

Nurse-practitioner-led models and their influence on primary care provision for Canada

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With increasing numbers of Canadians requiring diverse health care services for their varying needs,^{1,2} it is vital that differing models of primary care delivery are explored. The nurse practitioner-led clinic (NPLC) model, currently funded by the Ontario Ministry of Health and Long-Term Care, is one delivery strategy Ontario is evaluating to reduce health disparities for residents by improving access to primary health care.^{3,4} The NPLC model tends to be located in rural/remote and inner-city communities due to difficulties recruiting physicians to these areas of the province.⁵ Its use has improved patient outcomes and enhanced the overall health status and well-being of clients utilizing its services.^{6,7}

The NPLC model adopts a patient-centered approach to care based on the nursing paradigm and with an emphasis on health information technology,⁸ health promotion, disease prevention and chronic illness management.^{3,9} For instance, a nurse-led healthy heart initiative based out of McGill University Health Centre has led to improvements in identifying women at risk of heart disease by focusing on lifestyle education and chronic disease management.¹⁰ Early detection through preventative healthy heart information, extended education and consultations has helped the region to identify women with previously undiagnosed or inadequate treatment of cardiovascular disease.

The purpose of this commentary is to describe data collected for a graduate course practicum that looked at the NPLC model and its impact on access to primary care within the province of Ontario. Inquiry was guided by the question: "How is access to primary care impacted by nurse practitioners (NPs) through the NPLC model?" Findings were collected from qualitative interviews with four NPs who worked in the NPLC model in several rural communities in Ontario.

Findings of the NPLC Model

Data was collected through semi-structured telephone interviews with four (4) NPs who worked within the NPLC serving areas of Waterloo, Sudbury, Colchester, Essex and other areas of Northern Toronto. Due to the lack of primary care providers in some remote and rural areas of Canada, in part due to a lack of or closing down of physician practices,⁵ residents of these communities may have gone for long periods of time without consulting a primary care provider. As a result, they were more likely to have been without follow-up treatment services, screening for various illnesses such as colorectal or breast cancer, and management and support of chronic conditions such as diabetes, hypertension, and heart failure. Unique to one NPLC model was a primary care outreach service to patients in palliative conditions and those requiring mental health management, due to their inability to access the NPLC centers where they were registered. Two main findings emerged from these interviews: 1) the lack of a primary care provider and 2) the scope of practice restrictions/service provision.

Lack of primary care providers

Interviews with one NP indicated that patients experienced a higher incidence of chronic conditions, directly related to the lack of routine monitoring and treatment by a primary care physician. She stated that "there are escalating chronic illness conditions as a result of patients being unattached to a primary care provider." A second NP described a lack of support for chronic illness management, reporting "a lack of mental health support, leadership and chronic illness management for patients particularly within rural and remote communities". ▶

Scope of practice restrictions/service provision

All NPs reported working within their full scope of practice including chronic illness management and supportive services. For example, when describing the challenges with chronic illness management, one NP noted that “some patients can’t stay in their homes related to chronic illness care; others need support managing comorbid chronic conditions.” A description of daily practices ranged from tasks such as assessing patients to performing follow-ups, setting up and facilitating various health workshops, screening, as well as performing clinical duties, teaching, and counselling. Some of the NPs reported clerical duties due to a lack of appropriate administrative staff, or an inability to replace other specialized staff members (e.g. a dietician on sick leave) as well as the lack of educational support. NPs within the NPLC model encountered challenges with ordering specialized tests and procedures. For example, one NP stated that “diagnostic tests have to be put under a physician’s name, the results go to other areas, and we have to call hospitals for these results.” This restriction impedes the NPs’ ability to provide primary care in an organized, timely manner. Further, they disrupt communication and professional trust between NPs and their patients.

Conclusion

The NPLC model is likely to improve access to primary care services for all communities, but its impact is yet to be evaluated in relation to its financial impact upon the health care system. Findings suggest the NPLC model has improved access to primary care services in categories such as clinical, follow-up, counselling, disease management and supportive services, which can contribute to patients and families living healthier lives and making better health-facilitative decisions. Thus, it appears that the negative health and financial effects on individuals who do not have an attached primary care provider can be diminished within remote, rural and inner city communities. More case studies in conjunction with qualitative studies evaluating the effectiveness of the NPLC model on improving primary care access and patient outcomes are required. ■

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