Introduction

A Nurse Practitioner (NP) is an advanced practice nurse (APN) that is licensed in a distinct nursing classification by the College of Registered Nurses of British Columbia (CRNBC). Nurse Practitioners provide comprehensive clinical care including the diagnosis and management of disease/illness, prescribing medications, ordering/interpreting laboratory/diagnostic tests, and initiating referrals to specialists. NP practice does not require physician supervision. NP's provide care in both primary and acute care settings including rural, remote and urban centers.

There are a number of barriers that are currently preventing nurse practitioners (NPs) from working to their full scope of practice within British Columbia. These include the need for further legislative changes, lack of understanding of the role of the NP by both the public and some of our healthcare colleagues, limited available positions and perhaps most significantly, the lack of a sustainable funding model.

> *Nurse practitioners are advanced practice nurses (APN) who provide accessible, affordable, high-quality, patient-centered care [Triple Aim] that integrates mind and body, high patient satisfaction, and produces outcomes that are as good as and often better than the care provided by MDs [medical doctors] in traditional primary clinical settings (Hansen-Turton)*

B.C. has struggled to figure out how to appropriately regulate and utilize this growing profession despite the fact that nurse practitioners in many jurisdictions have clearly demonstrated that they can make significant inroads in providing primary care and minimizing the number of orphan patients (i.e., patients who cannot find a family physician). It is absolutely critical that government, health authorities, and healthcare leadership work with NPs to uncover the promising practices and models that are working throughout Canada, and around the world – and make some bold and decisive decisions about how this profession will be supported in the future in British Columbia.

The BCNPA respectfully submits this briefing document to the Select Standing Committee on Health (2016), with the hope that by increasing understanding of the barriers currently limiting full integration of NPs into the B.C. healthcare system, we may help to further the discussion and encourage resolution of some of the challenges that are preventing NPs from providing all British Columbians with the primary health care they deserve.

The History of Nurse Practitioners in British Columbia

Nurse Practitioners were introduced into B.C.'s health care system in 2005, with a goal to providing improved access to primary health care services for British Columbians'. Their advanced educational preparation (which includes clinical skills such as medical diagnosis, interpreting laboratory and diagnostic tests, and prescribing), legislative authority and self-regulated scope of practice ideally situates NPs to deliver primary health care services that meet the same quality and standards required of their physician and midwifery colleagues.

Nurse Practitioners attend to determinants of health, contributing positively to long-term health improvement, and healthier future generations, meeting British Columbia Ministry of Health's objectives (MoH, 2015)

Efforts to implement the NP role began in earnest in 1997 with joint efforts of the B.C. Ministry of Health (MoH) and the Registered Nurses of British Columbia (RNABC[1]) to define the role for the B.C. context (RNABC, 1997). Between 2000 and 2005, the MoH, partnering with the CRNBC and in consultation with other key stakeholders, developed a regulatory and legislative framework to register NPs and define their practice.

Legislation establishing the NP title and scope of practice was proclaimed in 2005 (MOH, 2006), and B.C.'s first NPs graduated, were registered by the CRNBC and hired into regional health authorities in late 2005. The defined NP scope of practice was intended to allow for a professional practice model of autonomous NP practice, with minimal restrictions (CRNBC, 2006a; CRNBC, 2006b). Because of this, NPs were expected to increase accessibility to acute, long-term, and primary health care (PHC) services; expand health care options; and fill gaps in the B.C. healthcare system (RNABC, 2004).

A 2012 survey of NPs working in British Columbia found the following (adapted from Sangster-Gormley, 2012):

[A robust and thriving]… body of literature supports the position that NPs provide care that is safe, effective, patient-centered, timely, efficient, equitable and evidenced based. Furthermore, NP care is comparable in quality to that of their physician colleagues. Patients under the care of NPs have higher patient satisfaction, fewer unnecessary hospital readmissions [cost savings], potentially preventable hospitalizations [cost savings], and fewer unnecessary emergency room [ER] visits [cost savings] than patients under the care of physicians (AANP, 2015, para. 2)

- The majority of B.C. NPs practice in community based settings where they are the only NP in the practice. They provide care for a variety of populations such as First Nations, homeless, seniors, and new immigrants.
- Most B.C. NPs spend the majority of their time engaged in direct patient care activities. Most often they manage and monitor chronic illnesses and mental health concerns, and provide counseling and education. NPs provide care for frail seniors in their homes or residential care facilities, and practice in youth clinics and homeless shelters. They assess, diagnose and manage a variety of acute and chronic conditions, order diagnostic tests and prescribe medications.
- When not providing direct patient care, non-clinical activities involve participating in team meetings and educating others, such as NP, medical and allied health students. In the communities in which they practice, NPs engage in community outreach by facilitating health workshops, presenting at nursing educational rounds, and liaising with other healthcare providers.
- NPs perceive that they contribute to the healthcare system by increasing access to care, managing chronic diseases, supporting other providers, and reducing the use of acute and/or emergency departments.
- There remain barriers to implementing the NP role in BC. These include inadequate support from administrators and physicians, and a lack of understanding of the role by others. In spite of this, there are numerous physician and patient champions of the NP role.

[1] *Now the College of Registered Nurses of British Columbia (CRNBC)*

In general, Nurse Practitioner care is thought to be excellent, high quality, extensively researched care that has been shown to improve healthcare outcomes, improve access to care and promote efficiency and cost-effective healthcare delivery. Why then is B.C. struggling so hard to fully integrate NPs into the healthcare system?

Current Barriers

Lack of Planning

Although there are arguably a number of reasons why NPs have not been fully integrated into our healthcare system in B.C. (e.g., the need for further legislative changes, resistance from some physician groups, etc.), BCNPA and many NPs recognize that the lack of a sustainable funding model for nurse practitioners continues to be the most significant challenge to increasing accessibility to this important profession. Most NPs in British Columbia are health authority employees, paid to work with a specific, marginalized population (e.g., First Nations, youth, etc.). As a result, many healthy British Columbians have no opportunity to see a nurse practitioner, even if they would prefer one. As a result, NPs have become specialized, rather than working as primary care providers focusing on health promotion and disease prevention as originally intended.

"Daily there is a steady flow of patients at the front desk of our clinic asking for primary care services – and yet they do not 'fit' the criteria which has been set for intake of patients. There is an NP whose 'criteria' for intake is frail seniors – and she is overwhelmed with patients who are complex, frail, sometimes have a GP or whose GP wants to transfer managing the care to somebody else. She sees so many chronic, complex patients and her GP partner bills for the incentive funding for these patients. The NP is salary based through IH – and sees none of this incentive funding while doing all the work." -- B.C. NP-F (Interior)

Primary care sites with NPs sometimes provide access to a wide range of populations – but often the criteria for the NP funded program excludes many people who want access to primary health care. For example, most working families with kids who are only episodically ill don't have access to an NP – although one member of the family may have access because they fit the "criteria" for services. This model actually segments families and their care among different providers.

NPs are autonomous care providers. But health authorities pay 'salary' – and that often limits NPs from opening their own practice, despite demands of the population and a willingness to venture into independent, NP group practice or other types of collaborative practices.

Nurse Practitioners have a distinct educational preparation following the completion of an undergraduate degree in nursing and work experience as a Registered Nurse (RN). The NP provider completes a graduate (Master-level) degree that focuses on diagnostics/pharmaceuticals and the treatment and management of disease as well as advanced nursing science education including health promotion/prevention, research, and leadership in both clinical practice and health systems management. Many NPs obtain Doctoral Degrees. (BCNPA, 2016)

The Fee-For-Service Challenge

One of the often unspoken challenges of the fee-for-service model is the power differential between the model by which physicians (GPs) are paid and the model by which NPs are paid. This power differential results in less voice, input and autonomy for NPs working in a collaborative model because the GPs and the Ministry of Health consult with the administrators, planners and executives rather than the NPs. As a result, decision-makers frequently forget to include the NP voice, even if NPs are a vital part of the organization.

For example, in Kamloops and area there are approximately 30,000 people without a primary care provider. The region is working to develop the concept of primary care homes - a new venture that will provide a platform for professionals to work together. The challenge, however, is that by remaining employees of a health authority, NPs, by default are not viewed, treated or consulted as colleagues within the primary care home.

The majority of NPs in B.C. are working to full capacity and often the responsibility for their patient follow up spills over from their regular working hours – resulting in late hours, home visits, and other unpaid hours as a result of time spent beyond regularly mandated hours - there is a tight limit on overtime and no flex time available. Unlike acute care providers or physicians, primary care NPs are not able to 'sign off' a patient to another provider.

Studies of funding approaches indicate that a fee-for-service model is the least likely to promote collaborative practice and discourages a system oriented toward prevention and health promotion (BCMA, 2004). Evidence also indicates that fee-for-service is oriented toward volume of activities and may lead to some patients being over-served while others are left unable able to obtain a primary health care provider (CNPI Technical Report, 2006).

BCNPA Funding Model Principles

1. **Patient Centered**: Funding models will encourage and foster public participation in health care decisions.

   Rationale: Adhering to public participation in healthcare ensures respect for individual, community and cultural diversity (CNA, 2002).

   a) Funding models will be thoughtfully structured to facilitate improved access
   b) Funding models will be outcomes based rather than volume driven
   c) Funding models will improve access to primary health care in difficult to recruit regions of the province by including incentives and supports
   d) Funding models should be utilized according to patient needs and multiple models may be required to depending on the setting and population served

2. **Nurse Practitioner Autonomy**: Nurse Practitioner practice is self-regulated by the CRNBC and funding models must reflect self-regulation.

For every four NPs approximately, 3200 patients have continued access to quality primary care services that are cost-effective and patient/person-centered (i.e. approximately $407/patient/year) (Lakehead Nurse Practitioner-Led Clinic

a) Funding models will reflect and support autonomous practice for nurse practitioners as well as support collaborative relationships within the interdisciplinary team

b) NP funding will be directly related to the NP and not a second (2nd) party

c) NPs will negotiate their own contracts within various clinical settings

3. **Equity**: Funding models will remunerate NPs to reflect their scope of practice, responsibility and accountability:

   a) When nurse practitioners deliver the same clinical standards of care as other health care professional colleagues they should be remunerated accordingly

   b) Funding models will remunerate care which focuses on prevention and health promotion as well as treatment

   c) Funding models will deliver standardized NP income/salary/benefits within BC and include overhead/operating/infrastructure expenses

4. **Value Added**: NPs are advanced practice nurses with unique educational preparation that prepares the NP for advanced clinical care along with specific training in patient education, health promotion/prevention, research, case management, and leadership in clinical and professional practice.

   a) Funding models will recognize and compensate the NP's unique skill set.

   b) Funding models will recognize the NPs' focus on health promotion, education and injury prevention across the lifespan. Rationale: Individuals, families and communities develop skills to maintain and enhance their own health thus reducing the demands for acute, rehabilitative and curative care (CNA, 2002).

   c) Funding models will reimburse the NP when a provider colleague consults the NP for patients who benefit from the NP's unique skills and educational preparation.

5. **Evidence based**:

   a) Outcomes and processes for evaluation are built in for ongoing quality improvement.

Funding Considerations

NPs need options and choice on the model in which we chose to work – and even though the primary healthcare model is changing – the NP employee model is not. Funding should flow directly to NPs if they choose to have a practice outside of health authority funding. This would allow the NPs presently in primary health care to increase their accessibility – after hours follow up, same day appointments, home visits etc.

BCNPA supports health care funding models that allow for the inclusion of Nurse Practitioner practice into B.C.'s healthcare delivery system that reflect the following principles (BCNPA, 2016):

NPs offer a viable approach to improving access to primary health care services. However, at this time, there is no public policy supporting a strategy for funding NP services over the long-term. Such policies will have to reflect the variety of responsibilities and settings in which nurse practitioners work. They must also reflect the responsibilities and legal liabilities of the nurse practitioner.

Four approaches to funding nurse practitioner services have been suggested: budget/request based funding; utilization-based funding; capitation/population based funding; and needs based funding. The fee-for service model, while mentioned here, is not seen as a solution. The pros and cons of each model are presented as follows (CNA, 2002):

Funding Approach	Description	Pros	Cons
Budget/request Based	Specifies costs of delivering services	• Build on administrative & historical information • Group services to highlight roles of nurse practitioners and other professionals	• Not tied to health status of population served • Outcomes not captured & linked to a particular profession
Utilization based	Allocates funding according to past use of particular services	• Data available • Comparability among regions	• Not linked to assessment of health needs • Difficult to introduce new services
Capitation/ population based	Allocates funding for health services based on population demographics	• Groups services & providers • Encourages appropriate health human resource (HHR) use	• Administratively complex
Needs-based	Allocates funding among provider agencies based on assessment of relative health status and outcomes of populations served	• Targets resources and services to maximize population health	• Absence of data
Fee for service	Direct billing to a client's health insurance plan for insured health services	• Promote focus on volume of interventions	• Distract from comprehensive care focus

Capitation/Population-Based Funding

While all four of the funding models could be (and in some cases are) used in B.C., the capitation or population-based model should be further explored. There have been numerous demonstration sites across B.C. using a capitation funding model, and evidence of better treatment and control of chronic disease (Tu, 2009). Nurse practitioners should be able to access the Alternate Payment Program to provide population based funding where it is most needed as opposed to the current model where patients must fit certain criteria and live within certain geographical areas to receive care from an NP.

A revitalized capitation system is optimal because providers are rewarded for adding patients to the practice and keeping them healthy over the long term (Robinson, 2001).

The anecdotal feedback from demonstration sites is that the capitation model of funding is difficult to administer. However, with consistent electronic medical records in place as well as an efficient way to track the patients' care received outside of the practice, the model can be a success. For this reason, BCNPA supports a revitalized capitation model with proper supports in place. Currently, midwives in B.C. are paid in this manner through a Master Agreement with the Ministry of Health and administration through MSP. This could also work for nurse practitioners.

In a capitation model all providers can be included and paid in a manner commensurate with education and responsibility. A clinic manager is needed to manage the practice. Physicians, particularly newly graduated family MDs, will be attracted to a practice in which they do not need to manage a business and where they can practice collaboratively across disciplines. Some physicians, in particular those currently employed by walk-in clinics, may be attracted to such a practice.

Nurse practitioners are the lead primary care providers of the [NP-Led] clinic's interprofessional team of health care providers and support staff. Nurse practitioners assess, diagnose, treat and monitor a wide range of health problems using an evidence based approach to their practice. In addition to nurse practitioners and collaborating physicians, other professionals on the clinic's team may include registered nurses, registered practical nurses, registered dietitians, registered social workers, health promoters, mental health workers, pharmacists, occupational therapists, physiotherapists, and other health care providers (OHLTC, 2015)

Conclusion

Nurse practitioners in British Columbia continue to be recognized as a valued and significant profession that is also, unfortunately, underutilized and inaccessible to many who could benefit from this type of primary health care. Since 2005, nurse practitioners have been employed by health authorities in B.C. – some on stable salaries, others on pilot or short-term funding projects. As a result, many NPs are limited to working with specific populations, and British Columbians, by and large, have limited ability to access NPs. Without clear, consistent decision-making around the funding models required to fully utilize this profession, B.C. runs the risk of losing NPs to other jurisdictions, leaving numerous 'orphan' patients who could otherwise have their primary health care addressed efficiently and effectively by an NP.

BCNPA recommends the following:

1. **Establish Funding Models to Enable NP Integration in B.C.**

   NPs have been working in B.C. since 2005, and yet there continues to be no significant direction toward endorsing or establishing funding models that work long term. The more time that elapses since the 2005 introduction of NPs, the harder it becomes to set a funding model in place that will ensure long-term sustainability of the profession. And yet, there is still no conclusive evidence of which funding models should be embraced for B.C.

   BCNPA recommends that government immediately strike a task force solely focused on NP funding models which will explore every viable option and deliver a long-term plan under which NPs will be employed. This task force should include representatives from across the healthcare system (nursing, medicine, midwifery and others), government, the health authorities, and the regulatory body. It should also include appropriate funding and financial experts who will help to guide the process and ensure B.C. implements a permanent, long-term solution to this critical issue.

2. **Communicate the Value of NPs to the Public**

   B.C. has done a poor job of communicating the role and value of NPs to the public. Aside from the occasional mention in a news release, strategic plan or speech by the Minister, there has been little to no attention paid to helping British Columbians understand the value of the NP. By limiting where NPs can work, and who they can work with, there is further disconnect with the public around what an NP is able to do. Government has a high profile role in describing, explaining and advocating for a single profession – and it would be helpful if NPs could be intentionally and continuously highlighted by Government.

3. **Work with Physicians to Increase Awareness and Acceptance of the NP Role**

   Many physicians in B.C. would love to have a nurse practitioner as part of the interdisciplinary team, but are unable to integrate NPs into their existing practice. Yet there is consistent evidence, and numerous requests for NPs, to suggest that the role has largely been accepted by physicians in this province. Government guidance and direction around including NPs in programs such as the Divisions of Family Practice

would provide greater opportunities for interprofessional collaboration within primary health in B.C.

4. **Develop Primary Care Clinic Pilot Projects**

   While NPs are tired of short-term funding projects that enable hiring of NPs for a time-limited period, there is great interest in assessing and implementing primary care projects that are supported by a primary health care team (with a variety of options for personnel mix and funding arrangements). There is no one size fits all approach for the delivery of primary health care that is responsive to all patients' needs. NPs are ready to demonstrate their flexibility in this area, and would welcome opportunities to show how a variety of approaches to primary healthcare would be beneficial for patients and for the healthcare system.

NPs are a valuable resource within the primary health care system and are used widely across Canada and throughout the United States. B.C. has an opportunity to move to the forefront of integration and implementation but it will require concentrated effort on the part of government, NPs and health authorities to fully develop funding models that enable long-term sustainability of the profession. After ten years, it is more than time for the province to recognize that NPs are a successful and integral part of our healthcare system, and there is responsibility on all sides to ensure they are a sustainable and growing resource for British Columbians.

REFERENCES

- American Association of Nurse Practitioners (2015e). Quality of nurse practitioner practice. Retrieved from https://www.aanp.org/images/documents/publications/qualityofpractice.pdf
- BCMA and MOHS (2004). Recommendations from the Maternity Care Enhancement Project, December 2004.
- CNA. (2002) Primary Health Care: A New Approach to Health Care Reform. Retrieved from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-fr/phc_presentation_kirby_6602_e.pdf?la=en
- CNA. (2002) Fact Sheet: Financing Nurse Practitioner Services. Retrieved from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-fr/fs12_financing_nurse_practitioner_services_march_2002_e.pdf?la=en
- CNPI. (2006). Technical Report: Nurse Practitioners, The Time is Now. Retrieved from http://www.npnow.ca/docs/tech-report/section1/01_Integrated_Report.pdf
- CRNBC. (2006a). Creating a regulatory framework for nurse practitioners in British Columbia. The consultation process. Vancouver, BC: Author.
- CRNBC. (2006b). Scope of practice for nurse practitioners (Family). Pub. # 424. Vancouver, BC: Author.
- Hansen-Turton, T. (2015). Introducing nurse-managed models. In T. Hansen-Turton, S. Sherman, & E. S. King (Eds.), *Nurse-led clinics: Operations, policy, and opportunities* (pp. 1-2). New York, NY: Springer Publishing Company.
- Lakehead Nurse Practitioner-Led Clinic (2014). A team approach to quality health care. 2013-2014 annual report. Retrieved from http://lnplc.com/wp-content/uploads/2011/12/ANNUAL-REPORT-2013-2014.pdf
- MOH. (2006). Resource manual for nurse practitioners. Retrieved from http://www.health.gov.bc.ca/msp/infoprac/np/msp_resource_np.pdf
- MOH. (2015). 2015/16 – 2017/18 Service plan. February 2015. Retrieved from http://www.bcbudget.gov.bc.ca/2015/sp/pdf/ministry/hlth.pdf
- Ontario Ministry of Health and Long Term Care (2015). Nurse practitioner-led clinics. Retrieved from http://www.health.gov.on.ca/en/common/system/services/npc/
- Registered Nurses Association of British Columbia (RNABC) (1997). Advanced nursing practice discussion paper. Towards a definition of advanced nursing practice. Vancouver, BC: Author. RNABC (2004). Nurse Practitioners: BC's newest providers of health care services. Nursing BC, June, 5-7.
- Robinson, James (2001). *Theory and Practice in the Design of Physician Payment Incentives*. The Milbank Quarterly; Volume 79, Number 2.
- Sangster-Gormley, E. (2012). A Survey of Nurse Practitioner Practice Patterns in B.C. Retrieved from http://www.uvic.ca/hsd/nursing/assets/docs/news/np_practice_patterns.pdf
- Tu, Karen; Cauch-Dudek, Karen; Chen, Zhongliang (2009). *Comparison of primary care physician payment models in the management of hypertension*. Canadian Family Physician; 2009, 55: 719-727.