



Position Statement ***Team-related bonuses is the correct way to go¹***

The Nurse Practitioners' Association of Ontario supports the government of Ontario's commitment to improving access to primary health care and enhancing preventive and comprehensive care for the people of Ontario. These initiatives are critical to helping Ontarians become healthier and stay healthy.

One of the key strategies to improving access to care is the development of interprofessional teams. Within primary health care, the focus over the past three years has been to establish 150 Family Health Teams (FHTs) and expand the number of Community Health Centres (CHCs) across Ontario. Primary Health Care Nurse Practitioners (PHCNPs) are recognized as valued members of these interprofessional teams. As well, one component of the financial framework for these initiatives was the implementation of financial incentives² for physicians to direct preventive care and screening practices in primary health care.

While there are potential benefits to the utilization of incentives as a policy to influence practice, this approach is in conflict with the policy that underlies primary care reform, specifically the development of effective patient-centered interprofessional teams. Negotiated as part of Ontario Medical Association (OMA) – Ministry of Health and Long Term Care (MOHLTC) bilateral agreements, these physician compensation models present significant negative implications for the successful long-term implementation of interprofessional models of health care delivery and threaten the integration of nurse practitioners as part of these new and emerging teams. As currently structured, this model is inequitable and inconsistent with the government's commitment to interprofessional teams.

The purpose of this paper is to provide additional background information related to the implementation of the incentive payment policies and to describe the experiences of nurse practitioners working in these practice environments. It also includes recommendations that the Nurse Practitioners' Association of Ontario believes, if implemented, would enable high functioning effective interprofessional teams.

Ontario's Experience with Financial Incentives in Primary Health Care

In the late 1990's and the early 2000's, as new models of primary care were implemented in Ontario (e.g., Primary Care Networks, Family Health Networks), the MOHLTC began to introduce incentive payments to reward and/or change physician practice patterns. In these early years, payments to physicians were achieved based only on physician activity. There was no capacity to include activity from other members of the team. The result was that work that could have been done by the NP was done by the family physician in order to obtain additional compensation. This did little to enhance collaborative practice from the NP perspective.

Under the current OMA-MOHLTC agreement, physicians negotiated the ability to include the work of nurse practitioners towards achieving targets for the incentive based activities. Within this agreement, the incentive compensation model was expanded to include a wider variety of physician compensation models (e.g., FHTs and similar group practices such as Family Health Networks, Family Health Groups, Family Care Organizations). More recently, policy decisions were made that the incentives would also apply to CHCs, despite overwhelming opposition from Community Health Centre physicians. Incentive payments cover a wide range of activities ranging from smoking cessation counseling, influenza vaccines and immunizations to office procedures, PAP smears, mammograms and colorectal screening. They are also provided to support change in access to care by encouraging home visits, seniors care, and emergency department coverage. Therefore,

¹ This title has been used with permission from the Toronto Star from the headline of a column by Dave Feschuk, Monday October 29, 2007. The column was about the implementation of team based bonuses in pro sports and specifically in basketball.

² A variety of different terms are used to describe incentive payments both in the memorandum of agreement negotiated between the OMA and MOHLTC and in the common vernacular. These include, but are not limited to, premiums, special payments, fees, incentives, performance payments, and bonuses. For the purposes of this document, all of these payments will be referred to as "incentive payments".

under this compensation model, the work of nurse practitioners is tracked and submitted as part of a financial incentive claim by a physician or group of physicians working within an interprofessional team model. Given the extent of overlap in scope between physicians and nurse practitioners related to these activities, the work of the nurse practitioner becomes invisible.

Policy Perspective on the Implementation of Incentives

In developing its transformation agenda for the primary health care system, Ontario has followed the American trend with monetary incentives for primary health care physicians. It is thought that incentives result in physicians developing greater adherence to evidence-based practice, improve quality reporting and increase focus on high risk groups or conditions. Yet, there is conflicting evidence as to the real value of incentives and questions arise whether the benefits are a cost effective use of health care dollars (Bell & Levinson, 2007). In all instances where incentives are newly introduced, there is little data to support positive outcomes or whether models of reimbursement actually benefit patients, improve quality of care, access to care or develop sustainable overall systems changes (Bufalino et al, 2007; Bell & Levinson, 2007). Changing physician practice towards seeing greater volumes of specific patient conditions or performing certain procedures does not denote quality health care in itself.

The current incentive model interferes with team development, yet it is perceived that "Teamwork is no longer elective in primary care..." (Dodoo, Roland & Green, 2005). While there is no literature suggesting incentives for the entire team produce better outcomes than incentives for physicians, examples in Australia and the U.K indicate new reimbursement models are being developed to reward interprofessional teams not individuals (Oandasan et al, 2006). Challenging prevailing systems and norms that act as barriers to interprofessional team practices is considered necessary for real health care change (Ginsburg & Tregunno, 2005). The current mixed message of policies directed to support implementation of primary health care teams in Ontario does not challenge or transform an old and ineffective system.

Conditions Necessary to Support Successful Interprofessional Teams

As Ontario moves to the second stage of Medicare, with models of care focusing on patient needs and interprofessional teams, successful team practices require trust, respect and recognition of the skills and contributions of all professionals within the team. Evidence of the Ontario government's commitment to an interprofessional approach to health care has been demonstrated in the recent referral by the Minister of Health and Long Term Care to the Health Professions Regulatory Advisory Council to review mechanisms to facilitate and support interprofessional collaboration among regulated health Colleges, the release of the HealthForceOntario Interprofessional Care project report "Blueprint for Action", the Liberal Party election commitment to add another fifty Family Health Teams and twenty-five nurse practitioner led clinics, the implementation of new health care provider roles to expand existing teams (e.g., anaesthesia teams) and the recent request for proposals for the Interprofessional Care/Education Fund.

Yet the conflict arising from inequitable funding arrangements for physicians as members of a team is interfering with developing team practices. In the spirit of team development, the notion that one provider is being paid an incentive for the work of others is incompatible and inconsistent with the interprofessional approach to care. In the 2006 Canadian Health Services Research Foundation report "*Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada*" one of the main messages included "The larger policy context can promote teamwork by providing consistent government policies and approaches: health human resource planning; legislative frameworks to break down silos; and models of funding/remuneration that encouraged collaboration" (p i). The current Ontario model of financial incentives for physicians versus team incentives does not support this principle.

Impact on Nurse Practitioner Practice

NPAO takes the position that the incentive payments, as currently structured, contradict rather than support an interprofessional team approach to care. Legally, this payment model can be seen as a form of unjust enrichment wherein one person is unjustly enriched at the expense of another without any legal reason for the enrichment. Some may argue that physicians are entitled to these payments based on the requirement within nurse practitioner practice for a collaborative relationship with a physician. However, the work that is included in these payments can be completed by the nurse practitioner within his/her scope of practice. Further, there

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are specific payments within the OMA-MOHLTC agreement designed to support interprofessional relationships (i.e., Nurse Practitioner Consultation Pilot Project, Practice Nurse Compensation Pilot). Finally, the perception may exist that, given that the salary for the nurse practitioner to provide patient care is funded through the public health care system, that compensating physicians for the work done exclusively by the nurse practitioner is a form of double dipping.

From a health care perspective, this inequitable distribution of compensation has multiple negative effects including:

- Undermining the trust and respect that should be at the core of the collaborative relationship and that is essential to interprofessional team development.
- Devaluing the work of nurse practitioners as part of primary health care teams as their work is attributed to the physician members of their teams through shadow billing³.
- Impeding the ability of nurse practitioners to utilize their full scope of practice. Some nurse practitioners have reported that their caseload is focused on preventive care for which incentive payments can be achieved. Others have reported that they do little preventive care that is within their scope of practice as the incentive payment agreement is not well understood.
- Interfering with the collection of reliable data on the important contributions of nurse practitioners to Ontario's health care system.

Anecdotal comments reflect the personal and moral discomfort, distress and unease nurse practitioners are feeling as a result of this policy. From a health human resource perspective, this does not bode well for recruitment to the profession or retention of those already practicing.

- *Doing well women care is fully within my scope and I love this part of my practice. Knowing that the physicians are paid for NP activity just doesn't seem right to me because there is no consultation and no need for collaboration.*
- *This feels like the dark ages; the care that NPs deliver is hidden from any public accountability.*
- *I explained it this way to my Maple Leaf crazy family – it is like the Leafs giving Mats Sundin a bonus whenever Darcy Tucker scores a goal, regardless of whether Sundin is on the ice or not.*
- *OHIP bulletin 10003 specifically states that professional services must be personally performed by the physician who claims for the service and these cannot be claimed if delegated or performed by an RN(EC). When I started practice ten years ago, this meant that a local physician in my home community couldn't employ me, so I moved away to take a funded NP job. How is shadow billing to collect an incentive payment any different from fee for service?*
- *The time I have to spend inputting data takes away valuable patient time as there are no clerical resources available to support my practice.*

Conclusions and Proposed Next Steps

The Nurse Practitioners' Association of Ontario strongly supports an interprofessional approach to patient care. Further, NPAO believes that, in order to fully realize the objectives of interprofessional care, funding for teams and compensation for all providers must recognize the unique contributions of each profession consistent with this team based approach to care.

NPAO believes that continued utilization of incentive payments directed to only one member of the team undermines interprofessional care. The result of this unjust enrichment is to make the work of nurse practitioners invisible and has the potential to limit NP scope of practice. This model of compensation reflects an outdated and hierarchical model of care that is not sustainable within a transformed patient focused health care system.

The NP Integration Task Team concurs: "... some of the funding policies undermine progress in achieving NP integration and are inconsistent with Ministry objectives regarding appropriate HHR utilization. They also are inconsistent with the spirit of interprofessional collaboration." (Task Team, 2007)

³ Shadow billing refers to the process of recording service information to OHIP for non fee-for-service funding arrangements. The OHIP system records the activity without triggering fee-for-service payment.

NPAO also believes that all team members deserve fair compensation for the skills, knowledge and judgment that they bring to patient care. A financial model that uses incentives needs to be tied to improved patient care outcomes not merely volume driven activity.

In Ontario, rather than introduce incentives that divide teams and prevent collaboration we should heed the guidelines around incentives put forth by the Institute of Medicine Quality Chasm Report (IOM, 2001):

- Provide fair payment for good clinical management of the types of patients seen.
- Provide an opportunity for providers to share in the benefits of quality improvement.
- Provide the opportunity for consumers to recognize quality differences in health care and direct their decisions accordingly.
- Align financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes.
- Reduce fragmentation of care.

NPAO recognizes that there are better models to compensate health providers. However, the standing of the OMA-MOHLTC Memorandum of Agreement regrettably requires nurse practitioners and the taxpayers of Ontario to accept participation in this process by virtue of existing employment relationships. To that end, NPAO recommends the following:

- That data collected in order to achieve performance targets and indicators under the current -MOHTLC Memorandum of Agreement be extracted and compiled in such a manner so as to clearly demonstrate the role and contribution of nurse practitioners to primary health care goals. Further, this data must be made available to the nursing community for purposes of accountability and transparency.
- That the Ministry of Health and Long Term Care give serious consideration to alternatives to all incentive payments directed solely to individual physicians in view of the government's commitment to interprofessional care. This is consistent with implementation strategy 21 of the Task Team Report.
- That nurse practitioners and other health care professionals involved in interprofessional teams have input into any further development of any incentive payment models based on team performance. This is consistent with implementation strategy 23 of the Task Team Report.

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