency and conformity across the province, funding for Public Health services should be funded directly by the Ministry of Health through the LHINs. It makes no sense to have the majority of health services planned and funded at a regional level while a segment of health services is partially
planned and funded by municipalities. True integration needs to happen for all health services.

Addressing the determinants of health in an inter-sectorial way needs to be the mandate of the health care system writ large. Working “hand in glove” with the LHINs, the Public Health Units should become the “think tank” for population health planning at the LHIN and Sub-LHIN level. A population health approach goes beyond looking at death, disease and disability and fully integrates the social determinants of health in all aspects of health planning and evaluation. Borrowing from the work of Tim Evans and Hilary Brown (2003), the acronym PROGRESS could be used to capture many of these determinants. This stands for place of residence; race/ethnicity/culture; occupation or employability; gender; religion; educational level; socio-economic status; and social capital/ social network. Public Health Units should be augmented to provide more information to the LHINs and local health leaders regarding population health planning. This would include having more epidemiologists and population health researchers on staff. The Ministry should mandate the utilization of a standard deprivation index such as the Ontario Marginalization Index developed by St. Michael’s Hospital and McMaster University. Information from this type of data would help to inform planning and resource allocation for the LHINs and sub-LHINs.

In addition, direct clinical care (e.g., sexual health clinics, vaccines, well baby clinics) currently being provided by some Public Health Units should transition to primary care teams. The provision of family health services, such as the promotion of breastfeeding and the provision of prenatal education, should be fully integrated into primary care settings so that clients can receive integrated care as close to home as possible by a team of providers whose very mandate is to provide continuous, comprehensive family care.

The Health Promotion and Protection Act requires modernization that reflects changing scopes of practice and current trends in health human resources. For example, the Medical Officer of Health need not necessarily be a physician as the emphasis of this role is on administrative and managerial functions, overseeing a diverse range of staff. The manager of the public health unit should sit on the LHIN Board or have a strong affiliation with the LHIN. NPAO would be happy to provide further recommendations specific to amendments required to the Health Promotion and Protection Act. We trust the Ministry will engage relevant stakeholders in a robust consultation process regarding proposed amendments to various pieces of legislation. We recommend that key stakeholders be provided with a schedule of proposed legislative amendments in order to provide engagement with members to inform feedback and advice.
5. Establish a Culture of Continuous Quality Improvement Across the Health Care System

The province and the LHINs must foster a culture of continuous quality improvement. Ontario will continue to be scrutinized against benchmarks set nationally and internationally such as the Commonwealth Fund. We will be compared to exemplars of excellence from other regions and countries. Bring it on!

Health Quality Ontario has established eight domains that capture important health goals: accessible, integrated, efficient, effective, safe, patient-centered, population-based, and appropriately resourced. In addition, a health equity lens applies to all of these categories. Ontario has done an admirable job of identifying benchmarks and defining indicators for hospitals, home care, long-term care and for primary care (Health Quality Ontario: Primary Care Performance Measurement Report, 2014). Experts, stakeholders and clinicians have agreed upon quality indicators at the provider level, the practice level, and the system level. However, a better job could be done to establish indicators of horizontal and vertical integration. We don’t want one area of the health care system working at cross-purposes or pitted against another area of the health care system.

All essential decision-making, whether it be the assessment of health indices for planning purposes, the allocation of resources, or performance management and program evaluation, must be predicated on accurate, standardized data that is available in a timely manner. We can no longer primarily rely on CIHI and physician-billing data to make complicated and sophisticated decisions at a provincial or LHIN level. As an example, the unique contribution of Nurse Practitioners across the health care system is generally invisible in major data sets because Nurse Practitioners do not bill OHIP and because they always work as part of a team. As such, it is challenging to make funding decision and HHR decisions without having supportive data that reflects the unique scope of Nurse Practitioners and NPs’ contribution to health outcomes.

Data within an EMR is a critical source of data that remains largely untapped. Health care professionals are compelled to finish their clinical notes in a timely manner and yet are often called upon to record redundant information on spreadsheets by managers and administrators. Mining the EMR for strategic data needs to be supported. The work of the province and the LHINs cannot be accomplished without dedicated IM support that is made available to all providers and teams.

Conclusion: What Do People/Patients/Clients Really Want?

What is most important for the people of Ontario? The people of Ontario want and deserve:
• Self-care and resources that supports health and wellness goals such as nutritional support, massage therapy and traditional healing;
• Access to exercise to help prevent and treat many chronic illnesses;
• Access to locally-available, reasonably-priced food so that everyone can enjoy fruits, vegetables, fish, and locally sourced produce;
• Access to dental care that reflects that a person’s body does not exclude their teeth or mouth;
• Essential curative, rehabilitative and restorative services provided in a timely way as close to home as possible when ill or injured; a plan of care that takes an individual’s life into consideration;
• An understanding of the team, people’s roles and clear lines of accountability when something goes wrong;
• Care based upon evidenced-based best practices and best exemplars internationally;
• Appropriate time with providers to be heard and to be understood; enough time with a provider in order to make an informed decision about their care and understand the implications of the treatment plan;
• To be treated with respect and dignity and to have their voice integrated into the plan of care;
• Not having to repeat their health history and/or have redundant lab tests/diagnostic imaging tests;
• To receive care so that their family members and informal care-givers are not so burnt out that they end up becoming patients themselves;
• To re-orient our illness-cure system to a health care system;
• To die peacefully and with dignity surrounded by loved ones;
• Appropriate investments and funding so that this world-class health care system remains for their children’s children.

You can’t always get what you want. But if you try sometimes, you get what you need. We look forward to working with the Ministry and the LHINs to achieve our collective goals.

About NPAO

The Nurse Practitioners’ Association of Ontario (NPAO) is the professional voice for Nurse Practitioners in Ontario. Formed in 1973, NPAO has been active in policy development, advocacy, awareness, professional development and knowledge dissemination for more than 40 years. NPAO is the professional voice of more than 2,868 Nurse Practitioners across Ontario.

Nurse Practitioners are registered nurses with advanced university education and experience who provide a full range of health care services. Nurse Practitioners are authorized to independently prescribe all medications with the exception of controlled drugs and substances. By the way, Ontario is now the last jurisdiction to
Nurse Practitioners work across the health care system in a wide variety of settings including hospitals, Family Health Teams, Community Health Centres, Nurse Practitioner Led Clinics, long-term care facilities, public health units, and with home care and palliative care teams. In some settings, NPs provide primary care services to individuals and families from newborns to the elderly. In other settings, NPs provide very specialized care, assessing and treating complex clients with multiple conditions, preventing complications and improving outcomes.

If you have questions or comments, please feel free to email Theresa Agnew, Executive Director of NPAO at tagnew@npoa.org or admin@npao.org

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References


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College of Nurses of Ontario Annual Statistical report 2015


A summary of NPAO’s recommendations regarding Patients First

• Every person in Ontario who wants one should have access to a Family Physician or Nurse Practitioner as his or her Primary Care Provider.
• NPAO firmly asserts that Primary Care is best provided in the context of a co-located inter-professional team that works collaboratively to meet the goals of the client.
• Primary Care Providers and /or IPCO team members should be available 24/7 so as to reduce avoidable visits to ER.
• All providers in the circle of care should have secure access to the client’s electronic health record through an on-line portal.
• Patients should be able to expect that their diagnostic imaging results, hospital discharge notes, and/or lab results would be available to key providers involved in the circle of care.
• The utilization of e-mail and other electronic communication (using a secure portal) should be enabled to communicate with patients and other providers in the circle of care. Dedicated IM support is required for all providers and teams.
• E-Prescribing, E-referral, e-consults, telemedicine, tele-derm and also electronic monitoring should be promoted and enabled.
• The Ministry and the LHINs should adopt an up-stream approach that focuses on the determinants of health and invests in health promotion, primary prevention, and injury prevention.
• Funding needs to wrap around the patient, not the provider. Remuneration mechanisms need to support collaborative practice and team outcomes.
• The government needs to immediately remove barriers to the current scope of practice for NPs by enabling them to prescribe controlled drugs and substances, complete a Form 1, and order all diagnostic imaging tests.
• Expanding the number of NPLCs and the capacity of NPLCs would enable them to register more clients and take call as needed. Increasing the number of NPLCs would also provide more people in the province with a patient-centered primary care home.
• The Ministry should commit to the expansion and integration of the ECHO model and the ISAEC program.
• The MOHLTC needs to enable Nurse Practitioner-to-Nurse Practitioner referrals.
• The boundaries of Public Health Units should be changed to conform to the boundaries of the LHINs; funding for Public Health services should be funded directly by the Ministry of Health. Public Health Units should become the “think tank” for population health planning at the LHIN and Sub-LHIN level.
• Addressing the determinants of health in an inter-sectorial way needs to be the mandate of the health care system writ large.
• We recommend that key stakeholder be provided with a schedule of proposed legislative amendments in order to provide engagement with members to inform feedback and advice.
• Engagement and communication needs to be fulsome and include all key providers.