Report on Visit to Sudbury District Nurse Practitioner-Led Clinic

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On December 9th, 2008, Drs. DiCenso and Wyman visited the Nurse-Practitioner (NP) -led clinic and met with Marilyn Butcher (NP, clinic co-founder and director), Roberta Heale (NP, clinic co-founder, president of the board of directors), and Esther Allen-Fogarty (member of the board of directors/NP at Espanola FHT). For the second half of the meeting a consulting Family Practitioner to the clinic joined the discussion.

Our report is written in the context of the following background summarized from the MoHLTC website on NP-led clinics.

Background:

As part of the Family Health Care Strategy, the MoHLTC plans to establish 25 NP-led clinics over the next 4 years. The mandate of the NP-led clinics is virtually the same as that of FHTs. The MoHLTC describes the intent of the NP-led clinics on its website (http://www.health.gov.on.ca/transformation/fht/np_clinics.html) as follows:

- The clinics will form a new model of care that will see NPs working in collaboration with doctors to provide health care to many Ontarians who previously did not have a primary health care provider.
- NP-led clinics will improve timely access to comprehensive family health care for all Ontarians through the development of interdisciplinary teams.
- NP-led clinics are locally driven primary health care delivery organizations which will include Registered Nurses in the Extended Class, Registered Nurses, family physicians and a range of other health professionals who are committed to working together collaboratively to provide comprehensive, accessible, coordinated family health care service to a defined population – *the majority of which do not currently have a primary health care provider* (MoHLTC emphasis).
- In addition to the provision of direct health care services, NP-led clinics will focus on chronic disease management and community-based health promotion and disease prevention activities in conjunction with other community-based health care organizations such as health units.

- The location of these clinics will be in areas where there are high numbers of unattached patients who do not have a regular primary care provider.
- NP-led clinics will be expected to reduce the number of unattached patients in their community and to participate in other family health care initiatives such as integrated screening and chronic disease management programs.
- NP-led clinics will not be a one-size-fits-all approach. There are diverse communities across Ontario and there must be flexibility in scope and focus of clinics to allow them to be tailored to meet the needs of the local client population; the make-up of the interdisciplinary team will be tailored to the size of the population served and their health care needs.
- NP-led clinics will do the following:
    - provide comprehensive family health care services through an interdisciplinary team with all member working within their scope of practice
    - provide system navigation and care coordination linking patients to required services
    - emphasize health promotion, illness prevention, early detection/diagnosis
    - serve as a driving force for the development of new comprehensive community based chronic disease management and self-care programs
    - provide patient-centred care where the patient is a key member of the team
    - be linked with other health care organizations in the community and adapt to community needs
    - use information technology as the backbone of system integration linking patient records across health care settings

Report on Our Visit to the NP-Led Clinic:

The clinic opened in August 2007 and now has six full-time NPs with two consulting physicians who are there a total of five half days a week. They have been able to register approximately 2,000 unattached patients so far split amongst the NPs. They plan to expand to a second location in the near future (in the community of Dowling) at which point they will have two NPs there and three and a half at the Riverside Drive site (one NP splits her time with administrative duties). They also serve the remote community of Chapleau (one day outreach clinics offered periodically and staffed by one NP and a volunteer RN). The overall goal is to register 4,500 patients within 3 years of operation (although they feel this may be

lower given the unexpected complexity of the patients they are currently registering).

We were provided with a summary of a client satisfaction survey that they conducted earlier this year. From March 13 to May 8, 2008, patients were asked to complete a client satisfaction survey. The survey was given to them by the receptionist when they arrived at the clinic and they were asked to complete it after their clinic visit and return it in a sealed envelope before leaving the clinic. They did not identify themselves on the survey. Clinic staff did not have any involvement with the patients regarding the survey and did not have access to any completed surveys. A total of 224 surveys were returned representing 20.4% of the registered patients at the time. Patient satisfaction was very high and open-ended responses positively highlighted the themes of thoroughness, quality of NP care, time spent with the client and caring attitude. Two areas for improvement were identified: increased accessibility through expanded hours into the evening and full physician integration to better facilitate care when the NP must consult with the physician.

Objectives of our Visit:

1) To assess potential learning points that can be applied to the implementation of the new NP-led clinics.
2) To identify benefits and challenges that have become evident with the initiation of NP clinics in the provision of primary care.
3) To assess the complexity of patients seen at this clinic.

Observations:

1) Learning points from implementation of this clinic:
    a. Through discussion, it was determined that numerous factors have contributed to the initiation and initial success of this clinic:
        i. Availability of NP human resources in the community. Sudbury, prior to the institution of this clinic, had unemployed NPs in the community who were able to be hired for implementation of the clinic.
        ii. Large number of unattached patients in the community.
        iii. Lack of physician resources in the community.
        iv. Dedicated NPs with extensive clinical and administrative experience.
        v. Strategic planning group to help with administrative activities such as choice of EMR, organizational structure, development of vision and mission statements, etc.
    b. Through discussion with the group, there were also recommendations for maximizing success for future clinics:
        i. Mentorship of leaders of new clinics by those who have previously introduced an NP-led clinic.
        ii. Mentorship of novice NPs.
        iii. A critical mass of NPs, ideally with a mixture of experience.

iv. Public awareness and education about the role of an NP in primary care and the role of an NP-led clinic. This could potentially be done in partnership with the MoHLTC.
v. Physician support and involvement in the clinic.
vi. Recognition of start-up work required that may result in initial slow patient registration.
vii. Assessment of administrative support that may be required.

2) Benefits and challenges of the Sudbury NP clinic initiative in the provision of primary care:
   a. Benefits:
      i. Registration of unattached patients with positive and rapid community response.
      ii. Opportunity to have an NP-led governance structure.
      iii. Initiation of new community programs that include "Why Weight" (obesity program), smoking cessation clinic, HPV vaccination and education clinic.
      iv. Positive collaboration with MDs in clinic.
      v. NP able to care for patients with MD positioned in a consultative role, allowing the NP to continue with ongoing care for these more complex patients.
      vi. MD able to act as consultant and become involved in other aspects of medicine that include hospital care and emergency medicine.
      vii. By registering patients to the clinic rather than rostering them with an MD, patients are not orphaned when that MD retires or leaves the practice.
      viii. NPs and MDs are not eligible for the MoHLTC incentives paid to MDs in other models of care (cost-saving benefit for MoHLTC).
   b. Challenges:
      i. Extensive administrative responsibility was required for clinic start-up.
      ii. Negative response from the organized medical community with comments that included that the clinic would give "inferior care", "add an unnecessary level of care".
      iii. Volume of patient response for registration to new clinic.
      iv. Complexity of patients registering at the clinic:
         - Difficult to screen patients for acceptability to clinic for a variety of reasons that include: patients who have not received health care for many years and patients who may not realize the extent of their illness.
         - Difficult to turn away patients with significant illness and co-morbidity given that there are no other options for primary care for these individuals.
      v. Complexity of patients impacts on overall workload

- May reduce number of patients who can be registered.
- Increases need for physician involvement on a regular basis in the clinic.

vi. Concern about adequacy of administrative/secretarial support:
- Concern that one secretary at the new site with 2.5 NPs will not be sufficient, thereby removing NPs from direct patient duties in order to attend to administrative tasks such as stocking rooms or cleaning the examination room after the patient leaves.

vii. Concern about MD support:
- Difficulty attracting MDs to work in the clinic; lost one MD due to negative pressure from the OMA.
- Difficulty attracting MD due to compensation:
  a. Issue around stability of funding.
  b. Funding related to NP rather than physician time commitment. For example, if the clinic takes on a third physician, then the consultation money will need to be split three ways instead of two ways.
  c. Issue around mechanism of compensation related to FFS which does not reward consultative and collaborative work between professionals. Does not compensate for extensive amount of time needed to develop medical directives. Does not compensate for non-patient activities that may include program development or administrative responsibilities. MD could elect to see every patient, for whom an NP requests a consultation in order to generate FFS income but this would 'defeat' the model of care since, with MD consultation, the NP can continue to provide care for these complex patients.
  d. Compensation not competitive with other potential sources of income for MDs in the community.

viii. Medical directives:
- Require many hours to develop.

ix. Pressure:
- Heavy pressure to succeed from MoHLTC, CNO, RNAO and community.

3) <u>Patient complexity:</u>
   a. During the visit, we did not directly assess the complexity of the patients who are seen at the clinic. The general feeling of the group

that we met with was that the patients that they picked up were those with multiple complex needs who did not have a primary care provider. They worked on a first-come, first-serve basis and did not turn away patients. Because some of the patients had not seen a physician in many years, there were many untreated conditions that needed stabilization. There was no intention to screen for low risk patients.

4) Other insights:
   a. The NP-led clinic is functioning as a family practice at this point in time and if it is to continue in this fashion, will likely require increased and more consistently funded physician support. This is largely due to the complexity of unattached patients who have registered with the clinic.
   b. The NP-led clinic is under the FHT umbrella but does not have access to the Telephone Health Advisory Service (THAS) or the support provided to FHTs by the Quality Improvement and Innovation Partnership (QIIP).
   c. The reviewers wondered if the clinic model is more aligned with a CHC model than a FHT model?

Summary:

The features and mandate of the NP-led clinic are, for the most part, consistent with the MoHLTC intent of the NP-led clinic as described in the Background section above. This new initiative has had a variety of challenges since its inception. The clinic is functioning at this point but feels it requires more resources than it is currently receiving both in terms of medical and administrative support. The NPs have been dedicated to the success of the clinic and to the patients whom they serve. It is important to learn from this clinic prior to starting new NP-led clinics. There is a need to be clear about the goal of the NP-led clinic and its expected role from the perspectives of both the NP-led clinic and the MoHLTC. Based on our visit and review of MoHLTC expectations of NP-led clinics and documents from the NP-led clinic, we offer the following preliminary recommendations:

Recommendations:

1) Given the large number of unattached patients with highly complex needs and the MoHLTC mandate that NP-led clinics will register patients, "*the majority of which do not currently have a primary health care provider*", the NP-led clinics need to be prepared to care for these patients; this means that at least some of the NPs staffing the clinic should be highly experienced and that physicians who are part of their interdisciplinary team should be willing to provide substantial time and commitment to NP consultation and delivery of clinic services.

2) If NP-led clinics are to be introduced into communities that have: a) NP availability; b) a large number of unattached patients; and c) a shortage of physicians, then the MoHLTC must enlist OMA's support for this service. The OMA must support the physicians who choose to be part of the interdisciplinary team in the NP-led clinic rather than pressing physicians to avoid these roles.

3) Perhaps the title 'NP-led clinic' is a poor choice. Given that FHTs are not called MD-led clinics, perhaps the 'tensions' created by this term can be somewhat diffused by considering a different term that reflects the interdisciplinary nature of the care delivery. Perhaps these clinics are simply FHTs with NPs leading and governing rather than MDs.

4) Given the complexity of the unattached patients who are very grateful to be registered with the NP-led clinic and given the extensive amount of time that physicians need to spend in the clinic consulting with the NPs, a fair method of remuneration for the physicians needs to be developed. The physicians could, if they chose to, insist on seeing every patient in order to bill fee-for-service to ensure adequate compensation for their work and yet, to do so, would contradict the model of care that is heavily based on the provision of NP consultation.

5) Ensure adequate resources in terms of NPs, MDs, and administrative support to register and care for the anticipated number of complex unattached patients. Support from the MoHLTC for the NP-led clinics should be based on the fact that they are enrolling unattached highly complex patients, which in hindsight is understandable. In the best of all worlds, NP-led clinics may have focused on wellness care, disease prevention, health promotion, managing stable chronically ill patients, but the reality is that there are many unattached high priority patients in Ontario and that this service is allowing these patients to be cared for by an NP with MD consultation.

6) Given the similarity in mandates of the FHTs and the NP-led clinics, these two entities should be treated equally with respect to resource allocation and with respect to available support services. This includes the Telephone Health Advisory Service (THAS) and the Quality Improvement and Innovation Partnership (QIIP).