The Peterborough 360 Degree NPLC

Alternative Model of Primary Health Care

Commitment to Health Equity and the Social Determinants of Health

The Peterborough 360 Degree Nurse Practitioner-Led Clinic (NPLC) team operates from a commitment to improving health equity and access to the social determinants of health. All staff develop the skills necessary to provide welcoming, nonjudgmental front-line interaction with all people including those with eccentric behaviours and substance use issues. We have started asking all clients to provide demographic data pertaining to the eight key indicators associated with lack of health equity including income, disability status, and food security.

Because over 70% of our patients have incomes below Statistics Canada's "Low Income Cut Off," and because we understand the direct epidemiologic (disease-causing) relationship between income and morbidity/mortality (illness and premature death), we are committed as primary care providers to creating high impact health interventions that increase people's incomes. The NPs spend large amounts of time completing forms to assist our patients to be eligible for financial supports. Our Social Workers have developed expertise in assessment of a client's financial situation to ensure they are receiving all the supports to which they are entitled.

Low Threshold Accessibility

The 360 NPLC Nurse Practitioners (NPs) use flexible scheduling options for our clients, including same day, next day, walk in and pre-booked appointments. This system allows our patients to call or come in on the day they wish to be seen and get an appointment for that day or the next day. Because we understand that some of our patients' lives are characterized by instability, we do not discharge people from our practice for missing appointments. Importantly, our salaried funding model supports this alternative model of care approach.

Homeless individuals without a primary care provider are usually seen within 1 or 2 business days for an initial appointment because we know that the instability of homelessness makes it difficult for people to be contacted for future appointments. Our no-cost laundry and shower services assist with meeting the practical needs of low income and homeless individuals and also provide a low-threshold way for service avoidant people to come to the clinic. When they are treated with respect and dignity, it often opens the door for a wary or guarded person who may have had negative experiences in the health care system to become connected to one of our NPs.

Interdisciplinary Team Approach

Each NP is responsible for their registered patients. Most of our patients also see one or more members of our team of interdisciplinary providers for specialized services and collaborative

care. Our Registered Nurses (RNs) provide expert chronic disease management education, monitoring, and support to assist patients to increase self efficacy in management of their chronic conditions. They spend much time on client advocacy and system navigation on behalf of clients who have significant challenges doing so on their own, perhaps due to not having telephones, or perhaps due to intellectual disabilities.

Our RNs support our patients in smoking cessation and medication management. Our Social Workers provide single session and short term counseling, case management, and system navigation and advocacy for our clients who are at constant risk of falling through the cracks in the social safety net. Our Registered Dietitian supports clients around food insecurity issues. Our interdisciplinary team offers group programing around issues such as healthy eating and chronic pain self management.

We have created infrastructure which supports interdisciplinary care including interdisciplinary rounds monthly with all clinicians. As well, each Social Worker reviews shared patients with the Most Responsible NP every 6-8 weeks.

Harm Reduction Approach

We operate from a harm reduction approach to substance use. We provide our clients who use substances with harm reduction supplies including safer injection kits and safer inhalation (smoking) kits; and with information, education and interventions along a spectrum from teaching someone how to reduce substance-related harm to supporting abstinence as the client wishes. We provide training and distribution of naloxone, which is an opioid reversal agent. We recognize that substance use is a symptom of underlying grief, trauma and other mental health issues which have often been undiagnosed and untreated, sometimes for decades. We participate in the coalitions and community partnerships which address systemic issues around substance use and harm reduction in our local region.

Collaboration with Community Partners

360 NPLC staff are linked with numerous community partners and community initiatives in order to advocate for the needs of our patient populations. We provide street and community outreach in order to connect with service-avoidant individuals. We are linked with all of Peterborough's shelters and homeless-serving agencies. We connect with individuals in the community at the request of our community partners, including urgent outreach contacts to people with serious health crises as appropriate. We connect with people who are profoundly functionally disabled in order to assist them to complete provincial disability benefits forms, the receipt of which can make the difference in income between homelessness and being able to find a place to live.

360 NPLC team members work "upstream" to ensure the health needs of vulnerable populations in our communities are met. Examples include participation in our local High Risk Perinatal Network; in the Shelters and Health network; in the High Risk Situation Table; in the Peterborough Coordinated Care Planning Working Group and at the Central East LHIN Peterborough Sub-region Planning Table.