Nurse Practitioner-Led Clinics in Ontario: An Overview of the Nurse Practitioner Led Clinic Model and Recommendations for Future Development

Prepared by the Nurse Practitioner Led Clinics Association and the Nurse Practitioner's Association of Ontario

November 2019

"Since becoming a patient at the Nurse Practitioner-Led Clinic my health and quality of life has improved more than I ever imagined. I really value this clinic and the staff that work there (who always show such care for my well-being). Thank you for restoring my trust in health care and for being such an amazing resource to the community." [NPLC Client, March 2018]

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ABSTRACT

First established in 2007, Ontario's Nurse Practitioner Led Clinics [NPLCs] are innovative non-profit primary care teams where Nurse Practitioners [NP] are the Most Responsible Primary Care Provider [NP MRP]. With care, access and quality outcomes that exceed provincial standards in a fiscally responsible manner, NPLCs represent opportunities to improve healthcare system function with an innovative model of care delivery.

With 25 clinics serving over 100,000 formerly unattached people across the province, NPLCs are the embodiment of patient focused, team based care. NPLCs are viewed as community leaders thanks to clinical leadership all levels and the provision of full scope care by all team members. Despite numerous challenges since opening, the clinics have continued to meet the changing needs of communities through innovative approaches and partnerships.

This document provides a high level overview of NPLC history, clinic structure, community integration, clients served, quality outcomes, and recommendations. The paper is intended for a professional audience; please direct comments and questions to the Nurse Practitioner Led Clinics Association at nplca@npao.org.

HISTORY OF THE NPLC MODEL OF CARE

Improving access to primary care is a key driver to health system efficiency, improving quality and function, while reducing overall health care costs (Canadian Institute for Health Information, 2012). In 2005, the government of Ontario invested in several innovative primary care models that targeted population healthcare needs. The NPLC model was one of those innovative models, established to meet an underserviced community in high need of primary care providers. Notably, the NPLC model was the first to formally use NPs as MRPs within inter-professional teams. Since their inception, NPLCs have proven corporate resiliency and success, with high rates of staff retention and the development of cross provincial support networks.

In 2005, in response to high levels of primary care unattached clients and an underemployed Nurse Practitioner workforce, Ontario's first Nurse Practitioner-Led Clinic was developed in Sudbury, Ontario. Under the leadership of Marilyn Butcher and Dr. Roberta Heale (both NPs), the Sudbury District NPLC incorporated as a non-profit business, funded to provide inter-professional primary care services to 4800 unattached local residents. The unique contribution of the NPLC model was the use of Primary Care NPs as the client's MRP. This successful proof of concept model of care delivery provided the foundation from which other clinics would develop.

Successfully building towards full client capacity, and with improved care access and health outcomes, the Ministry of Health [MOH] developed a formal application process for NPLC development. Three annual 'Requests for Proposals' [RFP] were announced from 2008-2010, with protected funding for an additional 25 NPLCs. Applications were community-driven, requiring extensive business case development, demonstration of need, inventory of local services, documentation of community support, and demonstration of workforce availability. Interest in NPLC development exceeded funding opportunities; in the third and final RFP, over 50 applications were received, of which twelve were provided with funding for development (personal communication, MOH 2010). Since that time, neither formal RFP announcements nor clear application process for new NPLCs has been repeated.

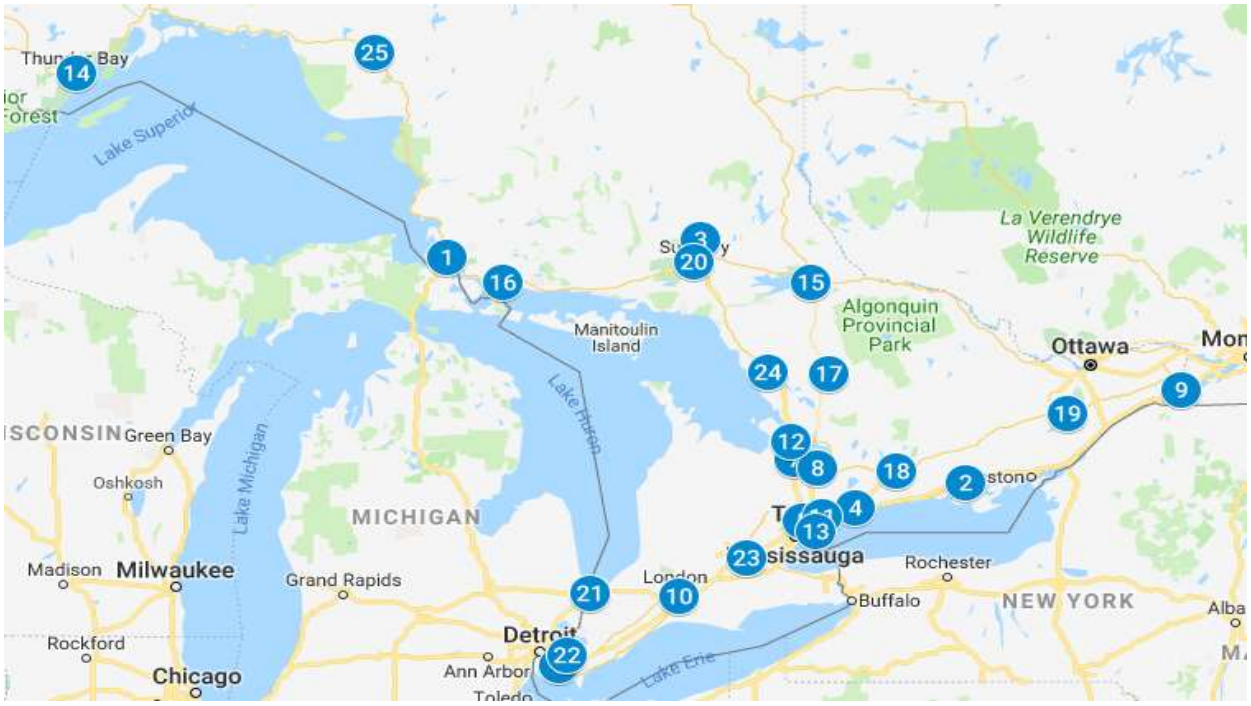
Over the past decade, 23 of Ontario's original 26 NPLCs have continued operations as per their initial funding through MOH agreements and budgets. Three NPLCs did not continue; the Niagara NPLC ceased function very early into operations, citing governance challenges, French River NPLC and Anishnawbe Mushkiki NPLC have more recently merged with other local primary care teams.

In 2018, following a call for proposals for Inter-professional Primary Care Team Expansion, two new NPLCs were approved for development; Northern Neighbours in White River and West Parry Sound Rural NPLC, bringing the current total number of NPLCs in Ontario up to 25 in

2019. During this call for proposal, three NPLCs were also funded to open additional sites to serve marginalized populations.

Many NPLCs have maintained original leadership and have a strong reputation for staff satisfaction and retention. Subsequently, this well-connected supportive network now includes complete NPLC provincial collaboration and is also serving as mentors for groups across Canada who are interested in the NPLC model.

NPLC GEOGRAPHIC LOCATION, October 2019



1) Algoma
2) Belleville
3) Capreol
4) CMHA Durham
5) Emery-Keelesdale
6) Essex County
7) Georgian
8) Georgina
9) Glengarry
10) Health Zone
11) HF Connecting Health
12) Huronia
13) Ingersoll
14) Lakehead
15) North Bay
16) North Channel
17) North Muskoka
18) Peterborough 360
19) Smith Falls
20) Sudbury District
21) Twin Bridges
22) VON
23) Waterloo
24) West Parry Sound Health Centre
25) White River (Northern Neighbors)

CLINIC STRUCTURE AND FUNDING MODEL

NPLCs are funded as non-profit organizations through "Evergreen Agreements" directly with the MOH. This arrangement provides NPLCs with predictable revenue upon which to hire staff and distribute resources at the local level. Resource allocation follows a set of agreed upon parameters and program priorities.

At a governance level, the majority of NPLCs developed a distinct non-profit Board of Community Directors. With a lack of a required governance structure from the Ministry of Health, most clinics have applied Sudbury's model of NP Leadership, adopting corporate By-Laws to maintain clinical leadership at all the operational levels within the non-profit governance structure. In this model, NPLC mission, vision, values, and strategic goals were developed with a robust understanding of both community needs/services gaps as well as the unique contributions and skills of the NP and nursing workforce, contributing to successful provincial operations and outcomes.

At the operational level, most NPLCs were initially funded for four full time equivalent [FTE] Nurse Practitioners, one FTE Administrative Lead, three FTE administrative supports, and four FTE interprofessional health care providers (i.e. Registered Nurses, Registered Practical Nurses, Dietitians, Social Workers, Pharmacists, Health Promoters and others). In addition to this HR funding, NPLCs receive a stipend of $840 per FTE NP monthly to support collaborating physicians; an additional $10,000 annual stipend is allocated to support an "NP Clinic Lead" (also called Clinic Director, Executive Director, or other similar title across the province). Throughout the NPLCs, nursing leadership is brought into all levels of care. The NP Clinic Lead has responsibilities spanning from direct client care provision, to management of operations, local and provincial leadership, community integration, collaboration, quality assurance, strategic oversight, and governance support. See Appendix A for the most common organizational structure.

While the majority of NPLC operational budgets have remained unchanged until recently, several clinics have had the opportunity to expand staffing complements through business case submission or through local resource access and collaborative funding agreements. Currently NPLC staffing complements can range from 10-25 FTE with budgets ranging from $1 million to $3 million annually. Clinic structure varies from single site to multi-site, with one clinic having six individual sites in operation to serve the rural and remote communities. Each clinic has a registered client base of 2500-7200 individuals and each will also see unregistered populations for program attendance (i.e. Diabetic education).

CURRENT FISCAL CHALLENGES

Despite predictable increases in operating costs over the decade, NPLCs have worked within operating budgets that remained unchanged since funding was first announced. Unfortunately, NPLCs recently saw reductions to their budgets and many are concerned they will be unable to meet the requirements of their communities in the future, ultimately impacting ongoing clinic function. NPLCs notably lack clear financial mechanisms or pathways to allow or support required adjustment of staffing ratios or to improve community supports. For example, by 2018, the number of registered primary care NPs in the province had doubled but this has not translated to a reciprocal increase in NPs working in the NPLCs. Additionally, there are approximately one million Ontarians who currently lack a primary care provider. The inability of an NPLC to hire from this available workforce, apply for or adjust required budgets to meet community needs means that some Ontario communities will continue to have significant numbers of unattached clients. Moreover, increasing community demands for direct care may result in adjustments to valuable community healthcare programs, such as diabetic education currently offered by the NPLC. Additionally, from 2008-2017, all staff of NPLCs were subject to a prolonged public sector wage freeze. Although small improvements in HR compensation have since occurred, NPLCs continue to receive funding for staff support that falls well below cross sector comparators and below the recommended rates based upon an external review and analysis (Korn Ferry, 2018). See Appendix B for Hay Report wage grid and Appendix C for budget template.

Despite these challenges, the sector has demonstrated resilience and excellent retention rates in an environment of frozen operational budgets, prolonged sector wage freeze, and ongoing sector wage disparity.

RECOMMENDATIONS

1. Development of a clear and ongoing mechanism that supports NPLCs to adjust budgets that better match community needs;
2. Harmonize wages across sectors to support ongoing recruitment and retention of qualified staff in the primary care sector;
3. Consider funding to allow for cost analysis and cost benefit review of NPLCs.

COMMUNITY INTEGRATION AND LEADERSHIP

Across Ontario, NPLCs are viewed as community leaders for full scope care provision and the realization of quality health outcomes for clients. Using strong nursing leadership, NPLCs

practice in a framework that recognizes health as a "dynamic state of wellness comprised of interacting physical, physiological, psychological, emotional, cognitive, sociocultural, economic, and spiritual dimensions" (COUPN, 2019). Since their inception, NPLCs have been engaged participants in local and provincial programs to improve client health and to fill health care gaps. NPLCs have become skilled community leaders in collaborative, client-focused network development.

Currently, cross sector collaborative work may include bilateral program referrals, joint program development and delivery, off-site care provision, space sharing, collaborative case conferencing, leadership support, active involvement in Health Links and sub-regional planning tables, joint governance agreements, Ontario Health Team (OHT) development, and more. Additionally, with the growing opioid crisis, several NPLCs are matching NP work with community gaps, working with local mental health and addictions agencies to reduce the devastating impacts of the toxic, illicit opioid supply and to treat opioid use disorder using an NP led model of care. Several clinics have focused their work around marginalized residents, those experiencing chronic homelessness, income insecurity, those with complex health needs, and people who experience mental health issues and addiction. With the strength of the NPLC provincial networks, NPs have opportunity to discuss and collaborate in improving client and community health within their own individual communities. With this support, these networks can be further developed or expanded to increase supports in underserved communities or populations, further reducing hospital overuse and keeping people healthier for longer.

RECOMMENDATIONS

1. Develop community-focused clinics within NPLCs, such as opioid harm reduction or mental health and addiction clinics that target a specific vulnerable population within a community.

NPLC CLIENTS

During NPLC proposal development, the target set by the MOH for number of clients for each FTE MPR NP was 800. It is now known that across Canada, primary health care NP panel size varies from 400 to 1100 clients (Bryant-Lukosius et al, 2015). NP panel size is influenced by many factors including client specific characteristics (age, gender, socioeconomic status, health status, co-morbidities), organizational factors (team dynamics, types of visits offered, and team composition) and provincial factors (including legislated scope and funding) (Bryant-Lukosius et al, 2015). Panel size expectations for the NP Lead must also consider concurrent management and strategic responsibilities. Data collected in 2014/2015 suggests NPLC clinics demonstrated

higher than average client complexity, with as much as a 57% increased expectation for care needs as compared to a general family practice in the province (Appendix D).

PROVINCIAL METRICS

Currently most inter-professional primary care teams in Ontario, with the exception of NPLCs, have regular access to externally produced client complexity and quality outcome data through agencies such as the Institute for Evaluative Sciences [ICES], Health Quality Ontario [HQO], Cancer Care Ontario [CCO], Association of Family Health Teams of Ontario [AFHTO], and/or Alliance of Healthier Communities [AHC].

In 2013, as the models of NPLCs continued to develop, the Report of the Auditor General of Ontario recommended that the MOH "monitor the NPLCs more closely to ensure that they are meeting program requirements and achieving their patient targets and program objectives". Through 2014-15, much work was completed in collaboration between NPLCS and the MOH to enable the linkage of MRP NP to their clients using the OHIP identifier. In a 2015 communication from the MOH, enrolment would permit "patients in NPLCs to be "counted" in the Ministry's Client Agency Program Enrolment (CAPE) system, utilized for system and sector planning, performance measurement, evaluation and improvement". Clinics were also informed that the "CAPE system has been modified to allow for patient enrolment to NPs" (MOH Communication, Nov 2015). Unfortunately significant delays have occurred in this process and clients are not yet enrolled to the MRP NP.

In 2013/14, several NPLC members of the Alliance of Healthier Communities (formerly Association of Ontario Health Centres) signed agreements with ICES to allow for external review of client base characteristics. Following several delays, the complexity report was received by eight of the 25 clinics in 2017 (backdated for 2014/15).

While NPLCs are in strong support of client data collection or complexity score to improve care delivery, since that time, further collection of NPLC specific client data has not occurred. This suggests there is an overarching lack of external data available to understand NPLC client base.

With data available to all other primary care models, provincial data inequity has been consistently recognized by this sector. To date, no external review of NPLC client complexity and quality outcomes has been completed despite continued advocacy to review enrollment to NPs.

RECOMMENDATION

In order to ensure clinic is meeting targets:

1. Develop a system to support linkage of clients to their NP MRP at the provincial level;
2. Complete a complexity analysis to inform care delivery and to support resource allocation.

QUALITY CARE OUTCOMES

Health care system cost savings result from the reduction in use of ambulatory services, reduced morbidity and mortality, and an improved health of the population (CIHI, 2012). With the development of HQO Primary Care Quality Improvement Plans in 2012, NPLCs began to engage in quality data, analysis and improvement. As previously stated, NPLCs do not receive external data through HQO or CCO to understand NPLC quality of care provision. Through internal chart reviews and the cross sector support of the Quality Improvement and Information Management Specialists (QIIMS), the NPLCs continually monitor and improve the quality of care provided.

Using HQO quality standards, the December 2018 cross-clinic analysis is as follows:

Standard Quality Indicator	NPLC Average	Ontario Average
7-day post hospital discharge follow up	83.2%	34%
Same/Next Day Appointment Use	52.4%	43.1%
Patient Involvement in Care	94.3%	86.4%
Cervical Cancer Screening Rates	68.9%	60%
Colorectal Cancer Screening Rates	48%	34.5%

It is important to recognize that NPLCs achieve quality results that surpass provincial standards despite the lack of external data analysis support or financial incentives. As noted in the Auditor General report 2018, and excluding base payments, incentive care bonuses funded for primary care physicians in 2014/15 accounted for $364 million of the healthcare budget (Auditor General, 2018). NPLC data continues to support meeting greater than average targets without these additional incentives.

NPLCs achieve higher than average rates of same and next day access, hospital discharge follow up, client engagement and cancer screening rates. The clinics continue to provide this care without supports and analysis available to other models. This suggests that cost savings to the system can occur with further support and growth of the NPLC sector.

RECOMMENDATIONS

1. Growth and support of the NPLC sector in primary care delivery.

INTERNAL AND EXTERNAL FACTORS THAT INFLUENCE NPLC WORK

Since 2008, several internal and external changes occurred directly impacting the ground-level work of the NPLCs. NP scope expanded, improving care delivery and changing the role of collaborating physicians. Advancements in information technology have been embraced by this sector; processes are streamlined and care is improved. The populations served continue to change as Ontario copes with the opioid crisis and an aging population. These factors have influenced the work of the clinics and the opportunities that exist for model optimization.

Scope of practice has been a key driver to improving efficiency, continuity, and role clarity for the NP MRP. Legislative changes now authorize NPs to independently order controlled drugs and substances (including opioid agonist therapy), order all x-rays and ultrasounds, order MRI and CT scans (as of Winter 2020), refer clients directly to physician specialists, and admit, treat, and discharge clients from hospital. NPs are also legislatively permitted to support clients in the provision of Medical Assistance in Dying [MAiD]. These changes have greatly improved care continuity, efficiency, safety, and communication in addition to reducing duplication of care, billing and services.

From a technology perspective, the NPLCs have been early adopters of technological advances to improve care provision. Since 2008, NPs have been added to Scott's Directory, allowing hospitals to recognize the NP as MRP, thus improving bilateral communication. NPLCs have embraced the Ontario Telemedicine Network as a means of facilitating client access to specialist visits while saving transportation costs. NPLCs have participated in "Hub and Spoke" training and education through Project ECHO opportunities for mental health, pediatrics, addiction, and chronic pain management. Improvements in Electronic Health Records have led to timely access to hospital reports via Hospital Report Manager [HRM], laboratory results via Ontario Laboratory Inventory Services [OLIS], and cross sector client data through Connecting Ontario. With these changes, privacy legislation, safety, and reporting expectations have expanded, requiring increased corporate investments to ensure compliance and client information safety.

With several changes that have improved care efficiency, the role of the NPLC collaborating physician has also changed. Direct care provision hours have been greatly reduced and fewer on-site hours are required with physicians generally participating in a collaborative team care manner for complex case management.

In addition, the population of our communities and clients have changed. The population is aging and management of complex co-morbidity is a challenge for all healthcare organizations. NPLCs are perfectly suited to do this work well. Using an inter-professional, client-centered approach that respects client goals, understands the "whole person" and recognizes gaps in the system, the NPLCs have adapted several approaches to offer more home visits, ensure access, increase staff education, and ensure care continuity for complex clients, thus reducing hospital admissions and keeping people at home for as long as possible.

In response to the opioid crisis, NPLCs are working with clients and community partners to expand access to addiction medicine, particularly in rural and remote communities. Clinics are working together to build supports and mentorship to spread these innovations.

SUMMARY

Across Ontario, NPLCs represent an investment in a truly innovative approach with proven results. Utilizing NP leadership at all organizational levels, NPLCs fundamentally recognize that health is more than the absence of illness. These clinics are changing how work is done. NPLCs work with community networks and supports and provide exceptional access, demonstrating quality outcomes that exceed provincial standards.

With a decade of learning, it is apparent that NPLCs have a strong and important role in a well-functioning health care system and are poised to expand and grow to both serve the general unattached population and high risk specialized populations across the province of Ontario.

RECOMMENDATIONS:

1. CLARIFY AND STREAMLINE THE PROCESS FOR NPLC APPLICATION and/or EXPANSION
    a. Clarify the process for proposal submission, review, and approval.
    b. Provide feedback for unsuccessful applicants to reduce missed opportunities.
    c. Allocate resources for NPLC development and model growth.
    d. Provide funding to NPLCA to support NPLC mentorship program.

In response NPLC A will:

a. Work with local NPs, communities in need, and providers to support application design and submission, clinic development, and ongoing operations.
b. Develop and sustain a mentorship program and network.

2. FORMALLY RECOGNIZE NP MRPs THROUGH PROVINCIAL DATABASES

a. Link NP MRPs in NPLCs to their clients in order for system and sector planning, performance measurement, evaluation and improvement to take place.
b. Include NP and NPLC data in My Practice Profile, HQO, CCO, ICES and other data sources and reports.

In response, the NPLCA will:

a. Develop and implement a process for client consent an NPLC enrolment.
b. Fully support the analysis and utilization of practice profiles to drive clinical care improvements.
c. Engage with the College of Nurses as required to review and amend regulation and legislation to support full scope of practice.
d. Engage with key stakeholders with the MOHLTC to remove all remaining barriers

In response, NPLCs will:

a. Use improved efficiencies to increase timely access to services.
b. Amend and re-negotiate relationships with collaborating physicians to better reflect changing roles and requirements.

3. INCREASE NPLC BUDGET FLEXIBILITY AND AVAILABILITY

a. Commit to increasing HR budgets when there is proven community need and available staff resources.
b. Provide NPLCs with flexibility to increase corporate management of their budgets.
c. Provide contingency HR funding to support role transitions and maintain care continuity.
d. Increase base budget allocations for rents, utilities and information technology in response to rising operational costs.
e. Move compensation toward the recommendations in the Hay Report.

In response, the NPLCA will:

a. Develop budgetary guidelines and mentorship to maximize the workflow and efficiency of the NPLCs.

b. Develop a network to provide locum and support services for workflow management.

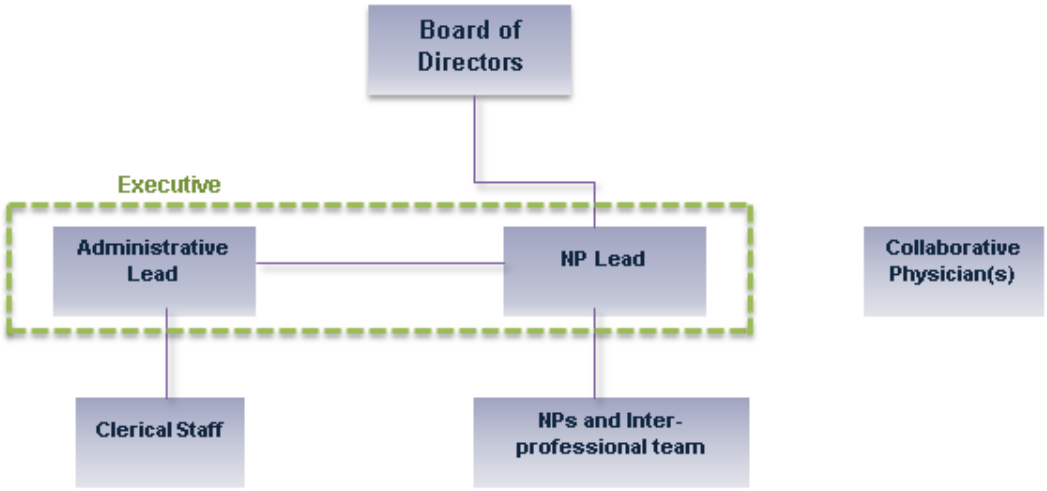
4. REVISIT ROSTER SIZE EXPECTATION

a. Support funding for external analysis of NPLC client characteristics and complexity.
b. Develop mechanism to revisit roster size expectation using evidence.

In response, the NPLCA will:

a. Use evidence and NPLC complexity data to make recommendations for appropriate NP MRP roster size.
b. Review the role of the NP Lead and provide recommendations to standardize role and roster size expectations.

APPENDIX A – Recommended NPLC Organizational Structure



APPENDIX B – 2017 Recommended Salary Structure Hay Report

Pay Band	Position Title	Minimum	Step 2	Step 3	Step 4	Step 5	Maximum
13	Executive Director	$134,321	$138,749	$143,324	$148,049	$152,929	$158,025
12	(No Positions)	$115,757	$119,573	$123,515	$127,587	$131,793	$136,185
11	Director	$100,674	$103,993	$107,421	$110,963	$114,621	$118,440
10	Manager HR Manager Finance Manager Traditional Healer	$87,554	$90,441	$93,422	$96,502	$99,683	$103,005
9	Supervisor Community Health Planner	$76,130	$78,640	$81,233	$83,911	$86,677	$89,565
8	Chiropodist Social Worker (Therapist) Data Coordinator Occupational Therapist Physiotherapist Registered Nurse Speech Pathologist Registered Dietitian Health Promoter/Educator Respiratory Therapist		$67,384	$70,116	$72,958	$75,916	$79,275

7	IT Technician		$60,155	$62,593	$65,131	$67,771	$70,770
6	Counsellor Community Health Worker Office Administrator Executive Assistant Volunteer Coordinator		$54,175	$56,371	$58,656	$61,034	$63,735
5	RPN Bookkeeper Administrative Assistant		$48,552	$50,520	$52,568	$54,700	$57,120
4	No jobs currently		$43,554	$45,320	$47,157	$49,069	$51,240
3	Medical Secretary Clinical Assistant Secretary		$39,270	$40,862	$42,519	$44,242	$46,200
2	Receptionist		$35,343	$36,776	$38,267	$39,818	$41,580
1	Maintenance Worker		$32,130	$33,433	$34,788	$36,198	$37,800

Market Exceptions

Pay Band	Position Title	Minimum	Step 2	Step 3	Step 4	Step 5	Maximum
10	Nurse Practitioner Psychologist	$108,488	$115,333	$122,178	$129,022	$135,867	$142,712
9	Pharmacist	$93,312	$94,285	$95,257	$96,230	$97,203	$98,175

APPENDIX C – Budget Template

Approved Annual Base Funding Budget Beginning 2018-2019			
HUMAN RESOURCES SALARIES & BENEFITS			
1. Stipend	**#**	**Stipend**	**Approved Funds**
Collaborating Physician ($838.40/month/FTE)			
Nurse Practitioner Lead (stipend is yearly)		$10,000	
Total Stipends			***$0***
2. Inter-professional Health Providers (IHP)	**# of FTE**	**Salary**	**Approved Funds**
3. Management and Administrative (M & A) Personnel	**# of FTE**	**Salary**	**Approved Funds**
Total Salaries			
Total Benefits			
Recruitment and Retention			
TOTAL HUMAN RESOURCES			
OVERHEAD			
1. Equipment (INCLUDES HST)			**Approved Funds**
Telecommunication, oxygen, etc.			
2. General Overhead (INCLUDES HST)			**Approved Funds**
Advertising, Bank fees, Supplies/materials, Postage/courier, Operational service contracts, etc.			
3. Information Technology (IT) (INCLUDES HST)			**Approved Funds**
Hosting Support and Maintenance, Connectivity, Software License, etc.			

4. Insurance/Professional Liability (INCLUDES HST)	**Approved Funds**
Director's, General Liability, Contents, etc.	
5. Premises (INCLUDES HST)	**Approved Funds**
Property Taxes, Utilities, Building Maintenance, Office Maintenance, Rent, etc.	
6. Service Fee (INCLUDES HST)	**Approved Funds**
Audit, Legal, Travel (for Clinical Purposes only), Professional Development, General Consultant Fees, Recruitment, Contingency, Retention, Relief, etc.	
TOTAL OVERHEAD	
Total Funding	

APPENDIX D - NPLC Practice Profiles - April 1, 2013 - March 31, 2015

"The data below shows the client complexity and expected resource utilization is reflected in the adjusted diagnostic groups (ADGs), resource utilization bands (RUBs) and the Standardized ACG morbidity index (SAMI). RUBs are estimates of expected overall health care utilization, overall morbidity and anticipated health care costs. These data are presented as quintiles (RUB 1 represents clients with the lowest resource use whereas RUB 5 represents clients with the highest expected resource use). ADGs are used to measure the burden of client illness by counting the number of co-morbid condition types that a person has based on aggregations of similar health conditions. This data is presented as a percentage and indicates the % of your NPLC clients with a certain number of ADGs. This data helps you understand the complexity of the clients seen at your NPLC. The SAMI represents the average ACG weight of expected resource use for primary health care. This data can be interpreted as an expected need for health care and has been standardized so that the average Ontarian has a SAMI that equals one. For example, a SAMI of 1.30 can be interpreted as an expected need for health care that is 30% higher than in the general Ontarian population. The methodology for the SAMI has been recently refined so data has been reported for a three year period." (ICES, AOHC, May 2017 – Main contact - Jennifer Rayner (jennifer.rayner@aohc.org)

Client Complexity and Expected Resource Utilization

	5850	5856	5857	25697	26000	26903	27707	27908	Total NPLC
Adjusted Diagnostic Groups (ADGs) (%)									
None	0	0.0	0.0	0.0	<=5	1.0	2.0	0.9	0.5
1-4	26.9	29.8	34.1	43.5	46.5	38.0	40.0	38.5	38.0
5-9	44.8	46.9	47.8	45.0	43.2	46.4	43.6	46.4	45.4
10+	28.2	23.3	18.2	11.5	10.2	14.6	14.3	14.2	16.1

Resource Utilization Bands (%)									
1	5.0	3.4	6.0	4.7	1.9	4.6	9.6	4.7	4.8
2	10.9	16.9	16.2	19.9	12.4	19.5	18.0	26.1	17.5
3	51.3	46.7	53.4	48.6	56.6	34.6	44.6	34.4	46.7
4	19.2	26.2	18.1	20.7	19.5	23.6	21.8	21.6	21.5
5	13.6	6.7	6.3	6.0	9.6	17.8	6.0	13.2	9.5
Standardized ACG Morbidity Index (SAMI) – 2015	1.57	1.38	1.27	1.14	1.31	1.28	1.18	1.18	1.28

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ENDORSING NPLCs

This document has been endorsed by the following NPLCs:

Belleville
Nurse Practitioner-Led Clinic
Clinique dirigée par du personnel infirmier praticien Belleville

Canadian Mental Health Association
Durham

CNPLC
Capreol
Nurse Practitioner-Led Clinic

Essex County
Nurse Practitioner-Led Clinic

Georgian
Nurse Practitioner-Led Clinic

Georgina
Nurse Practitioner-Led Clinic

Glengarry Nurse Practitioner-Led Clinic
Cliniques dirigées par du personnel infirmier praticien de Glengarry

Health Zone
Nurse Practitioner –Led Clinic
Ontario

HF Connecting Health
Nurse Practitioner-Led Clinic

Huronia
Nurse Practitioner-Led Clinic

Ingersoll Nurse Practitioner-Led Clinic
Ontario

Lakehead
Nurse Practitioner-Led Clinic

North Bay
Nurse Practitioner -Led Clinic

North Channel
Nurse Practitioner-Led Clinic

North Muskoka
Nurse Practitioner-Led Clinic

Northern Neighbours
Nurse Practitioner-Led Clinic

Peterborough 360 Degree
Nurse Practitioner-Led Clinic
Ontario

Smiths Falls
Nurse Practitioner-Led Clinic

Sudbury District
Nurse Practitioner-Led Clinics

Twin Bridges
Nurse Practitioner-Led Clinic

VON Nurse Practitioner-Led Clinic
Cliniques dirigées par du personnel infirmier praticien de VON
Ontario

Waterloo Region
Nurse Practitioner-Led Clinic

West Parry Sound Health Centre
Rural Nurse Practitioner-Led Clinic