Submission to: Hon. David Caplan

Response to HPRAC's Report Critical Links: *Transforming and Supporting Patient Care. A Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration and a New Framework for the Prescribing and Use of Drugs by Non-Physician Regulated Health Professions January 2009*

February 28, 2009

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1. Introduction

The Nurse Practitioners' Association of Ontario (NPAO) is pleased to have this opportunity to provide feedback on the recommendations presented to Minister of Health and Long-Term Care David Caplan, by the Health Professions Regulatory Advisory Council (HPRAC) in *"Critical Links: Transforming and Supporting Patient Care."*

NPAO, an interest group of the Registered Nurses' Association of Ontario (RNAO), represents the professional interests of all nurse practitioners in Ontario. Our mission is to achieve full integration of nurse practitioners to ensure accessible high quality health care for Ontarians. NPAO represents over 1200 members including adult, paediatrics and primary health care nurse practitioners as well as students in nurse practitioner education programs and advanced practice nurses who are preparing to write the nurse practitioner registration examinations. Over 85% of nurse practitioners registered with the College of Nurses of Ontario (CNO) are members of NPAO; this is a very high membership retention rate for a voluntary professional association.

In 1998, Ontario demonstrated incredible leadership as the first Canadian jurisdiction to regulate the nurse practitioner role. However, the regulatory framework for nurse practitioners has failed to keep pace with emerging health system needs, nurse practitioner capabilities and patient care needs and expectations. Other jurisdictions learned from Ontario's experience and established regulatory and legislative environments that enable nurse practitioners to provide comprehensive, innovative, leading edge patient-centred care.

Since the role was regulated ten years ago, nurse practitioners together with NPAO and RNAO as the professional associations that represent them, have actively participated in numerous public consultations and studies to review barriers to practice and strategies to support integration of the role in various settings at both the provincial and federal levels. (Appendix 1) Successive Health Ministers, Tony Clement (2002) and George Smitherman (2004) commissioned in-depth reports to review barriers to nurse practitioner practice in Ontario and recommend strategies to address these issues. The '*Integration Report*'[1] identified the drug list as a significant barrier and the '*Task Team Report*'[2] made specific recommendations in support of open prescribing.

It is time to take the significant steps that are necessary to address the legislative, regulatory and policy barriers that restrict the capacity of Ontario's nurse practitioners to work to their full scope of practice and reduce the effectiveness of interprofessional teams. Most importantly this process must address those barriers that restrict access to safe, effective, evidence-based,

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[1] Report on the Integration of Primary Health Care Nurse Practitioners in Ontario (2005) retrieved from http://www.health.gov.on.ca/english/public/pub/ministry_reports/nurseprac03/nurseprac03_mn.html
[2] NP Integration Task Team Report Submitted to the Minister of Health and Long-Term Care, March 2007 retrieved from http://www.npao.org/Uploads/members/NP%20Task%20Team%20March07.pdf

quality care for patients. NPAO and nurse practitioners across Ontario look forward to the government's response to all of HPRAC's reports.

2. *Objectives and Principles - Government and HPRAC*

Premier McGuinty, at the announcement of three new NP-Led Clinics on February 20, 2009, commented that "nurse practitioners have much to offer to the citizens of Ontario" and "…we need to take advantage of their talent, knowledge and expertise … in improving access to family health care."[3] Minister Caplan, also spoke on this same theme at the November 2008 NPAO Conference and further commented on the high quality, innovative and safe care that nurse practitioners provide to patients in all practice settings across the province.

NPAO has paid close attention to the health needs of Ontarians and to the commitments of government to meet those needs. In our view, the key agendas of the McGunity government for Ontario's health care system are:

- to deliver high quality, patient-centred care;
- to maintain safety for both patients and providers;
- to support innovation and value leadership;
- to ensure the sustainability of the system by reducing waiting lists and maximizing use of health human resources;
- to improve access to health care for families;
- to enable high-functioning, effective interprofessional health care teams.

Consistent with the government's agenda, HPRAC proposed the following principles to guide the interprofessional collaboration review process:[4]

- Meeting public expectations for improved access to high quality, safe services and patient-centred care;
- Optimizing the contribution of all health professionals;
- Applying rigorous standards for regulation of health professionals;
- Using resources efficiently;
- Sustaining the health care system;
- Maintaining self-regulation.

NPAO's analysis of the recommendations brought forward in this report and the feedback provided in this submission was prepared through the lens of the commitments of government and HPRAC.

3. *Framework for NPAO Response*

"Critical Links" is a very complex report and HPRAC is to be commended for the significant work it represents. NPAO has focused this response specifically on those recommendations that most directly impact nurse practitioners in relation to their prescribing authority. Furthermore, to a great extent our comments are based on assumptions regarding the Minister's response to HPRAC's report on the RN(EC) Scope of Practice, in particular necessary legislative changes to the *Nursing Act (1991)* and the *Public Hospitals Act (1990).*

[3] Retrieved February 23, 2009 from http://www.premier.gov.on.ca/news/Product.asp?ProductID=2871&Lang=EN (video stream)
[4] Critical Links: Transforming and Supporting Patient Care, HPRAC, January 2009 p 3

Each section of this submission is structured with the following components:

- A summary of the request for change proposed by either CNO and/or NPAO as part of the RN(EC) referral submitted in the fall of 2007;
- The response from HPRAC as presented in *"Critical Links";*
- NPAO's feedback on HPRAC's recommendation;
- NPAO's recommendation to Minister Caplan.

4. Nurse Practitioner Authority to Dispense, Sell and Compound

CNO / NPAO Request for Change:

The College of Nurses of Ontario requested that nurse practitioners be authorized to dispense, sell and compound drugs in addition to their prescribing authority. NPAO supported the changes proposed by the College.

HPRAC Response:[5]

Recommendation 1 (Profession of Nursing)

a) That NPs, RNs and RPNs be authorized to dispense drugs that are prescribed by an authorized prescriber;
b) That the authorization should be based on adherence to transparent standards of practice;
c) That the standards of practice for dispensing drugs should be developed by an interprofessional committee;
d) That the standards of practice be equivalent to those required of physicians; and
e) That the standards of practice address therapeutic needs of the patient.

Recommendation 2 (Profession of Nursing)

a) That NPs be authorized to compound and sell drugs that are prescribed by an authorized prescriber;
b) That the authorization be based on adherence to transparent standards of practice;
c) That the standards of practice for compounding and selling drugs be developed by an interprofessional committee; and
d) That the standards of practice be equivalent to those required of physicians.

NPAO Feedback on HPRAC Response:

NPAO supports HPRAC's recommendation to authorize nurse practitioners to dispense, sell and compound drugs.

NPAO Recommendation to Minister Caplan:

NPAO recommends that Minister Caplan implement HPRAC's Recommendations 1 and 2 related to the Profession of Nursing.

5. Nurse Practitioner Authority to Prescribe Oxygen, Blood and Blood Products

NPAO Request for Change:

NPAO recommended that nurse practitioners be authorized to prescribe blood and blood products and oxygen. NPAO's submission included the following comments:

- Nurse practitioners prescribe oxygen, blood and blood products under delegation and medical directives authorized by physicians.
- Oxygen, blood and blood products do not fit in the controlled acts model.

[5] Ibid p 295

- Previous attempts to provide nurse practitioners with this authority through CNO's annual review of the drug list were not successful.
- Therapeutic oxygen has been classified as a drug that midwives may order and administer under the *Midwifery Act (1991) Designated Drugs Regulation*.
- Nurse practitioners in other jurisdictions such as Alberta and Nova Scotia already have or will shortly have the authority to prescribe blood and blood products.

HPRAC Response re Oxygen:

HPRAC concludes that an emergency kit should be available to NPs as required in some practice settings. Oxygen is included as one of several emergency medications. Further, HPRAC identifies that CNO will need to establish standards, protocols and practice guidelines for emergency situations, including a requirement that members maintain current certification in basic cardiopulmonary resuscitation.

HPRAC Response re Blood and Blood Products:

HPRAC did not include any recommendations in response to blood and blood products.

NPAO Feedback on HPRAC Response:

NPAO specifically raised the issue of oxygen, blood and blood products at a round table session organized by HPRAC with health professional associations and regulatory organizations. HPRAC indicated awareness of the specific challenges related to these substances and indicated a preference to include them as part of the prescribing review. For purposes of this response, NPAO will refer to "prescribing" as the mechanism to authorize nurse practitioners access to oxygen (beyond emergency situations), blood and blood products.

HPRAC is recommending oxygen only for emergency situations and did not comment on blood or blood products for nurse practitioners. The following stories support the need nurse practitioners to have authority to prescribe oxygen, blood and blood products

I am the NP on a Transitional Care Unit part of Complex Care in the hospital. My collaborating physician is on the unit two half days per week. After being started on chlorambucil for Chronic Lymphocytic Leukemia, a patient was transferred to the unit following an acute care hospital admission. He suddenly developed shortness of breath. To manage him in a timely, safe manner, oxygen had to be started immediately. Blood work results indicated that the cause of his shortness of breath was an adverse effect (anemia) of his chemotherapy drug. To ensure that his oxygen saturation improved enough for his safety and comfort, packed red blood cells had to be ordered and given as soon as possible. To call and search for the physician for each step of this situation and await his arrival to assess the patient places the patient at risk of harm. As an NP I have the knowledge, skill and ability to complete advanced assessments, think critically, and make decisions for patient care. Not only was I concerned for and treating the comfort of the patient, I was acting swiftly to reduce the risk of adverse cardiac events related to low haemoglobin and low oxygen.

I have a 53 year old woman with Behcet's disease who regularly travels from Sault Ste. Marie to Toronto to see a Gastroenterologist who specializes in this disorder. The patient needs occasional blood transfusions due to severe chronic anemia as suggested by her Toronto specialist. When she comes to me as her primary care provider I am unable to order the blood transfusions and have to go to my collaborating physician who doesn't know the patient for the order. This is an unnecessary step which delays access to care

for the patient. The patient doesn't understand why I can't provide the care she needs. This is something I need to be able to order to provide timely care to this patient.

I was providing care to a very elderly patient with several co-morbidities, including congestive heart failure. His health was failing, but he and his wife were committed to caring for him at home. I assessed him in clinic, and found him to be weak, short-of-breath and hypoxic (low oxygen level). He refused to go to hospital, but did agree to home-oxygen treatment. I contacted the local company who administers home-oxygen and was able to arrange for them to meet him at his home that same day, assess his oxygen needs and get him started on a home program, for palliation. In order to be able to make these arrangements, I had to interrupt my physician partner several times to have him sign forms, etc. while he was seeing other patients. It would have been much more efficient, if I could have provided the prescription for home oxygen and completed the forms independently – saving the patient and his wife, my physician partner, and myself considerable time and effort.

My practice is an isolated, northern Ontario community where I am am the only primary care provider. Last summer, an elderly female visitor from another province presented with questions about her chronic oxygen dose. This patient suffered from Pulmonary Fibrosis and required ongoing supplemental oxygen therapy. She left the care plan instruction from her physician at home. With these instructions she would have been able to self-manage. However, she was feeling increasing respiratory discomfort due to the heat and humidity level and presented to the clinic for advice regarding the titration of her oxygen concentration. After ruling out other serious causes for her increased respiratory distress, I was unable to provide health care advice about supplemental oxygen titration under my own "scope of practice." This is an example where I had the knowledge, skill and judgment to provide important instruction to improve the quality of life for this patient but was unable to proceed due to limits on my ability to prescribe.

As an NP in an ICU, I need to be able to order blood products. A patient was admitted with a hemothorax after slipping on the ice and hitting his side on his car bumper. He was relatively stable but having shortness of breath and pain. I needed to insert a chest tube to drain the blood from his thorax and allow his lung to expand. He was on warfin (an anticoagulant) and his INR was elevated. To correct his coagulation prior to inserted chest tubes I needed to order fresh frozen plasma.

NPAO Recommendation to Minister Caplan:

NPAO recommends that the Minister immediately consult with the College of Nurses of Ontario on possible strategies to enable nurse practitioners with the authority to provide patients with oxygen, blood and blood products.

6. Open Prescribing for Nurse Practitioners

CNO / NPAO Request for Change:

The College of Nurses of Ontario requested that limitations on prescribing be removed from the *Nursing Act (1991)*. The College also requested that limitations on the authorized act of administering a substance by injection or inhalation be removed for NPs. The College recommended that any conditions necessary to protect the public be placed in the RN(EC) Practice Standard rather than in legislation. NPAO agreed with the proposals put forward by the College.

HPRAC Response:[6]

HPRAC does not recommend open prescribing for nurse practitioners. Based on this recommendation there was no response related to the removal of limitations on administering a substance by inhalation or injection.

NPAO Feedback on HPRAC Response:

NPAO is extremely disappointed in HPRAC's recommendation to support yet another list based model for prescribing by nurse practitioners. For over a decade, nurse practitioners have consistently and repeatedly identified the significant limitations and the multiple barriers that result from lists, in particular lists contained in regulation and/or legislation and the negative impact this has for Ontarians, health care providers and Ontario's health care system. These assessments have been confirmed in numerous reports to government (Appendix 1). NPAO has consistently and repeatedly advocated for open prescribing and for the removal of unnecessary restrictions on nurse practitioner practice since the role was first regulated in 1998. The NP Task Team proposed the same recommendation in their report to then Minister of Health and Long-Term Care George Smitherman.[7]

As noted in our previous submission to HPRAC on the non-physician prescribing referral, NPAO does not view a 'one size fits all approach' for all non-physician prescribers as the appropriate course of action especially for professions who care for diverse patient populations.[8] This is especially true for nurse practitioners who, like physicians and dentists, provide care to a diverse range of patient populations across all ages and in a wide variety of settings, and therefore require a broad and flexible approach and a comprehensive range of drugs to manage the overall health needs of patients.

HPRAC's assessment of nurse practitioner prescribing in other jurisdictions was limited, referring only to Alberta, British Columbia and Great Britain. The College of Nurses of Ontario has undertaken an extensive review of other Canadian jurisdictions, the United States and the United Kingdom.[9] This report notes that the trend is very clear; jurisdictions are moving toward more open prescribing. As noted in a separate submission to Minister Caplan from Loretta Ford, RN, PNP, EdD, FAAN, FAANP and co-founder of nurse practitioner practice in the United States, forty-eight states currently support full prescriptive authority for nurse practitioners in every category of scheduled drugs.[10] The American Journal for Nurse Practitioners, an internationally recognized peer-reviewed journal, recently published the annual state-by-state review of nurse practitioner legislation and healthcare issues and confirms this trend in prescribing authority in the United States.[11]

NPAO is puzzled by HPRAC's assessment of the risk of harm. It appears that HPRAC's concern is entirely based on concerns expressed by only one profession, "Physicians told HPRAC … they are concerned about the implications of bypassing the traditional gate-keeping role of MDs and pharmacists if open prescribing by NPs were to become a reality."[12] For over forty years, nurse practitioners have been prescribing safely in Ontario both under independent

[6] Critical Links: Transforming and Supporting Patient Care, HPRAC, January 2009 p 295
[7] Report of the NP Integration Task Team Submitted to the Minister of Health & Long-Term Care. March 2007 pg 18
[8] Submission to HPRAC: Non-Physician Prescribing. November 2008. p 4
[9] Approaches to Prescriptive Authority for Nurse Practitioners, A Consultation Document. College of Nurses of Ontario. September 2008 pgs 2-3
[10] Personal correspondence, email, February 26, 2009
[11] The Pearson Report: The annual state-by-state national overview of nurse practitioner legislation and health care issues retrieved on February 26, 2009 http://www.webnp.net/downloads/pearson_report09/ajnp_pearson09.pdf
[12] Critical Links: Transforming and Supporting Patient Care, HPRAC, January 2009 p 291

authority and under medical directives. For the last decade, nurse practitioners have demonstrated safe and effective prescribing within a regulatory framework. Futher, in the jurisdictional review HPRAC notes, "In summary, HPRAC's literature review indicates that the limited evaluative reviews published to date generally support the introduction of new prescribing authority, particularly related to nursing and pharmacy."[13]

Individual physicians, especially those who work directly with nurse practitioners, report that they value the knowledge, skill and judgment of nurse practitioners and recognize that they deliver safe, effective, quality care to patients. Many also express frustration with the limits of nurse practitioner scope of practice and support expanded scope of practice including prescribing.[14, 15, 16, 17]

The submission of the College of Physicians and Surgeons to HPRAC on the nurse practitioner referral states, "The CPSO feels that the current method of regulating RN(EC) prescribing and diagnostic/laboratory privileges inhibits the ability of RN(EC)s to readily adapt to changes in viable treatment options, and may constrain nurse practitioners in providing the most effective care to their patients. Ideally, RN(EC)s should be permitted to prescribe all the treatment options that fall within their scope of practice. Where patient safety or resource availability is of concern, then specific exceptions can be made excluding those options from RN(EC) practice."[18]

HPRAC contends that "with the introduction of a new drug approvals framework, many of the concerns about the regulation-making process will be addressed."[19] NPAO respectfully disagrees with this perspective for the following reasons.

a) Timely Access to Best Practice Medications for Patients

HPRAC has provided no assurances that the proposed new drug approval process will actually result in any efficiencies that will shorten the review process. In NPAO's assessment, it is unlikely that it could be any faster than the current process. Regulatory colleges will still be expected to demonstrate due diligence in preparing their recommendations for changes. For nursing, the current process requires between 12 and 16 months. The NP Task Team concluded there was no room for additional efficiencies in this process[20] and it is NPAO's opinion that no additional efficiencies would be available even with the new Nurse Practitioner Standards Committee. Furthermore, given the breadth and depth of nurse practitioner practice it is reasonable to envision that in order to achieve timely access to care for patients, CNO will forward requests for changes to the nurse practitioner drug list several times a year.

[13] Ibid p 64
[14] Submission by Dr. Peter Bell to HPRAC as retrieved on February 26 at http://hprac.org/en/projects/resources/hprac-nursing.response_CNO.PeterBellfinal.pdf
[15] Submission by Dr. Angus Daniel to HPRAC as retrieved on February 25 at http://hprac.org/en/projects/resources/hprac-nursing.response_CNO.AngusDanielnew.pdf
[16] Submssion by dr. Stephan Ragaz to HPRAC retrieved on February 26 at http://hprac.org/en/projects/resources/hprac-nursingresponse_CNORagaz-PNFHT.pdf
[17] Submission by Dr. Zahir Poonja to HPRAC retrieved on February 25 at http://hprac.org/en/projects/resources/hprac-nursing.response_CNO.ZahirPoonjanew1218.pdf
[18] Submission by College of Physicians and Surgeons of Ontario to HPRAC retrieved on February 26 at http://hprac.org/en/projects/resources/hprac-nursingresponse_CNOCPSOnew2.pdf
[19] Critical Links: Transforming and Supporting Patient Care, HPRAC, January 2009 p 293
[20] Report of the NP Integration Task Team Submitted to the Minister of Health & Long-Term Care. March 2007 p 17

b) Decreased Reliance on Medical Directives

There will be a continued reliance on medical directives for any item not on the list or with restrictions and while items proceed through the review process. HPRAC has acknowledged that medical directives are cumbersome and ineffective and have a negative impact on both system efficiency and interprofessional teams. Both CNO and NPAO have consistently indicated that reliance on medical directives over time is an implicit recognition that delegated activities need to be subsumed by the receiving profession.

c) Reflect Current Competencies, Education and Practice of Nurse Practitioners

Regulated lists do not allow for full utilization of nurse practitioner knowledge, skill and expertise – the very thing the Premier and Minister stated their government intends to take advantage of! It is also inconsistent with the government's objectives for HealthForceOntario to ensure that Ontario is a leader in enabling health professionals to work to the full extent of their knowledge and expertise.

d) Enable Self-Regulating Professions

Self-regulation is based on the concept that members of a profession are in the best position to determine entry to practice and ongoing competencies, establishing and enforcing standards of practice for the profession and having appropriate quality assurance programs to ensure ongoing competence.[21] Both government and HPRAC have consistently stated their commitment to self-regulation. It is the assessment of NPAO that HPRAC's recommendation to continue with lists based in regulation for nurse practitioners is inconsistent with this stated commitment. Further, with the recommendation of two additional levels of review and approval, the self-regulating role is significantly diminished.

HPRAC has recommended that many regulatory colleges, including the College of Nurses of Ontario, establish statutory interprofessional committees with responsibility to develop standards of practice and advise regulatory Councils. NPAO supported this recommendation in our submission to Minister Caplan on the RN(EC) Scope of Practice Review.[22] If implemented, NPAO suggests that based on the proposed composition of the Nurse Practitioner Standards Committee that adequate mechanisms would be in place to provide expert advice to CNO Council on restriction and/or limitations for nurse practitioner prescribing.

Finally, it is important to review the findings and recommendations of the NP Integration Task Team. In November 2004, then Minister of Health George Smitherman established the NP Integration Task Team comprised of nursing, medicine and public representatives. Their mandate was to review, prioritize, implement or advise on the implementation of the recommendations of The Integration of Primary Health Care Nurse Practitioners into the Province of Ontario report. Dr. Alba DiCenso, BScN, MSc, PhD, CHSRF/CIHR Chair in Advanced Practice Nursing and Sue Matthews, RN, BA, MHScN, PhD, then Provincial Chief Nursing Officer were appointed as co-chairs. Nurse practitioners, physicians and staff and representatives from the Ministry of Health and Long-Term Care, NPAO, OMA and CNO chaired and/or participated in working groups.

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[21] Ibid p 16

[22] NPAO Submission to: Hon. David Caplan – Response to HPRAC Referral "A Report to the Minister of Health and Long-Term Care on the Review of the Scope of Practice of Registered Nurses in the Extended Class (Nurse Practitioners). January 30, 2009 p 9

The following summarizes the key findings of the Task Team in relation to nurse practitioner prescribing:

- There was little room to increase efficiencies in CNO's existing review process.
- Ontario's legal framework for nurse practitioners is one of the most restrictive in Canada.
- Regulated lists are inconsistent with self-regulation.
- Regulated lists do not allow for full utilization of knowledge and skills of nurse practitioners.
- Regulated lists are not responsive to patient needs, delays access to care and result in system inefficiencies.
- The lengthy process to review and update lists delays the ability of NPs to comply with best practices.
- CNO received overall positive feedback to their consultation and proposal to remove the drug list from regulation with the exception of the Ontario Medical Association.

The Task Team's conclusion in regard to nurse practitioner prescribing was that further consultation would be unlikely to generate new findings.

The Task Team recommended a broad strategy consistent with government objectives to improve access to care for patients, enable nurse practitioners to work to full scope and maintain public safety. The report emphasized two key elements related to nurse practitioners. First, nurse practitioner education is geared to enabling nurse practitioners to make patient-centred, evidence-based decisions. Students focus on critical thinking, assessment, problem-solving and decision-making not a "list" of drugs. Second, nurse practitioners like all health professions, practice within their knowledge, skill, judgment and competency.[23]

In concluding how to best move forward on the issue of prescribing, the Task Team recommended the following:

- "Recognizing the accountability of regulated health professionals to practice within their individual scope and area of competence, draft legislation that provides members of the Extended Class the authority to … prescribe drugs approved in Ontario."
- "This means that specific drugs … will no longer be listed in regulation and/or legislation."
- "Support CNO's commitment to: adapt its quality assurance program … and develop a standard for RN(EC)s that clarifies the basic principles of appropriate prescribing and the regulatory framework that governs prescribing practices."[24]

NPAO Recommendation to Minister Caplan:
To maximize the knowledge, skill and judgment of nurse practitioners, to further enable high functioning interprofessional teams to provide quality patient-centred care, to foster self-regulation of nurse practitioner practice and to achieve the government's health system objectives to improve access to care for patients and consistent with the recommendations of the NP Task Team report, NPAO strongly recommends that nurse practitioners be granted open prescribing and that government enact the necessary legislative and regulatory changes without further delay.

[23] Report of the NP Integration Task Team to the Minister of Health and Long-Term Care. March 2007 p 18
[24] Ibid

7. *Enabling Framework*

To the best of our knowledge, details of the enabling framework were not included in consultations or round table discussions with nurse practitioners. As noted above, NPAO continues to advocate for open prescribing for nurse practitioners. However, should the Minister accept HPRAC's recommendations, NPAO believes it is important to identify critical issues in regard to the proposed classes (heretofore referred to as "the list") and the enabling framework including the Council for Health Professions Regulatory Excellence and the Drug and Therapeutics Committee (CHPRE and DTPC respectively) (heretofore referred to as "the process").

HPRAC Response:[25]

Recommendation 3 (Profession of Nursing)

a) That the regulation under the *Nursing Act, 1991* designate drugs that NPs are authorized to prescribe by therapeutic classes;
b) That specific agents and any terms, limitations or conditions to be attached to the prescribing or administration of drugs included in the class be determined through a new drug approvals framework;
c) That standards of practice relating to the prescribing of drugs be developed by an interprofessional standards committee; and
d) That NPs not be authorized to delegate prescribing authority.

Recommendation 4 (Profession of Nursing)

a) That NPs be authorized to prescribe and administer drugs for use in emergency situations; and
b) That the CNO develop additional standards of practice for emergency situations.

Recommendation 5 (Profession of Nursing)

That the following therapeutic classes of drugs be included in a designated drugs regulation under the *Nursing Act, 1991*. The specific agents and any terms, limitations or conditions attached to the authority would be developed through a new drug approvals framework. At the outset, the specific agents that could be prescribed, dispensed, sold and compounded would include those listed below.[26]

NPAO Feedback on HPRAC Response re Classes of Drugs

HPRAC proposes a list of eighteen classes with over 120 specific agents/substances for nurse practitioners.[27] The list is based on the current nurse practitioner prescribing list and which was developed with only primary health care nurse practitioners in mind. As noted previously, this list is based on submissions made to CNO prior to January 2007 and is out-of-date. For example, new drugs of choice such as Champix which is within nurse practitioner scope are not on the list. Also, it does not reflect the prescribing needs of the new nurse practitioner specialties of adult, paediatrics or anaesthesia[28] which were not regulated until August 2007. NPAO appreciates that CNO is consulting with members and stakeholders on prescribing requirements for these specialties and preparing recommendations for CNO Council. HPRAC did not have

[25] Critical Links: Transforming and Supporting Patient Care, HPRAC, January 2009 p 295
[26] Ibid pgs. 296-304
[27] We note that there are several problems with the list. Several drugs currently authorized to nurse practitioners are not included; some drugs are misspelled or references are incomplete. Some substances are not listed under the correct class.
[28] No CNO members are currently registered in the NP-Anaesthesia specialty as the education program began in January 2009 at the University of Toronto and a registration examination has not yet been approved by CNO Council.

access to any recommendations for these new specialties as part of this process. It is our expectation that additional classes will be added by CNO.

Over the past four weeks, NPAO actively encouraged members to share information on current medical directives and to identify classes and sub-classes they would need for their practices. That information helped NPAO to developed a preliminary suggested list of therapeutic classes to be included in regulation (see Appendix 2). This list is not intended to preclude the work currently underway by CNO which will be more definitive and reflective of nurse practitioner practice. NPAO's list includes several additional classes and proposes two new classes based on the information provided by practicing nurse practitioners in the very short time available for this consultation. It is NPAO's expectation that CNO will ultimately provide a more comprehensive assessment and recommendations to support nurse practitioner practice across Ontario. These additional and new classes and rationale for each are outlined in the following chart.

Additional Classes of Drugs for Nurse Practitioners Proposed by NPAO		
Number	**Class**	**Rationale**
10:00	Antineoplastic Agents	NPs working in rheumatology clinics and in primary care regularly care for patients on methotrexate, a medication that falls within this class.
32:00	Contraceptives (foams, devices)	NPs working in primary care and in sexual health clinics routinely provide counseling regarding all methods of contraception and require the ability to prescribe all forms of contraceptives.
36:00	Diagnostic agents	The current RN(EC) drug list includes PPD-B (Mantoux); this was not included in the class-based list proposed by HPRAC but it is an essential component of NP assessments to be able to perform Tuberculosis testing. In addition, with the HPRAC recommendations re: scope of practice, NPs will be able to order a wider range of diagnostic investigations and in order to do this will require the ability to prescribe agents used during the investigation (e.g., barium).
86:00	Smooth muscle relaxants	NP-PHC and NP-Adult frequently care for patients with overactive bladder; these patients often benefit from medications in the Genitourinary Smooth Muscle Relaxant sub-class, such as oxyybutynin. In addition, some patients with COPD require treatment with theophylline, a Respiratory Smooth Muscle Relaxant (note: our list includes other medications which are used in the treatment of COPD).
92:00	Miscellaneous Therapeutic Agents	The subclass of Bone Resorption Inhibitors was included although the class was not. NPs require drugs from the following sub-classes: Alcohol Deterrents (ie. Disulfiram for detoxification purposes); Antigout Agents (ie. allopurinol, which is currently authorized to NPs but was not included in HPRAC list, plus colchicine); Immunosuppressive Agents (for NPs working specifically in transplant units) and Other Miscellaneous Therapeutic Agents (most hospital based NPs had Mucomyst in their medical directives to assist patients who are experiencing abnormal mucous secretions).

New Class	Theraputic Gases	Oxygen
New Class	Blood and Blood Products	

The advantage of classes of drugs listed in regulation rather than individual drugs could be less need for regulatory amendments to update or change drug lists. However, HPRAC is proposing that lists of individual agents or substances be included in each class along with any restrictions, limitations and conditions. As NPAO noted in our submission on the RN(EC) referral, "NPAO is concerned, especially in relation to prescribing, based on these recommendations that nurse practitioner practice will be subject to the same regulatory rules for prescribing as other non-physician prescribers with a "one-size-fits-all" approach utilizing categories of drugs in regulation. Such an approach fails to recognize the breadth and depth of nurse practitioner practice. This is not in the best interest of continuity of safe, quality, effective care for patients nor does it enable a health care system for the people of Ontario that is effective, efficient and safe."[29] NPAO also notes that this is precisely what the NP Task Team did not want to see implemented for nurse practitioners.

Several practical implementation issues have emerged that require clarification from HPRAC related to the proposed regulatory framework including: prescribing combination drugs, prescribing drugs with multiple therapeutic uses and adapting to the rapid changes in preferred prescribing as new drugs and therapies emerge.

In the current regulatory framework, members are not allowed to prescribe combination drugs even though each substance may be on their approved list. There is increasing reliance on combination drugs to ease administrative burden and enhance patient adherence to medication treatment plans. For example, antihypertensive medications are increasingly being combined with thiazide diuretics. Once dose is established, it is important for nurse practitioners to be able to access fixed dose combination medications for their patients.

It appears that this barrier will continue under the new regulatory framework. The following outlines examples of combinations that are within a nurse practitioners scope of practice and which they should be able to prescribe.

> *I have an elderly patient who is on multiple medications. She lives alone and has difficulty managing her medication. It would be most beneficial for her to have the least number of medications possible. She has private insurance that will pay for combination therapies. I would therefore like to be able to maintain her on Fosavance which contains both alendronate and Vitamin D in a once weekly formulation. I am unable to do this as it is a combination medication although I can prescribe both individually. She must therefore be advised to take Alendronate once weekly and Vitamin D 1000 IU daily.*
>
> *Both Hepatitis A vaccine and Hepatitis B vaccine are on the current drug list. A combination vaccine (Twinrix) is available for those travelling to countries where both Hepatitis A and B are endemic (which includes Mexico, the Caribbean, Africa, many European countries, etc.). The combination is cheaper and requires less injections. Until Twinrix is added to my list, I cannot prescribe this combination medication. Clearly, it is in no one's best interest to limit NPs from prescribing this combination vaccine; certainly, it is not a safety issue!*

[29] NPAO Submission to: Hon. David Caplan – Response to HPRAC Referral "A Report to the Minister of Health and Long-Term Care on the Review of the Scope of Practice of Registered Nurses in the Extended Class (Nurse Practitioners). January 30, 2009 p 11

Combination medications for the treatment of acne have been shown to be more effective than the agents used independently. This may be a prescription medication (i.e., antibiotic) plus an over-the-counter medication (e.g., benzoyl peroxide) or it could be two prescription medications (i.e., an antibiotic and an tretinoin).

NPs play a strong role in chronic disease management and many of our patients are on multiple medications. In fact, a patient being discharged after an acute myocardial infarction, may be on 5 new medications. It is much simpler for the patient to manage, and has been shown to improve compliance and reduce the number of medication errors (which in turn reduces re-hospitalizations), to limit the number of pills a patient must take each day. Many of these medications come in combination formulations. As new combinations come on the market (e.g.. Caduet which is a combination of an antilipemic and a calcium channel blocker, both on our list for renewal), NPs are unable to provide evidence-based care to our patients, without investing extra time in writing medical directives or having to consult with a physician.

Another question relates to those drugs with multiple therapeutic applications. With a drug specific list, this is not an issue. However, with classes of drugs it is unclear how this will be managed. The following examples may provide clarity on this issue.

I have several patients on phenytoin (antiseizure medication). One is a patient who has had a brain tumor removed last summer in Sudbury and needs this medication for prevention of seizures. I have other patients who have been prescribed this medication for control of chronic neurological pain related to post herpetic neuralgia or spinal stenosis.

Sildenafil (Viagra) is commonly prescribed for erectile dysfunction. In critical care and acute care respirology this drug is commonly used in patients with pulmonary hypertension to reduce the hypertension and reduce cardiac/respiratory effects and enable weaning people from mechanical ventilation. In fact, pulmonary hypertension was the original research for the drug, the effect on erectile dysfunction was a serendipitous finding from that research. It is certainly within nurse practitioner scope to prescribe under both therapeutic uses.

Beta-Blockers are used post-MI to reduce risk of CHF and are also used for rhythm control in those with irregular or fast heart rates. Under the classes, beta blockers are listed under Hypotensives. Under HPRAC's proposal, does this mean if a patient does not have high blood pressure, we cannot renew it?

OCP's are listed as contraceptives. Does this mean they cannot be used for menorrhagia or dysmenorrhea (which are heavy period and painful periods). These are well known "off label" uses of oral contraceptives often used in non-sexually active teens, or perimenopausal women who have had tubal ligation (or husband had vasectomy) for the benefits of lighter, less painful menses.

Gabapentin is used as an adjuvant for pain management. Gabapentin is listed in the anticonvulsant drug category, so would seem not to be relevant for orthopaedic practice. In fact, gabapentin is now routinely used by pain management specialists for both chronic and acute pain.

Upon reviewing HPRAC's recommendations, no other profession has nearly the number of classes proposed for regulation within the professional legislation or nearly the same number of proposed agents, within classes, as do nurse practitioners. The exceptions are dentistry and pharmacy. Pharmacy will likely have significantly less classes and agents than nurse practitioners. For dentistry, HPRAC determined there was no benefit to increased public protection in moving to classes of drugs and dentistry should continue to have access to open prescribing. In reviewing the evidence for this decision, many similarities with nurse practitioner practice emerged including:[30]

- Dentistry has an established history of safe and effective prescribing as do nurse practitioners.
- Dentists use of a wide variety of drugs in virtually all classes. The same would apply to nurse practitioners who care for people with a broad range of health conditions.
- Dentists have extensive education programs in pharmacology. Nurse practitioner education provides pharamacology education similar to that of physicians and dentists.
- Dentists participate in continuing education as do nurse practitioners.
- Dentists have access to an on-line adverse drug interaction program through their College. Nurse practitioners have access to similar information through e-health records in primary care settings, on-line formularies in hospitals and utilization of PDAs and access to evidence-based subscriptions such as Pepid and Lexicomp. One of the most popular education sessions at the annual NPAO conference are sessions on getting the most out of hand held technology.

It is unclear as to what criteria HPRAC is using to determine which professions should have access to open prescribing. For nurse practitioners, HPRAC's decision to not authorize open prescribing is even more confounding, given the strong recommendation from the NP Task Team to the Minister to implement open prescribing for nurse practitioners.

NPAO Feedback on HPRAC Response re Process to Review Prescribing Authority
HPRAC is proposing a rigorous, independent, two stage process to review and update drug lists for most regulated health professions. The process requires the establishment of a new agency, the Council on Health Professions Regulatory Excellence (CHPRE) and an advisory committee, the Drug and Therapeutics Formulary Committee (DTFC). In NPAO's assessment of the proposal for a new drug framework to regulate and maintain drug lists for certain regulated professions, several critical questions and concerns were identified.

Although HPRAC repeatedly confirms support for self-regulation, this onerous process appears to undermine this fundamental concept imbedded in the Regulated Health Professions Act (1991). Specifically, the report states, "HPRAC has reservations with the objectivity of the colleges … and that they may not consider the professional scope of practice fully in their deliberations."[31] In the case of the College of Nurses of Ontario, a rigorous review process, incorporating both consultation with external experts as well as members has been implemented to enable balanced assessment of any proposal to change the drug list.

NPAO also has significant concerns regarding the oversight role of the DTFC. First, the advisory nature of the committee is unclear. The proposed functions of the Committee are stated as advisory[32] but CHPRE is mandated to accept the advice of the Committee.[33]

[30] Critical Links: Transforming and Supporting Patient Care, HPRAC, January 2009 pgs 213-218
[31] Critical Links: Transforming and Supporting Patient Care, HPRAC, January 2009 p 69
[32] Ibid p 97
[33] Ibid p 93

As proposed, DTFC is predominately comprised of physicians and pharmacists.[34] NPAO respects and values the expertise of both professions. CNO's current consultation process for updating the drug list relies on their input and expertise. In fact, on several occasions it has been the external experts who have proposed additions to the drug list to enable best practice prescribing for nurse practitioners. Physicians and pharmacists have expert knowledge in pharmacology that is important to the review process. However, they do not fully understand the broad knowledge and expertise of nurse practitioners in all specialties and across a broad range of patient populations and practice settings.

To rely primarily on two professions for this critical task appears to contradict both government's and HPRAC's stated objectives in relation to interprofessional collaboration. HPRAC recognized "…the proficiency of many health professions in numerous aspects of drug therapy is a growing trend and that recently, there has been an increasing recognition that limitations on the authority to use this knowledge can be counter-productive,"[35] but failed to incorporate that knowledge into the drug review process. The proposed model perpetuates the current inability to manage overlapping scopes of practice where historical and hierarchical issues supersedes the real need to move to integrated care enabled by regulatory mechanisms. This is an opportunity to actually integrate an interprofessional approach to regulatory roles.

One of the critical reasons for the Minister's referral on non-physician prescribing was the length of time required to implement changes. Rapid changes in pharmacotherapy combined with lengthy review and approval process limited patient access to care and inefficiencies in delivery of health care to Ontarians. As noted earlier in this submission, HPRAC has not provided any assessment or guarantees that the proposed process to change drug lists will be any faster than the current process. There are no assurances therefore, that any of the many barriers for patients, providers or Ontario's health system will be effectively addressed. After over a decade of advocacy to address these issues, it is very discouraging to not have assurances that nurse practitioners and their patients will have access to the safe, effective drugs they need when they need them.

The following are just a few examples of the current limitations experienced by nurse practitioners from lists that are not updated in a timely way and the restrictions that do not enable full scope of practice.

> *Often in interprofessional practice teams, nurse practitioners are responsible for patient education and counseling, especially smoking cessation. The same week the drug list was updated to include Bupropion, a more effective pharmaceutical agent Varenicline was released. This required the development of another medical directive with my collaborative partners so I could prescribe optimal adjunct pharmaceutical therapy for my patients.*
>
> *I recently saw a patient who required birth control. She had experienced side effects from other prescriptions and there was a new product and based on best evidence would be indicated as appropriate. However, it was not on my "approved list". The patient had to travel 250 kms down a dangerous logging road to the nearest physician for something that was clearly within my scope.*

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[34] Ibid p 96
[35] Ibid p 9

I assess and manage patients with anxiety and depression on an almost daily basis. Cipralex is a new agent and not yet on our list. It is the drug of choice for a subset of patients. My choices are as follows:

- *a medical directive that subsumes my knowledge, skill and judgment.*
- *asking the patient to return when there is a physician available to prescribe. The physician will not have a therapeutic relationship with the patient.*
- *ask the patient to wait while I track down a physician who will to sanction the prescription.*
- *prescribe a potentially less effective drug.*

Last year a new medication for the management of diabetes mellitus II was launched (Januvia; sitagliptan). Many patients in my practice have been started on this medication (often because I have the consulted with my physician partner to initiate it), and it has been shown to be very effective in improving blood sugar control, and very well tolerated by patients. Unfortunately, this medication is not yet on the RN(EC) list, and therefore, every time I need to renew the medication, I must consult (again) with my physician partner, delaying care to the patient, and wasting valuable clinical time for both myself and my collaborating physician.

It is very frustrating to be providing chronic disease management care and not be able to adjust medications. Recently, I had a patient who I had been working with for some time regarding lifestyle changes to improve his health status; he was very motivated to reduce the number of medications he was on. He began exercising and improved his eating habits. As a result, he lost weight and gained muscle mass. His blood pressure improved and so did his lipid profile. I was thrilled for him, and yet I had to delay the "big reward" because I could not independently adjust his medications (in fact, this patient was able to discontinue one of his antihypertensive medications, and significantly reduce his antilipemic!).

A patient presented with abdominal pain and symptoms consistent with an infection from Helicobacter pylori. I ordered the appropriate laboratory test and the infection was confirmed. The gold standard treatment plan for this condition includes a proton pump inhibitor (PPI) medication, and is well within my scope of practice to prescribe. Because he was not on the medication at the time, I did not have the authority to order this combination of drugs. There were two alternatives. The patient could wait for his physician to return from vacation or I could send him to the local emergency department where he would have had to endure additional hours of waiting, only to be reassessed and re-examined unnecessarily by another provider who was not familiar with his case.

NPAO Recommendation to Minister Caplan:
NPAO again reiterates the request for open prescribing for nurse practitioners to enable safe, timely, evidence-based prescribing.

NPAO recommends a comprehensive evaluation and broad public consultation of the recommendations regarding the new enabling framework proposed by HPRAC with consideration to its efficiency and infringement on the self-regulatory process prior to the proposal of legislative and regulatory changes.

However, should the Minister decide to accept HPRAC's recommendation for classes of drugs in regulation for nurse practitioners, NPAO respectfully proposes:

That the Minister adopt a prescribing framework for nurses practitioners that incorporates an inclusive list of classes with limitations, restrictions or conditions as determined rather than individual agents or substances to enable a more flexible, responsive system for prescribing by nurse practitioners.

That the Minister actively review and consider if the proposed interprofessional Nurse Practitioner Standards Committee and similar committees for other professions could provide the balanced and objective review and updating of prescribing lists for professions. Furthermore, the Minister should actively review and consider if an expert panel such as the DTCF, with expanded interprofessional membership, could act as expert advisors to regulatory colleges on prescribing.

8. Ancillary Amendments

HPRAC Recommendation:

If the Minister accepts HPRAC's recommendations and implements the legislative recommendations set out in chapter four of this report, then the Minister will also need to consider making ancillary amendments to several other Ontario statutes and regulations, to ensure a consistent legal framework governs the expansion of prescribing and dispensing authority to non-physician professions.

NPAO Feedback on HPRAC Recommendation:

NPAO agrees that there are multiple Acts and regulations that require amendment. NPAO's submission to Minister Caplan on HPRAC's report on the RN(EC) referral identified multiple Acts for amendment.[36]

There was no comprehensive overview of the implications of the implementation of the nurse practitioner role on other legislation within the Ministry of Health and Long-Term Care or other Ministries when the role was implanted. As a result, NPAO has repeatedly had to advocate for changes to legislation, regulation and policy. Examples of work that has been done over the past ten years include:

- Changes to long term care legislation to enable nurse practitioners to practice in long term care homes;
- Changes to Regulation 965 of the *Public Hospitals Act (1990)* to enable nurse practitioners to practice to full scope in hospital emergency and outpatient departments.
- Changes to Ministry of Transportation policy to authorize nurse practitioners to submit drivers physicals and requests for accessible parking permits.

NPAO Recommendation to Minister Caplan:

NPAO strongly supports a comprehensive review of legislation and regulations within the mandate of the Ministry of Health and Long-Term Care as well as other Ministries, to ensure the necessary ancillary amendments are undertaken. Further, NPAO requests the Minister to immediately review and amend the *Public Hospitals Act (1990)* and related regulations. This legislation is the most significant barrier to integration of nurse practitioners in hospital settings.

[36] NPAO Submission to: Hon. David Caplan – Response to HPRAC Referral "A Report to the Minister of Health and Long-Term Care on the Review of the Scope of Practice of Registered Nurses in the Extended Class (Nurse Practitioners). January 30, 2009 pgs 13-14

9. Liability Coverage

HPRAC Recommendation:

> That section 22.4 of Schedule 2, Health Professions Procedural Code be amended by adding the following subsection:
> Each application for registration must be accompanied by evidence of professional liability insurance, or membership in a specified association that provides protection against professional liability, or an employer's insurance coverage of the applicant. Each registrant shall provide the Registrar with evidence of the maintenance of such coverage following registration and when requested by the Registrar from time to time. Such coverage shall satisfy the requirements specified in the standards of practice developed by the College.

NPAO Feedback on HPRAC Recommendation:

> NPAO supports HPRAC's recommendation to require all regulated health professions to demonstrate evidence of liability coverage. NPAO had previously recommended that coverage provided by an employer, consistent with the legal concept of vicarious liability, should be an option for situations where the professional is an employee.

NPAO Recommendation to Minister Caplan:

> NPAO recommends that section 22.4 of Schedule 2, Health Professions Procedural Code be amended as proposed by HPRAC.

10. Summary of NPAO Recommendations

NP Task Team noted that a change to open prescribing would "require strong government leadership to implement."[37] Challenging old, outdated paradigms of thinking about knowledge and hierarchical ways of practicing will require enabling regulatory processes if we are to make progress at the practice level toward integrated interprofessional models of care in a rapidly changing health care environment. Doing what is right to improve access for Ontarians to high quality care by a variety of health care professionals will take courage to break down the barriers at the regulatory level as a clear demonstration of strong and needed leadership to keep up with progress that is being made in other jurisdictions.

Nurse Practitioner Authority to Dispense, Sell and Compound

NPAO supports HPRAC's recommendation to authorize nurse practitioners to dispense, sell and compound drugs.

> **Recommendation:** NPAO recommends that Minister Caplan implement HPRAC's Recommendations 1 and 2 related to the Profession of Nursing.

Nurse Practitioner Authority to Prescribe Oxygen, Blood and Blood Products

NPAO provided multiple stories of nurse practitioners who require authority to prescribe oxygen, blood and blood products for their patients based on their knowledge, skill and judgement.

> **Recommendation:** NPAO recommends that the Minister immediately consult with the College of Nurses of Ontario on possible strategies to enable nurse practitioners with the authority to provide patients with oxygen, blood and blood products.

Open Prescribing for Nurse Practitioners

NPAO contends that a "one-size fits all approach" for all non-physician prescribers as the appropriate course of action especially for professions who care for diverse patient populations

[37] Report of the NP Integration Task Team to the Minister of Health and Long-Term Care. March 2007 p 2

such as nurse practitioners. The trend in Canadian and other jurisdictions is to move towards open prescribing; Ontario will continue to lag behind other jurisdictions if bold action is not taken by government.

NPAO summarizes the rationale behind the recommendation of the NP Task Team to support open prescribing for nurse practitioners. There is significant support for open prescribing from physicians including the College of Physicians and Surgeons of Ontario and individual physicians who collaborate with nurse practitioners.

NPAO's analysis concludes by commenting on the health system issues that will not be effectively addressed if list-based approaches are maintained.

> **Recommendation:** To maximize the knowledge, skill and judgment of nurse practitioners, to further enable high functioning interprofessional teams to provide quality patient-centred care, to foster self-regulation of nurse practitioner practice and to achieve the government's health system objectives to improve access to care for patients and consistent with the recommendations of the NP Task Team report, NPAO strongly recommends that nurse practitioners be granted open prescribing and that government enact the necessary legislative and regulatory changes without further delay.

Enabling Frameworks
NPAO presents a suggested list of classes expanding on the list proposed by HPRAC. Examples of practice stories are presented to highlight potential issues related to prescribing combination drugs, prescribing drugs with multiple therapeutic uses and prescribing when changes to nurse practitioner drug lists are not updated in a timely fashion.

> **Recommendation:** NPAO again reiterates the request for open prescribing for nurse practitioners to enable safe, timely, evidence-based prescribing.
>
> **Recommendation:** NPAO recommends a comprehensive evaluation and broad public consultation of the recommendations regarding the new enabling framework proposed by HPRAC with consideration to its efficiency and infringement on the self-regulatory process prior to the proposal of legislative and regulatory changes.
>
> **Proviso Recommendation:** However, should the Minister decide to accept HPRAC's recommendation for classes of drugs in regulation for nurse practitioners, NPAO respectfully proposes:
>
> > That the Minister adopt a prescribing framework for nurses practitioners that incorporates an inclusive list of classes with limitations, restrictions or conditions as determined rather than individual agents or substances to enable a more flexible, responsive system for prescribing by nurse practitioners.
> >
> > That the Minister actively review and consider if the proposed interprofessional Nurse Practitioner Standards Committee and similar committees for other professions could provide the balanced and objective review and updating of prescribing lists for professions. Furthermore, the Minister should actively review and consider if an expert panel such as the DTCF, with expanded interprofessional membership, could act as expert advisors to regulatory colleges on prescribing.

Ancillary Amendments

NPAO agrees that there are multiple Acts and regulations that require amendment.

> **Recommendation:** NPAO strongly supports a comprehensive review of legislation and regulations within the mandate of the Ministry of Health and Long-Term Care as well as other Ministries, to ensure the necessary ancillary amendments are undertaken. Further, NPAO requests the Minister to immediately review and amend the *Public Hospitals Act (1990)* and related regulations. This legislation is the most significant barrier to integration of nurse practitioners in hospital settings.

Liability Coverage

NPAO supports HPRAC's recommendation to require all regulated health professions to demonstrate evidence of liability coverage.

> **Recommendation:** NPAO recommends that section 22.4 of Schedule 2, Health Professions Procedural Code be amended as proposed by HPRAC.

Appendix 1
Provincial and Federal Reports re: Nurse Practitioners

Since 2000, the Provincial Ministry of Health and Long-Term Care has directly commissioned or indirectly supported through funding, many projects and reports that have analyzed and/or commented on both the contributions that nurse practitioners make to achieving provincial objectives such as improving access to care for Ontarians and supporting the development of interprofessional teams. These reports also identify the many barriers that limit the system from benefiting from the full potential of the role.

In particular, the Ministry of Health and Long-Term Care has commission two in-depth reports to review barriers to nurse practitioner practice and recommend strategies to address these issues. These include:

- Report of the PHCNP Integration Task Team (March 2007);
- IBM McMaster University Report on the Integration of Primary Health Care Nurse Practitioners in Ontario (2005);

Other reports that have identified the need for or demonstrated the impact and value added of nurse practitioners include:

- The Integration of Acute Care Nurse Specialists, Primary Care Nurse Practitioners and Physician Assistants in Ontario Emergency Department Teams - Final Report (2008)
- Living in our Vision World: A Roadmap for the Future Role of NPs in Ontario (2006) from the Accord Project, Primary Health Care Transition Fund Project;
- Supporting Interdisciplinary Practice: The Family Physician/Nurse Practitioner Educational and Mentoring Program. The Final Report from RNAO, OCFP, OMA, Jones Way and Associates and the University of Ottawa, Primary Health Care Transition Fund Project. (2006);
- An Overview of Nurse Practitioners in Public Health Units Across Ontario, Middlesex Public Health Unit (2006)
- Nurse Practitioner Workforce Survey and NPAO Electronic Registry Project Report (2006)
- The Ontario Nurse Practitioner in Long-Term Care Facilities Pilot Project in Ontario. Interim Evaluation, Final Report, aestima research (2005);
- The RN(EC)-GP Relationship: A Good Beginning, Ontario Medical Association and the Registered Nurses' Association of Ontario (2003);
- PriceWaterhouseCoopers reports on Evaluation of Primary Care Reform Pilots in Ontario Phase 1 – Final Report and Phase 2 – Interim Report (2001).

There have also been numerous health human resources and health system reports, both federal and provincial, that called for the expansion of the role, including:

- Report of the Special Advisor "Integrated Service Plan for Northwestern Ontario. Vision for the Restructuring of Health Services in Northwestern Ontario" (2005);
- Report from Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care "Commitment to Care: A Plan for Long-Term Care in Ontario" (2004);
- The Health of Canadians – The Federal Role (Final Report) (2002)
- Commission on the Future of Health Care in Canada, Hon. Roy Romanow Commissioner. "Building on Values: The Future of Health Care in Canada – Final Report" (2002);
- Expert Panel on Health Professional Human Resources "Shaping Ontario's Physician Workforce: Building Ontario's Capacity to Plan, Education, Recruit and Retain Physicians to Meet Health Needs" (The George Report) (2001);
- Health Services Restructuring Commission "Primary Health Care Strategy: Advice and Recommendations to the Hon. Elizabeth Witmer, Minister of Health" (1999);
- A report from Dr. Robert McKendry, "Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond" (1999);
- The Report of the Nursing Task Force "Good Nursing, Good Health: An Investment for the 21st Century" (1999).

Appendix 2
Suggested Therapeutic Classes of Drugs For Nurse Practitioner Prescribing

4.00 Antihistamine Drugs
- 4:04 First Generation Antihistamines
- 4:08 Second Generation Antihistamines
- 4:92 Other Antihistamines

8.00 Anti-infective Agents
- 8:08 Anthelmintics
- 8:12 Antibacterials
- 8:14 Antifungals
- 8:16 Antimycobacterials
- 8:18 Antivirals
- 8:22 Quinolones
- 8:24 Sulfonamines
- 8:30 Antiprotozoals
- 8:36 Urinary Anti-infectives
- 8:40 Anti-infectives, Miscellaneous (also known as 8:92)

10:00 Antineoplastic Agents

12:00 Autonomic Drugs
- 12:04 Parasympathomimetic (Cholinergic Agents)
- 12:08 Anticholinergic Agents
- 12:12 Sympathomimetic (Adrenergic) Agents
- 12:16 Sympatholytic (Adrenergic Blocking)
- 12:20 Skeletal Muscle Relaxants
- 12:92 Autonomic Drugs, Miscellaneous

20:00 Blood Formation, Coagulation, and Thrombosis
- 20:04 Antianemia Drugs
- 20:12 Antithrombotic Agents
- 20:16 Hematopoietic Agents

24:00 Cardiovascular Drugs
- 24:04 Cardiac Drugs
- 24:06 Antilipemic Agents
- 24:08 Hypotensive Agents
- 24:12 Vasodilating Agents
- 24:20 Alpha-Adrenergic Blocking Agents
- 24:24 Betal-Adrenergic Blocking Agents
- 24:28 Calcium Channel Blocking Agents
- 24:32 Renin-Angiotensin-Aldosterone System Inhibitors

28:00 Central Nervous System Agents
- 28:04 General Anesthetics
- 28:08 Analgesics and Antipyretics
- 28:10 Opiate Antagonists
- 28:12 Anticonvulsants
- 28:16 Psychotherapeutic Agens
- 28:20 Anorexigenic Agens and Respiratory and Cerebral Stimulants
- 28:24 Anxiolytics, Sedatives, and Hypnotics
- 28:32 Antimigraine Agents
- 28:36 Antiparkinsonian Agents

32:00 Contraceptives (foams, devices)

36:00 Diagnostic Agents
- 36.68 Roentgenography
- 36.84 Tuberculosis (PPD-B Mantoux)

40:00 Electrolytic, Caloric and Water Balance
- 40:08 Alkalinizing Agents
- 40:10 Ammonia Detoxicants

- 40:12 Replacement Preparations
- 40:18 Ion-removing Agents
- 40:20 Caloric Agents
- 40:28 Diuretics
- 40:40 Uricosic Agents

44:00 Enzymes

48:00 Respiratory Tract Agents
- 48:04 Antihistamines
- 48:08 Antitussives
- 48:10 Anti-inflammatory Agents
- 48:12 Bronchodilators
- 48:16 Expectorants
- 48:24 Mucolytic Agents

52:00 Ear, Eye, Nose, and Throat (EENT) Preparations
- 52:04 Anti-infectives
- 52:08 Anti-inflammatory Agents
- 52:24 Mydriatics
- 52:32 Vasocontrictors
- 52:40 Antiglaucoma Agents
- 52:16 Local Anesthetics

56:00 Gastrointestinal Drugs
- 56:04 Antacids and Adsorbents
- 56:08 Antidiarrhea Agents
- 56:10 Antiflatulents
- 56:12 Cathartics and Laxatives
- 56:22 Antiemetics
- 56:28 Antiulcer Agents and Acid Suppressants
- 56:32 Prokinetic Agents
- 56:36 Anti-inflammatory Agents
- 56:40 GI Drugs, Miscellaneous (also known as 54:92)

68:00 Hormones and Synthetic Substitutes
- 68:04 Adrenals
- 68:08 Androgens
- 68:12 Contraceptives
- 68:16 Estrogens and Antiestrogens
- 68:20 Antidiabetic Agents
- 68:22 Antihypoglycemic Agents
- 68:24 Parathyroid
- 68:28 Pituitary
- 68:30 Somatotropin Agonists and Antagonists
- 68:32 Progestins
- 68:36 Thyroid and Antithyroid Agents

72:00 Local Anesthetics

80:00 Serums, Toxoids and Vaccines
- 80:04 Serums
- 80:08 Toxoids
- 80:12 Vaccines

84:00 Skin and Mucous Membrane Agents
- 84:04 Anti-infectives
- 84:06 Anti-inflammatory Agents
- 84:08 Antipruritics and Local Anesthetics
- 84:16 Cell Stimulants and Proliferants
- 84:24 Emollients, Demulcents and Proctants
- 84:28 Keratolytic Agents

86:00 Smooth Muscle Relaxants
- 86:08 Gastrointestinal Smooth Muscle Relaxants
- 86:12 Genitourinary Smooth Muscle Relaxants
- 86:16 Respiratory Smooth Muscle Relaxants

88:00 Vitamins
- 88:04 Vitamin A
- 88:08 Vitamin B Complex
- 88:12 Vitamin C

88:16 Vitamin D
88:20 Vitamin E
88:24 Vitamin K Activity
88:28 Multivitamin Preparations

92:00 Miscellaneous Therapeutic Agents
5-alpha-Reductase Inhibitors
Antigout Agents
Bone Resorption Inhibitors
Immunosuppressive Agents
Other Miscellaneous Therapeutic Agents

Proposed new categories:
Therapeutic Gases: Oxygen

Blood & Blood Products:
Albumin
Packed Red Blood Cells
Fresh Frozen Plasma
Cryoprecipitate
Platelets
Whole Blood