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# Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario

## Executive Summary

Revised January, 2005



January, 2005

We are pleased to provide you with this final copy of the *Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario*. This report contains final revisions to the version released by the Minister of Health and Long-Term Care on January 30, 2004. The revisions are limited to minor corrections and do not alter the substance of the report.

This study was initiated in June 2002 and was overseen by a steering committee, which included representation from key nursing and medical associations as well as ministry program areas. IBM Business Consulting Services was contracted to conduct the study.

The report puts forth 29 evidence-based recommendations that the steering committee believes are vital to the full integration of nurse practitioners (NPs) into our health care system and that will support the government's commitment to fund more NPs. The Minister has announced the formation of a task team that will develop the strategies required to implement the recommendations.



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# Executive Summary

## Introduction

This executive summary describes:

- Background to the introduction of primary health care Nurse Practitioners (NPs) in the province of Ontario;
- Objectives of the Primary Health Care NP Integration Study;
- Data collection methods and analytic framework;
- Synthesis of key findings; and
- Recommendations based on the findings.

## Background

In Ontario, the term NP is used interchangeably to describe a number of advanced practice nursing roles, such as primary health care NPs and acute care NPs. In this report, the term NP refers specifically to primary health care NPs who are registered in the extended class (RN[EC]) with the College of Nurses of Ontario.

In 1998, the *Expanded Nursing Services for Patients Act* amended the Regulated Health Professions Act and Nursing Act (as well as other legislation) to provide NPs in the province of Ontario with an expanded scope of practice. With these amendments, NPs registered in the College of Nurses' "extended class" have the authority to communicate a diagnosis, order specified tests such as diagnostic ultrasound or x-rays, order electrocardiograms in non-acute circumstances, prescribe and administer specified drugs and order specified laboratory tests. Pursuant to the *Expanded Nursing Services for Patients Act*, the College of Nurses of Ontario regulates the NP scope of practice.

Since 1998, 402 NP positions have been funded by the Ontario Ministry of Health and Long-Term Care (MoHLTC) in Community Health Centres, the Underserved Area Program, long-term care facilities, Aboriginal Health Access Centres, Primary Care Networks and Public Health Units. The following are the major funding initiatives related to these positions:

- 1998 - 22.5 new positions were created in Community Health Centres and 90.5 nursing positions in Community Health Centres and Aboriginal Health Access Centres were upgraded to NP positions;
- 1999 - 107 positions were created in the Underserved Area Program, Aboriginal Health Access Centres, long-term care facilities and Primary Care Networks;
- 2000 - 5 positions were created in Public Health Units in the Cervical Cancer Screening Program;
- 2001 - 10 positions were created in Public Health Units in the Early Childhood Development Pre and Post Natal Program;
- 2002 - 20 positions were created for demonstration projects in communities that have limited access to family physicians; and
- 2002 - funding for 117 positions in underserved communities was announced.

In addition to these major funding initiatives, 30 NP positions have been funded since 1998 in Community Health Centres and Health Service Organizations.

The MoHLTC is committed to creating an additional 348 NP positions over the next three years. In addition, the government invests \$1.7 million annually for the NP education program.

# Objectives of the Study

The primary focus of the Primary Health Care NP Integration Study was to determine how best to integrate primary health care NPs into Ontario's health care system and specifically into various practice settings. The key questions to be answered by the study were:

1. What barriers must be overcome and what facilitators must be encouraged to further integrate NPs into specific practice settings?
2. What can be learned about the practice models in which NPs function; specifically, which models do not work well and why and which models work best to support integration of NPs?

# Data Collection Methods and Analytic Framework

## Data Collection Methods

We utilized the following data collection methods:

### Literature Review

A literature review focused on the NP role, practice models and settings, as well as barriers and facilitators for integration of NPs into the primary health care setting. Our focus was on the experience with NPs in Ontario. We also looked at a small number of articles from other provinces across Canada, as well as the United States and United Kingdom.

### NP Survey

A comprehensive mail-in survey was developed that asked questions related to NP demographics, workplace activities and satisfaction. The survey included two scales widely used in studies of NPs: the Misener NP Job Satisfaction scale<sup>1</sup> and the Jones and Way Scale for Collaboration.<sup>2</sup> The survey was pretested prior to its administration. The sample was drawn from a list obtained from the Ontario College of Nurses of all nurses with the designation RN(EC) (N=476) in 2002.

The response rate for the NP survey was 77%, representing 365 completed surveys. Given the research focus on practicing primary health care NPs in Ontario, a detailed analysis was conducted on the 253 NPs who met the study requirements while descriptors were provided on 54 non-practicing NPs. The remaining NP surveys were not included in the analysis as they were comprised of NPs working outside of Ontario and those identified as NP educators.

### Physician Survey A (physicians working with an NP)

A mail-in survey for physicians who worked with NPs was developed. These physicians were identified through a combination of methods including telephone calls to sites with funded NP positions to obtain names of MDs who worked with NPs. We asked physicians questions related to demographics and practice activities. In addition, we asked physicians similar questions to the NP survey related to satisfaction, as well as facilitators and barriers to integration of NPs. The survey was pre-tested prior to its administration. Just over 500 surveys were distributed to physicians.

As the total population of physicians who work with NPs could not be identified, we could not calculate a response rate. Based on the Janus 2001 National Family Physicians Workforce Survey,<sup>3</sup> approximately seven percent or 524 family physicians are estimated to work with NPs in Ontario. We received 225 completed physician surveys indicating that the results represent approximately 43% of the total population of MDs working with NPs.

<sup>1</sup> T.R. Misener and D.L. Cox, "Development of the Misener Nurse Practitioner Job Satisfaction Scale" (2001) *Journal of Nursing Management* 9 (1): 91-108.

<sup>2</sup> D. Way, L. Jones and N. Baskerville, "Improving the effectiveness of primary health care through NP/family physician structured collaborative practice", Final Report, University of Ottawa, March 31, 2001 (unpublished).

<sup>3</sup> 2001 National Family Physician Workforce Survey, Janus Project, Nurse Practitioners and Ontario Family Physicians, March 31, 2003.

### **Physician Survey B (physicians not working with an NP)**

A mail-in survey for physicians who were not currently working with NPs was developed. A mailing list of all family physicians in Ontario was obtained from the Ontario College of Family Physicians. A stratified (by region) random sample of 1600 physicians was drawn from this mailing list in an attempt to achieve regional representation. We asked these physicians questions related to demographics and practice activities. In addition, we asked physicians if they had worked with an NP in the past and if they would work with an NP in the future. The survey was pre-tested prior to its administration.

We received 492 completed physician surveys indicating that the results represent approximately 31% of the study sample.

### **Site Visits**

We visited 27 sites with funded NP positions in Ontario representing the following practice settings:

- Community Health Centres (CHCs);
- Long-term care facilities;
- Aboriginal Health Access Centres and Health Centres (AHAC);
- Primary Care Networks (PCNs);
- Health Service Organizations (HSOs);
- Emergency department, hospital outpatient and other clinics;
- Fee-for-service (FFS) physician practices;
- Public health units;
- Victorian Order of Nurses (VON);
- Community Care Access Centres (CCACs); and
- Other community agencies.

The purpose of the site visits was to gain a better understanding of the practice models employed in the various settings and the factors that contributed to making these models work effectively. Interview guides were developed to assist with qualitative data collection at each site.

All site visits included interviews with the NPs, physician and other members of the health team, where available, such as managers, registered nurses (RNs), social workers and health educators.

### **Patient Survey**

A survey for patients related to their experience with NPs and satisfaction with NP services was developed. Patient surveys were distributed to a sample of patients who saw NPs over a two week period at the sites we visited.

The patient survey was pre-tested with five patients who had seen an NP. We received 260 completed surveys from patients.

### **Population-based Survey (HealthInsider)**

IBM Business Consulting Services' National Survey Centre in Ottawa administered a survey to 428 Ontarians 15 years and older about their knowledge, use and satisfaction with NP services.

## Analytic Framework

The study was constructed based on practice dimensions that describe aspects of practice models and integration domains that were used to measure integration. Given the wealth of information collected in the surveys, a detailed analytical framework was developed to guide the data analysis. The analytical framework details the level of analyses by survey (NP, MD, patient and Ontario citizens) and the working hypotheses.

The analysis plan included basic statistics such as frequencies and cross-tabulations on the survey data, as well as selected multivariate statistical techniques to better understand the relationships among variables. The results of this analysis provided us with information on the similarities and differences between survey respondents and identified significant relationships among variables. The site visit findings were assessed and reported in a descriptive form based on the identified dimensions of practice models.

A project working group developed an analysis plan and identified the integration domains (outcome variables). Based on the literature and other information sources, we analyzed relationships among selected variables related to NP implementation and integration. The relationship among these variables was assessed based on:

- Identified measures of NP integration (outcome variables) e.g., satisfaction; and
- Identified factors that influence integration (explanatory variables) e.g., barriers and facilitators.

Variables were grouped into domains to allow the exploration of relationships between various factors in a methodical manner. The integration domains identified were as follows:

- NP role within the practice setting;
- External influences impacting the extent to which the NP is able to provide patient care within the scope of practice;
- NP role in decision making;
- NP workplace satisfaction; and
- Collaboration and team dynamics.

Factors that impact integration in terms of its relationship to practice models and barriers and facilitators were identified to answer the study's two research questions. Under each domain, a number of key comparisons were conducted through cross-tabulations and pairwise significance tests on selected indicators of integration.

Explanatory (predictor) variables were identified such as: demographics; practice model dimensions; length of time in practice; role characteristics; payment type; patient numbers and type; and hours worked per week. In addition, predictor variables specific to each integration domain were identified based on assessments by the working group and results from the exploratory statistical analysis. This enabled the analysts to isolate and examine the effect on integration of a combination of influences such as:

- Practice/Care Setting;
- Client Population;
- NP Scope and Responsibilities;
- Team Interaction;
- Organizational Characteristics;
- External Factors; and
- Employment Relationship.

Outcome (dependent) variables were also identified for each of the domains. For all integration domains, with the exception of external influences, the dependent variables were created using factor analysis.

Where the findings were deemed valid and meaningful, regression analysis was employed to evaluate the underlying relationships between factors and the relevant practice model dimensions.

Based on the results of the analyses described above, a matrix was developed to identify and summarize the measures and influencers of NP integration. The matrix synthesizes the factors that impact successful integration of NPs based upon the NP and physician survey results.

## Synthesis of Key Findings

In this section we set out our key findings from the data collection described above. We have divided the findings into the following themes:

- Practice Models;
- Shared Vision for the NP Role and Role Alignment;
- Role Definition and Clarity at the Practice Level;
- Team Dynamics;
- Resources;
- Scope of Practice Issues;
- Facilitators to Integration of Primary Health Care NPs into the Ontario Health Care System;
- Barriers to Integration of Primary Health Care NPs into the Ontario Health Care System;
- Other Findings; and
- Results of a Survey of the Public and Patients.

### Practice Models

An important question for this study was to determine what could be learned about the practice models in which NPs function. To accomplish this objective, a taxonomy of practice models was developed using a four-step process. The first step was to explore the literature in relation to practice models. The second step described dimensions and associated elements of NP practice through a working group. In step three, site visit interviews assisted in clarifying dimensions of practice, identifying elements that contribute to functionality in practice and informing the development of a taxonomy of practice models. The fourth and final step was to synthesize this information into a framework.

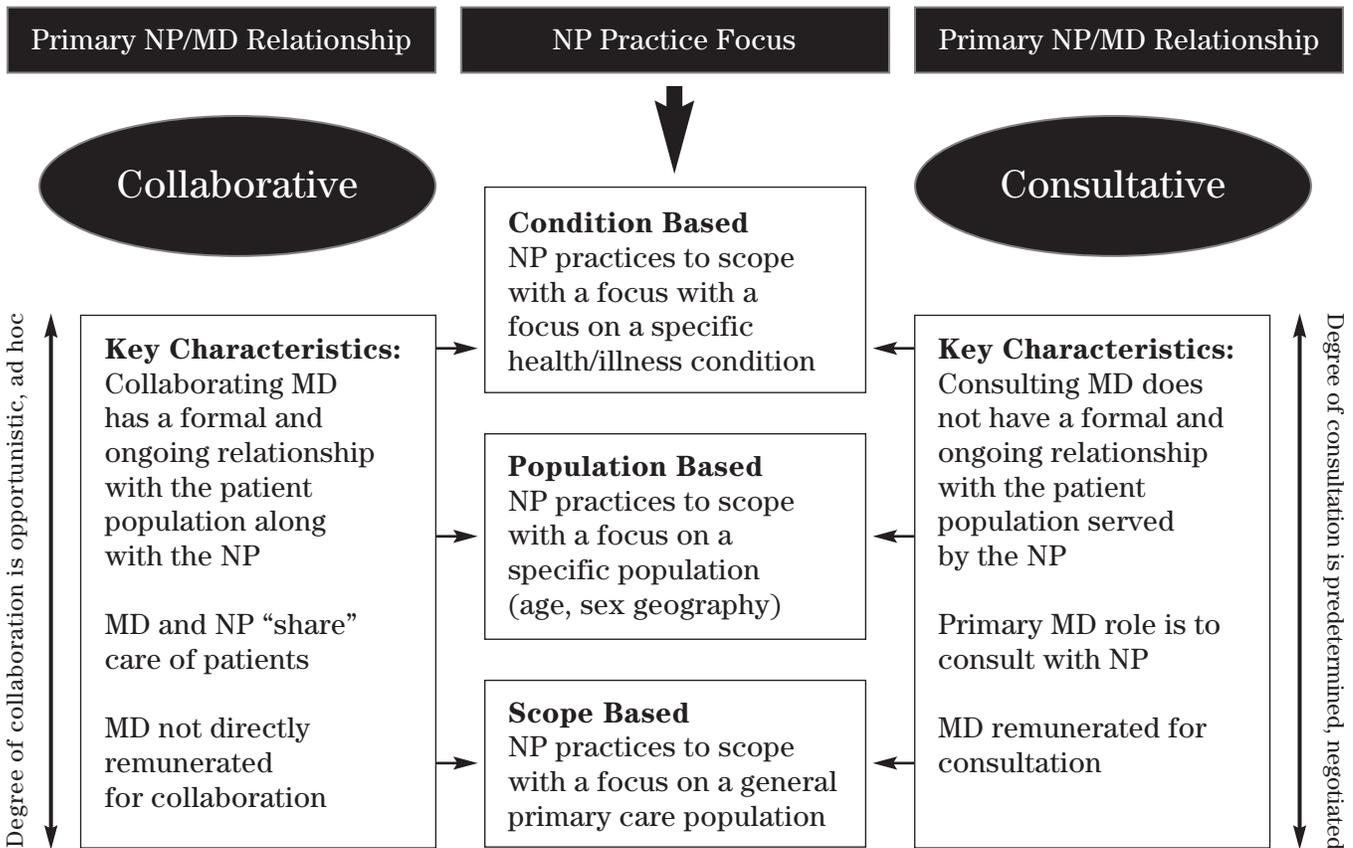
Information gathered from the site visits indicated that there were two main structures for the MD/NP relationship – collaborative and consultative as described below. Within these two relationship structures, the focus of the NP practice was condition-based, population-based or scope-based.

Thus, there were six possible practice models:

- Collaborative or Consultative – condition-based;
- Collaborative or Consultative – population-based; and
- Collaborative or Consultative – scope-based.

A schematic of the model is presented in Exhibit 1.

## Exhibit 1: Overview of practice model framework



### Collaborative Approach

The concept of collaborative practice was described in the literature as encompassing the “physician-nurse dyad working together in a joint effort toward a mission of excellent patient care” (Norsen et al., 1995),<sup>4</sup> where “effectiveness is based on cooperation, assertiveness, responsibility, communication, mutuality, autonomy and coordination” (Norsen et al., 1995<sup>5</sup>; Way et al., 2001<sup>6</sup>; Siegler et al., 1994<sup>7</sup>). Additionally, collaborative practice is described as “joint communicating and decision-making while respecting the unique qualities and abilities of each professional” (Hanrahan 2001<sup>8</sup>). A collaborative approach is based on establishing a collegial relationship that evolves over time based on experience.

<sup>4</sup> L. Norsen, J. Opalden, and J. Quinn, “Practice model, collaborative practice”, (1995) *Critical Care Nursing Clinics of North America*, 7(1).

<sup>5</sup> L. Norsen, J. Opalden and J. Quinn, “Practice model, collaborative practice”, (1995) *Critical Care Nursing Clinics of North America*, 7(1).

<sup>6</sup> D. Way, L. Jones and N. Baskerville, “Improving the effectiveness of primary health care through NP/family physician structured collaborative practice”, Final Report, University of Ottawa, March 31, 2001 (unpublished).

<sup>7</sup> E. Siegler, F. Whitney, M. Schmitt, “Collaborative practice: research questions”. In: Siegler, E., Whitney, F., (ed), *Nurse-Physician Collaboration: Care of Adults and the Elderly*, (NY: Springer 1994) 193-203.

<sup>8</sup> C. Hanrahan, C. Way, J. Housser and M. Applin, “The nature of the extended/expanded nursing role in Canada”, Consultants: Centre for Nursing Studies and the Institute for the Advancement of Public Policy, Final Report, March 30, 2001, (unpublished).

Our observations of collaborative practice in the selected sites visited included the following key features:

- Formal practice relationship between physician and patient;
- Formal relationship and responsibility between physician and NP;
- Physician not paid for supporting and consulting with NP;
- NP practices autonomously;
- Triage process often utilized to access NP;
- Referrals occur between physicians and NP and other members of the health care team; and
- Degree of collaboration most often on an ad hoc or opportunistic basis.

During the site visits, this type of practice model was seen in CHCs, fee-for-service settings, Primary Care Networks, a long-term care facility, VON, emergency departments, and an Aboriginal Health Access Centre.

### **Consultative Approach**

Although many of the features of a collaborative approach could also apply in a consultative approach – for example cooperation and mutuality - there were some significant differences observed in consultative practices that warranted differentiating these practices from others. The key features of a consultative practice were:

- No formal ongoing practice relationship between the physician and patient. In some cases, the physician may not see these patients;
- Physicians reimbursed for consultation with NP;
- Patients most often see NP as the primary provider;
- No triage process to access the NP; and
- Consultation between the NP and MD most often pre-arranged, structured and negotiated.

In this model, the NP calls on the physician when required, but the physician does not have an established or ongoing relationship with the patient population or the organization. His or her primary relationship is with the NP. In consultative practice models, the physician receives a payment for the consultation advice provided.

During the site visits, this practice model was found in a fee-for-service setting, a long-term care facility, VON, Public Health Units, a Community Care Access Centre, Aboriginal Health Access Centres and community agencies.

### **NP Practice Focus**

In addition to the nature of the MD and NP relationship, there were three major foci for the NP practice: condition-based, population-based or scope-based. In each of these practice models, the NP worked autonomously and consulted or collaborated with the physician in given circumstances.

With a condition-based focus, the NP practice was primarily based on a specific patient condition(s). Examples were practices where NPs only saw patients with congestive heart failure, diabetes, mental health issues or for chronic disease management.

With a population-based focus, the NP practice was primarily based on a specific type of patient population or geographic area. Examples of this practice were NPs who saw mainly teenagers, children, marginalized people or First Nations people.

With a scope-based focus, the NP primarily saw a broad-based primary care patient population and consulted or collaborated with the physician mainly with respect to issues beyond the NP's scope.

## Shared Vision for the NP Role and Role Alignment

During the site visits, we identified a shared “vision” for the practice as being an important factor in relation to successful integration of the NP. A shared vision encompasses common values, an understanding of mission and desired outcomes that are aligned with the NP role. Development of the vision for the NP included identifying community needs, assessing who could best meet those needs and educating the team and community about the roles NPs could play.

The shared vision can begin forming when an organization makes an application for a funded position for an NP. Obtaining funding for an NP requires that an organization:

- Identifies patient needs which can be filled by an NP; and
- Has an understanding of the scope of practice and contributions that an NP can provide.

Other factors that supported the development of shared vision included the length of time the NP had been a member of the health care team, the role of the NP in developing the vision, the extent to which there was an orientation for the NP, physicians and other staff with regard to the NP’s role and the functioning of the interdisciplinary team.

## Role Definition and Clarity at the Practice Level

One of the most important facilitators to NP integration was the need to clearly define the NP role at the practice level. This includes the need to:

- Spend time identifying the client and patient needs that the NP is expected to meet;
- Ensure understanding of health care team members’ practice styles and readiness for integrating the NP role;
- Identify the role of the NP in writing and circulate and discuss it widely to obtain buy-in to the position and facilitate education about the role;
- Develop guidelines and a position description to govern the role and practice of the NP and distribute it to members of the interdisciplinary team; it is important that there is an understanding of what the NP can and cannot do; and
- Allow the NP time to establish rapport with physicians and other members of the health care team to become familiar with each other’s practice style.

Thirty-one percent (31%) of primary health care NPs identified that they were not involved in developing their position/job description (Exhibit 35). Those involved in developing the position were more likely to identify higher levels of satisfaction with scope of practice within the practice setting, their role in the decision making process and collaboration and team dynamics within the practice setting.

Whether or not the NP’s current role was clearly defined was a predictor of integration on all domains (i.e., scope of practice, external influences, NP’s role in decision making, NP workplace satisfaction and collaboration and team dynamics). Those NPs who identified that their role was clearly defined indicated higher satisfaction rates on all domains. In addition, those NPs with clearly defined roles also indicated that both the physician and NP are less likely to express concern regarding NP scope of practice and/or liability. With roughly one in five NPs identifying that their role is not clearly defined, this could have significant impact on NP integration.

The NP survey found that 80% of NPs identified that their role is clearly defined (Exhibit 35).

In addition, NPs whose roles were clearly defined are more likely to:

- Work within their full scope of practice (85% vs. 65%) (Exhibit 61);
- Not be limited to certain types of patients (22% with clearly defined roles vs. 46% with poorly defined roles) (Exhibit 61); and
- Spend more time on clinical work and less on non-clinical and clerical work.

Those NPs who identified the narrowness of their role as a barrier to their ability to fulfill their NP role were less likely to be satisfied with their scope of practice within the practice setting and with their role in the decision-making process.

On average, 44% of primary health care NPs are the primary care provider for their patients. However, there was significant variation in NP responses with a range from 0 to 100%. Slightly more than one-quarter of NPs indicated that their practice is limited to specific patient populations. Fifty-one percent (51%) stated that the patient population is their chosen area of their specialty (Exhibit 22).

“Patients referred from outside the practice setting” was the least frequent option identified by NPs for method of patient assignment. The analysis showed that in comparison to other methods (i.e., patient books appointment specifically with NP, referral from colleagues within the setting, receptionist assigns patient, referral from another setting, triage), those primary health care NPs who were assigned patients from outside the practice setting were more likely to work within their full scope of practice. Further qualitative research should investigate reasons why this relationship is occurring.

Being able to deliver care in the way the NP likes was also a predictor of many of the integration domains. Three-quarters of NPs identified that they deliver care in the way they like (Exhibit 23). This was associated with higher satisfaction rates on the NP’s role in the decision-making process and collaboration and team dynamics. NPs who provide care the way they like are also more likely to work within their full scope of practice and less likely to have identified concerns regarding their liability. Sixty-two percent (62%) of NPs indicated that the most positive aspect of their job is the autonomy (Exhibit 54). Another 23% of NPs identified that limited autonomy is one of the most negative aspects of their job (Exhibit 53).

On average, primary health care NPs spend 73% of their time on clinical activities (Exhibit 24). However, there was variation in the response to this question with the percentage of time spent on clinical activities ranging from 19 to 100% (Exhibit 24). The analysis suggests that those NPs who spend a greater percentage of time on clinical duties are more likely to be satisfied with their scope of practice within the practice setting. Twenty-two percent (22%) of NPs reported that one of the most positive aspects of their job is the interaction with patients (Exhibit 54). Those NPs who participated in on-call activities are also more likely to have identified that they worked within their full scope of practice.

Very few patients reported dissatisfaction with NPs. In these situations, dissatisfaction was a result of lack of definition and clarity of the NP’s role. More than 70% of physicians (either working or not working with an NP) identified patient acceptance of the NP role as a facilitator to NP integration (Exhibits 101 and 102).

## Team Dynamics

Team dynamics are important to the successful integration of an NP. Organizations where NPs are successful team members spend some time devoted to dealing with team issues. We found that various sites do this in different ways; however, we conclude that key enablers for successful teams with an integrated NP position include the following:

- Respect for one another;
- Easy conflict resolution;
- All team members understand each other’s role;
- Team members are willing to help each other; and
- Institutional memory of the organization’s collaborative culture.

On average, primary health care NPs identified that they are satisfied with the open communication and amount of collaboration between the NP and the family physician(s) regarding patient care decisions. In fact, more than 30% of NPs indicated that the collaborative practice is the most positive aspect of their role (Exhibit 54). However, those NPs who identified that they are dissatisfied with the communication and collaboration with the family physician were more likely to identify that their physician has concerns regarding the NP's scope of practice and/or liability, which is a barrier to the NP's practice.

Where physicians expressed concerns regarding NP scope of practice and/or liability and the concerns were not resolved, NPs reported higher levels of workplace dissatisfaction. This speaks to the need for a conflict resolution process.

A number of factors influenced the level of satisfaction with collaboration and team dynamics. Those NPs who agreed with the following statements reported higher levels of satisfaction with collaboration and team dynamics:

- Co-operate in making decisions about patient care;
- Co-ordinate implementation of a shared plan for patient care; and
- Respect the other's knowledge and skills in making shared decisions about patient care.

Those NPs who had changed practice settings in the past three years reported lower levels of satisfaction with collaboration.

NPs who are satisfied with the acceptance and attitude of physicians also indicated higher satisfaction with collaboration and team dynamics. Interestingly, 40% of NPs also identified that the top negative aspect of their role is the lack of understanding from medical professionals (Exhibit 53).

Of MDs working with NPs, 84% agreed that they planned and 89% agreed that they cooperated with NPs in making patient care decisions (Exhibit 113). Roughly 90% reported that they communicated openly, trusted and respected each other when making patient decisions. Interestingly, two-thirds of physicians agreed that NPs and physicians shared responsibility for patient care decisions, compared with 80% of NPs (Exhibit 128).

Those NPs who identified isolation of practice as a barrier to fulfilling the NP role indicated lower levels of satisfaction with collaboration and team dynamics. One in five NPs identified that their isolation is a barrier to integration.

Seventy-seven percent (77%) of patients indicated they were very satisfied with the way the health care team worked together to help with their health problems (Exhibit 162).

A very sensitive topic between NPs and physicians is related to the distribution and expectations of the work between these two professionals. In some cases, there was clearly a difference of opinion regarding sharing responsibility for patient care, time allocation and work distribution. Some of these issues centred on on-call activities, hours of work, patient encounter time, MD time required to consult with/support the NP, and distribution of NP time between education, teaching and direct patient care.

In general, concerns about work and time allocation were more frequently expressed by physicians who work in fee-for-service settings. This concern often reflected the lack of physician remuneration for collaboration with the NP. Where MDs are compensated for consultation with the NP, these issues are less of a concern.

## Resources

The site visits confirmed that human, capital and financial resources are required to support NPs' work. Examples of resources included:

- Funding for salary and benefits (including vacation), overhead expenses, space and equipment, medical supplies and administrative services sufficient to support the work of NPs;
- Support for travel between multiple sites or home visits;
- Capital replacement costs;
- Patient/resident education materials;
- Information technology and decision support;
- On-call reimbursement;
- A sufficient supply of NPs so that recruitment efforts resulted in appropriate candidates;
- Access to continuing educational resources for NPs; and
- Access to peer support - especially for those who worked independently and in geographically remote areas.

### Salary and Other Benefits

Although it did not come up as a significant predictor to NP integration in the data analysis, almost one-third of NPs identified that lack of remuneration is the most negative aspect of their role (Exhibit 53).

Forty-six percent (46%) of physicians working with NPs agreed with the statement "inadequate funding for NP salary" is a barrier to integration (Exhibit 110). Thirty-one percent (31%) of NPs identified "limitations of funding" (e.g., lack of money for health promotion, travel) as a top-ranked barrier to integration (Exhibit 51).

Other findings include:

- Twenty-six percent (26%) of non-practicing NPs left practice because the salary was too low (Exhibit 11);
- Twenty-seven percent (27%) of non-practicing NPs indicated the primary reason for not practicing is because they cannot find employment; this includes those who could not find employment within their scope of practice (Exhibit 12); and
- Twenty-nine percent (29%) of non-practicing NPs are willing to relocate and 79% of those willing to relocate indicated that salary and relocation packages are factors to consider in relocating (Exhibit 13).

Furthermore, 13% of NPs would advise the MoHLTC that increased remuneration/salary equalization is required; and one in five NPs would advise that increased funding/more opportunities/more positions are required to better integrate NPs (Exhibit 55).

Key issues related to dissatisfaction included:

- Inequity of salaries for NPs across the province for similar MoHLTC funded positions;
- Requiring NPs to pay additional funds other than those from MoHLTC for overhead and other operating expenses;
- Lack of yearly cost of living or other adjustments;
- Lack of incentives and relocation costs to recruit NPs to under-serviced areas; and
- New NP positions funded at a different level than the current positions.

Seventy percent (70%) of primary health care NPs identified that they have full-time employment. Five percent have contract employment, almost 20% have part-time employment and 6% have casual employment (Exhibit 15). Those with permanent or contract employment are more satisfied with their role in the decision making process than those who indicated other employment. Sixteen percent (16%) of NPs have union membership. Those NPs working in a unionized environment indicated that they are less satisfied with their role in decision making.

NPs were also asked several questions regarding their education. Almost all primary health care NPs indicated attendance at lectures, conferences and or presentations; 86% used other education materials; 80% received education on clinical practice guidelines and two-thirds participated in small group learning, traineeships and workshops (Exhibit 43). In addition, 19% of NPs indicated that professional growth/increased knowledge/continuing learning is one of the most positive aspects of their role (Exhibit 54). Those NPs whose education expenses were reimbursed (86% identified that at least some expenses are reimbursed) indicated higher levels of workplace satisfaction (Exhibit 137).

### **Overhead**

Funding of overhead expenses for NPs was identified as a concern. The NP survey data showed that:

- Fifty-one percent (51%) of NPs state that they travel as part of their responsibilities (Exhibit 24) and 64% state that they travel to see patients (Exhibit 28);
- Fifty-eight percent (58%) of NPs have travel costs and 74% have these costs reimbursed;
- Seven percent of NPs pay a fee for medical or computer equipment (Exhibit 39);
- Six percent of NPs pay a fee to use support staff (Exhibit 39); and
- Seven percent of NPs pay a fee to use office space (Exhibit 39).

There was some dissatisfaction with the amount of funding designated for overhead payments among physicians. This was most strongly felt in settings where MDs have overhead responsibilities. Most sites reported that their overhead expenses related to NPs exceed the \$10,000 allocated by the Ministry for overhead. Some sites reported that the NP position is not sustainable unless additional money is received for overhead, including monies for secretarial support and a consultation fee for physicians.

The number one reason reported by MDs who do not currently work with an NP for not being interested in working with an NP is “inadequate funding for NP-related overhead (61%) and NP salary (59%)” (Exhibit 86). However, no physicians who had ceased working with NPs identified inadequate overhead funding as a reason for doing so.

### **NP Supply and Demand**

There were varying reports among the sites about the adequacy of the supply of NPs. Approximately 27% of NPs not currently practicing or unable to find employment within scope of practice indicated that they would like to work as an NP (Exhibit 12). This variation was not just related to geography or practice setting, although northern communities more consistently reported during the site visits that there is an insufficient supply of NPs. Among those NP survey respondents who indicated they were not working, 29% would consider relocating to a rural or remote area for either a temporary or long term position.

The perception exists that some settings, because of their structure or historical role, are more desirable and more easily able to recruit NPs. In addition, the top two factors determining NPs’ willingness to consider relocation to a rural or remote area are the ability to work within their full scope of practice and the availability of physician support.

## **NP Activity**

Across sites, NPs reported a wide variation in both the volume and type of activities they undertake. In all cases, this level of activity appears to be a negotiated situation between the NP and the site sponsor or clinical manager.

All three surveys asked respondents about the types of services provided by NPs to clients. NPs were asked to identify the various types of patient services they provided (e.g., wellness care) and the percentage of time spent on each type of activity. All physicians were asked to rate the perceived value of the NP services.

Many services provided by primary health care NPs are valued by MDs who work with NPs such as health promotion and wellness care, monitoring of chronic illness, and supporting post-episodic continuity of care (Exhibit 91). Almost all physicians with experience working with NPs indicated that care of episodic illness is a valuable contribution. Almost all NPs indicated that they provide care of episodic illness and about 70% of physicians interested in working with NPs indicated this service is valuable. About 90% of all physicians indicated that prevention/wellness care/health promotion is a valuable contribution. Almost 100% of NPs indicated providing this service, spending approximately 38% of their time doing so. Approximately three-quarters of physicians indicated that monitoring of chronic illness is a valuable service with 90% of NPs providing the service. Interestingly, more than 70% of physicians interested in working with NPs identified that psychosocial support, counselling and home visits to housebound patients are valued services. Not enough information from the NP survey was available to determine the percentage of NPs providing home visits to housebound patients.

Physicians who had experience working with NPs were more likely to see the value of NPs' services. This was related to length of time working with NPs as well as type of setting. Even working with an NP for one year increased the likelihood of seeing the value of their services. This related to wellness, minor acute, major acute, chronic, palliative care and psychosocial support and counselling.

For example:

- Thirty-eight percent (38%) of MDs without experience with NPs reported minor acute care is a valuable service NPs could provide; however, the odds of indicating value from this service tripled if MDs had current or prior experience with NPs; and
- Four percent of MDs without experience with NPs reported major acute care is a valuable service NPs could provide; however, the odds of indicating value from this service increased between four and six fold among MDs with current or prior experience with NPs.

MDs were generally satisfied with the NPs with whom they work. For example, more than 75% of MDs reported satisfaction in the areas of NP time with patients, ability of physician to access NP, NP time spent completing documentation, and with MD time required to support NP (Exhibit 122). Site or clinical managers reported that they would find it very helpful to have a "benchmark" report from the MoHLTC to help them determine an appropriate level of NP activity. This requirement also results from a desire to be accountable for NP resources and develop the ability to report to the community and funders regarding funding for NPs.

NPs are generally keeping encounter information as requested by the MoHLTC. In some situations, NPs are developing their own site-specific data collection tools in order to assist in reporting to local funders or clinical managers. Most NPs were concerned about the usability of the information submitted to MoHLTC since in most cases, the information does not reflect their true activity.

We found that access to the appropriate technology to collect and analyze information related to practice activity varied between sites. Many NPs keep paper records of patient encounters, while others have on-site access to a computer and the Internet.

Many NPs spoke of their interest in evidence-based practice, sharing best practices among NP colleagues, participating in research and making more referrals among NPs. Appropriate technology would support this objective.

## Scope of Practice Issues

There was little in the Canadian literature concerning scope of practice issues. However, it has been suggested by one researcher that it is important to clarify the meaning of the term “nurse practitioner” in order to discuss the future of the role (Haines, 1993).<sup>9</sup> Haines also argues that it is important to define the scope of the role so that only those within the scope can call themselves NPs.

### Referrals

The requirement to have physicians sign most of the referrals to specialists is seen as an unnecessary requirement by NPs and physicians alike. Many NPs suggested that one of the main reasons they refer patients to physicians is to obtain a referral to a specialist. The requirement to have physicians sign referrals is seen as time consuming. In addition, it causes fragmented or duplicated care and is costly and inefficient.

NPs who identified that they receive referrals from outside their practice setting are twice as likely to function within their full scope of practice relative to those who do not receive such referrals.

Inside the practice, most NPs refer patients to the physician whom they are working with when their patients' needs are outside their scope of practice. Forty-four percent (44%) refer when they are uncomfortable handling a case and 19% refer based on a preset arrangement with the physician (Exhibit 32). Most MDs reported they feel satisfied with the extent to which NPs practice within their scope, as indicated by appropriate physician consults.

### Ordering of Drugs and Laboratory Tests

During the site visits, there were a number of comments related to the types of drugs and laboratory tests NPs are allowed to order. One concern was that the drugs approved for NPs to order are listed by name instead of by classification. A preferred approach, that would be more time efficient, would be to list approved drugs by classification.

Other concerns related to the fact that some common laboratory tests and drugs are not included in the approved list for NPs, causing an unnecessary restriction on their practice.

In some settings, the local acute care hospital is the community resource for laboratory testing. Many of these hospitals require the NP to go through an “approval” process before he/she can refer patients to the hospital for laboratory tests and receive the results. In other cases, the results of laboratory tests ordered by the NP are sent to the physician. These processes can cause delays in patient care and disrupt continuity of care. Orientation of local laboratories, diagnostic imaging centres and hospital departments to the NP role and scope of practice is an important facilitator to NPs being able to access laboratory and radiology reports in a timely manner.

<sup>9</sup> J. Haines, “The NP”, Discussion Paper, Canadian Nurses Association (1993) (unpublished).

### **Access to Acute Care Patient Information and Hospital Admission Privileges**

Many NPs reported that limitations related to hospital admission privileges, lack of access to information on care provided during the acute care stay (diagnostic tests, laboratory results etc.) or lack of access to the discharge summary notes impacted continuity and quality of patient care. This concern was most often expressed by NPs who do not have regular access to a physician for consultation and collaboration and whose patients require hospital-based care. This was also a significant issue in practices where NPs provide primary health care to “orphan” clients.

### **Liability Issues**

Concern related to insurance coverage of NPs was also put forward by a number of sites. Questions arose regarding the site’s responsibility when a legal suit is lodged after an NP has left the practice. This is a concern because people have up to seven years from the date of service to pursue a claim.

More than 90% of RN(EC)s in Ontario currently have access to \$5 million in occurrence-based coverage through their membership in the Registered Nurses Association of Ontario (RNAO) from the Canadian Nurses Protective Society. NPs may purchase an additional \$5 million dollars of claims-made malpractice insurance through commercial carriers. The additional commercial policies carry an option to purchase tail insurance, also referred to as extended reporting protection. NPs who are employed in certain settings such as hospitals, long-term care facilities, and CHCs are covered by their employer and may be covered by the Ontario Nurses Association, if they are members.

Furthermore, many nurse practitioners have malpractice coverage under their institution’s policy; many of these institutions such as community health centres and hospitals have occurrence-based coverage through Healthcare Insurance Reciprocal of Canada (HIROC).

NPs were asked if they had concerns regarding their liability and reasons for these concerns. Those NPs who identified that they had concerns regarding the adequacy of their liability insurance were more likely to also identify that their physicians had expressed concerns regarding their scope of practice. In addition, those NPs that identified concerns regarding their liability because they are asked to practice outside their scope of practice had less workplace satisfaction.

### **Initial NP Orientation**

For many new NPs, their first position after they completed their formal NP education was their first time practicing independently within the full scope of practice as an NP. Many NPs indicated that it took six months to a year to become fully comfortable in their new role. During this time, they required greater assistance from the physician and other members of the team and in-service training. This was not particularly surprising as many family physicians or RNs (General Class) would report feeling the same when they entered practice as a novice. Some have suggested that this learning curve should be accounted for and that internships for NPs should be considered.

The NP survey data showed that virtually all NPs had worked more than five years as an RN with an average of 20 years of experience and a maximum of 40 years of experience indicating that this is a very experienced workforce (Exhibit 15). The analysis indicated that those primary health care NPs with the greatest number of years experience as RNs are less likely to identify as a barrier that their physician identified concerns regarding their scope of practice and/or liability.

In addition, those NPs who identified their work experience prior to entering the NP program as a barrier to fulfilling their NP role are less satisfied with their scope of practice within the practice setting (Exhibit 130). However, only 3% of NPs identified their work experience prior to entering the NP program as a barrier (Exhibit 51) while 58% identified this factor as a facilitator (Exhibit 52). Further research should explore the relationship between NP’s work experience and satisfaction with scope of practice.

## Facilitators to Integration of Primary Health Care NPs into the Ontario Health Care System

The literature suggests that in Ontario, key facilitators to integration of NPs include: introduction of policies that legitimize the NP role; the establishment of one recognizable title; patient awareness of the NP role; an understanding of the NP role by other health professionals; the view of collaborative practice by physicians as desirable; the provision of resources to sites that want to employ an NP; and policy changes to provide reimbursement to NPs and the physicians who work in collaboration with them (Hanrahan, Way, Housser and Applin, 2001;<sup>10</sup> Way, Jones, and Baskerville, 2001<sup>11</sup>).

A number of U.S. studies look at how different personal behaviours and characteristics define an effective NP. These include sound leadership skills, confidence, autonomy, and caring behaviour (Jones et al., 1990;<sup>12</sup> Brunton and Beaman, 2000;<sup>13</sup> Mark et al., 2001<sup>14</sup>).

We heard from several sites that the individual NP who held the position in part shaped the NP role. This was seen as both a facilitator and, in some cases, a barrier.

In many sites the team was particularly supportive of “their” NP. They indicated that the specific skills or personality of the NP they worked with was instrumental in the acceptance of the role within the organization and the high degree of satisfaction of the clients and team with the NP role. While this is positive for the individual concerned, there seems to be doubt that the skills that “their” NP contributes can be applied to NPs in general. This is likely a public education issue. Once the role that NPs play is more widely understood by the population in general, the particular skills that the NP brings may be better accepted as a factor of the profession rather than of a particular individual.

When NPs were asked for their general comments regarding integration of the role, many felt that a better understanding of their potential contribution would result in greater use of their services. Forty-three percent (43%) of physicians working with NPs and 37% of physicians not working with NPs identified that community acceptance of the NP role facilitated effective integration of NPs (Exhibits 101 and 102).

### **Skill Set**

We heard from many physicians and NPs that there is wide variation in the skill sets of NPs. Given that professional trust is a facilitator to an effective clinical decision-making relationship between the MD and NP, the NP skill set is very important. Many MDs and NPs spoke of a learning curve required to identify and develop the skills required for a particular position and the challenges of recruiting an NP to meet those requirements. MDs spoke of the need to have an understanding of the basic skill set that could be expected from NPs.

NPs were asked a series of questions regarding their education. When asked if primary health care NPs felt educationally prepared when they first started practicing, 54% indicated that they did not (Exhibit 42). This is a typical feeling for any learner leaving an educational program and beginning a new role as a novice. This dropped to 14% when they were asked if they currently feel educationally prepared (Exhibit 42). For those who indicated that they were/are not educationally prepared, they were then asked to identify their concerns. The majority of respondents indicated that they lacked some substantive knowledge and were/are not prepared for the complexity of health problems.

<sup>10</sup> C. Hanrahan, C. Way, J. Housser and M. Applin, “The nature of the extended/expanded nursing role in Canada”, Consultants: Centre for Nursing Studies and the Institute for the Advancement of Public Policy, Final Report, March 30, 2001, (unpublished).

<sup>11</sup> D. Way, L. Jones and N. Baskerville, “Improving the effectiveness of primary health care through NP/family physician structured collaborative practice”, Final Report, University of Ottawa, March 31, 2001 (unpublished).

<sup>12</sup> L. Jones et al., “NPs: leadership behaviours and organizational climate”, (1990) *Journal of Professional Nursing*, 6 (6).

<sup>13</sup> B. Brunton and M. Beaman, “NPs’ perceptions of their caring behaviours”, (2000) *Journal of the American Academy of NPs*, 12 (11).

<sup>14</sup> D. Mark, V. Byers and M. Mays, “Primary care outcomes and provider practice styles”, (2001) *Military Medicine*, 166 (10).

Sixty-three percent (63%) of those unprepared educationally when they first started practicing also indicated that they were not prepared for the level of independence of the role. It is to be expected that NPs will experience a learning curve as they move from novice to expert. For many NPs previous related experience was found to facilitate this learning curve.

Those primary health care NPs who identified they were not educationally prepared when they first started practicing suggested that their concerns could be addressed by:

- Having a longer practicum (73%) (Exhibit 42);
- Having an internship year (64%) (Exhibit 42);
- Having a masters level program (47%) (Exhibit 42);
- Creating a longer educational program (46%) (Exhibit 42) and
- Having greater emphasis on continuing education (41%) (Exhibit 42).

Those primary health care NPs who currently feel they are not educationally prepared (14%) identified that having greater emphasis on continuing education would address some of their concerns (60%) (Exhibit 42). Again, it is to be expected that NPs will experience a learning curve as they move from novice to expert.

Seventy-nine percent (79%) of physicians not practicing with NPs and 89% of physicians who are practicing with NPs identified NP expertise as a facilitator to integration (Exhibits 101 and 102). This view did not vary across practice settings, but the logistic regression analysis showed that MDs more experienced working with NPs place significantly higher importance on NP expertise as a key facilitator. Past MD experience with NPs doubled the odds of an MD reporting NP expertise as an integration facilitator.

## Barriers to Integration of Primary Health Care NPs into the Ontario Health Care System

The Canadian literature suggests that physicians and NPs have a different view of the barriers to NP integration (Hanrahan, 2001<sup>15</sup>). Barriers identified by physicians include: the negative impact on the income of fee-for-service physicians; potential for impeding physician recruitment and retention; inadequate nurse supervision; and responsibility and liability concerns for attending physicians when NPs see patients independently.

From the physician survey, it was identified that 63% of MDs practicing with NPs reported that the structure of the MD-NP working relationship is a strong barrier to NP integration and 20% ranked it as the most important concern (Exhibit 110). Although the concept of structure was not defined for survey respondents, the strength of the finding is meaningful. Fifty-six percent (56%) identified NP expertise as a barrier, with 34% ranking this as one of the top three barriers (Exhibit 110). Inadequate funding for NP salaries was raised as an issue for 46% of MDs, and 20% ranked this as the most important barrier (Exhibit 110). The barriers identified by NPs included: skill/knowledge limitations; restrictions on scope of practice (e.g., prescriptive authority, ease of access to referrals and diagnostic services); inadequate public and professional awareness; unsupportive physicians and resistance from physicians, especially those compensated by fee-for-service.

During the site visits, we heard that while there is no doubt about the positive contribution that NPs make to client care, they would be more highly used if those contributions were better understood by patients and members of the interdisciplinary team.

<sup>15</sup> C. Hanrahan, C. Way, J. Housser and M. Applin, "The nature of the extended/expanded nursing role in Canada", Consultants: Centre for Nursing Studies and the Institute for the Advancement of Public Policy, Final Report, March 30, 2001, (unpublished).

## Other Findings

### Practice Settings

NPs working in long-term care settings or in other settings unspecified by survey respondents identified that they are more satisfied with their scope of practice within the practice setting (Exhibit 130), their role in the decision making process (Exhibit 135) and their workplace satisfaction (Exhibit 137). Those working in an emergency department also identified higher levels of workplace satisfaction (Exhibit 137) and satisfaction with collaboration and team dynamics (Exhibit 139). On the other hand, those NPs working in a public health unit identified that they are less satisfied with their scope of practice within the practice setting than NPs in other practice settings (Exhibit 130).

Almost half of MDs not practicing with NPs are in private group practice and almost one-quarter are in solo private practice (Exhibit 83). This distribution is markedly different than that for MDs practicing with NPs; almost half of the MDs in that group work in a CHC and only nine percent work in solo and group private practice combined (Exhibit 84). Other points of note were:

- MDs in CHCs value NPs' role in prevention/wellness care/health promotion the most (Exhibit 92);
- Physicians in long-term care, emergency department, and fee-for-service practices value NPs' role in prevention/wellness care/health promotion the least (Exhibit 92);
- NPs' role in minor acute illness was perceived to be particularly valuable by MDs in CHCs and long-term care settings (Exhibit 93);
- Controlling for gender and experience, physicians in a fee-for-service setting are least likely to identify care of major acute illness as a valuable NP service (Exhibit 94);
- Monitoring of chronic illness by NPs is less important to physicians in fee-for-service settings and emergency practices than in other settings (Exhibit 95);
- MDs in long-term care settings are most likely to value palliative care services (Exhibit 96);
- Forty-five percent (45%) of fee-for-service physicians value the provision by NPs of home visits to house bound patients (see text above Exhibit 97);
- Physicians in fee-for-service settings, Health Service Organizations, Primary Care Networks are the most likely to identify night and weekend on-call coverage as a valuable NP service (Exhibit 98);
- Almost half of all MDs feel that NPs could provide linkages to community organizations (Exhibit 99); and
- Forty percent (40%) of fee-for-service physicians identified psychosocial support and counselling as a valuable NP service with more in CHCs and Health Service Organizations, Primary Care Networks and less in long-term care and emergency settings (see text above Exhibit 100).

### MD Willingness to Work with NPs

Of MDs not working with NPs at the time of the survey, 49% indicated they would be interested in practicing with NPs, 33% would not be interested, and 18% were uncertain (text below Exhibit 85). Controlling for practice setting, a key determinant of MD interest in working with an NP if given the opportunity is past experience working with an NP. Working with an NP in the past increases the odds of MD interest by 2.4 times, and this result was independent of duration of past work experience.

The propensity to be willing to work with an NP is substantially smaller for fee-for-service physicians relative to other MDs (Exhibit 88). For example, relative to the reference group, physicians in fee-for-service settings have 60% lower odds of being interested in working with NPs; the odds of MDs working in Health Service Organizations, Family Health Networks or Primary Care Network settings being interested in working with NPs is 36 times higher than for MDs in a fee-for-service setting. This does not indicate that fee-for-service MDs are mainly uninterested; roughly half of fee-for-service MDs did express interest; rather fee-for-service MDs are substantially less receptive than those observed in other settings.

Controlling for other factors, male physicians are one and a half times more likely to be interested in working with NPs.

### **Non-practicing NPs**

Of non-practicing NPs, 69% are between 35 to 54 years of age (Exhibit 10). This compares with roughly 85% of those respondents that are practicing in a primary care setting (Exhibit 14). A higher percentage of non-practicing NPs were identified in both the 25 to 34 age group and 55 and over age group (Exhibits 10 and 14).

Non-practicing NPs also reported higher levels of education than the practicing primary care NPs. One quarter of non-practicing respondents indicated having a Masters or PhD as their highest level of completed education. This compares with 18% of practicing primary health care NPs (Exhibits 10 and 14).

Forty percent (40%) of NPs who reported that they were no longer practicing as an NP identified that they have never practised (even though they were licensed to practise). Of those who practised in the past, the top three reasons for leaving practice included that salary was inadequate (26%), limitations were imposed by their employer (26%) and long distances between the setting and home (23%) (Exhibit 11).

## **Results of a Survey of the Public and Patients**

Forty-six percent (46%) of Ontario residents reported that they had heard of a health provider called an NP (Exhibit 152). Upon explanation of the NP role, two-thirds said they would be willing to see an NP for wellness care and for treatment of minor illnesses. Of those who had seen an NP in the past 12 months, satisfaction rates were high. Both the patient and the public surveys found females are more likely than males to use NP services. The majority of patients who had seen an NP at site visit settings and who completed surveys were higher income individuals in good health. Results from the *HealthInsider* survey of the public indicated a higher level of familiarity with NPs among these groups.

When asked what they liked about seeing an NP, patient survey respondents indicated the following: the amount of time the NP spent with them; the quality of care they received; the ease with which they were able to speak to the NP; and the information given about their health condition.

The findings also indicated a lower level of awareness of NPs and their role than might be expected. This finding leads to a recommendation for the MoHLTC to provide more consumer education in relation to the NP role. This is of great importance given the introduction of more NPs into the provincial health care system.

# Recommendations

We set out our recommendations below. We note in brackets next to each of the recommendations the key data that support the recommendations. The identified exhibits are not all inclusive but give an indication of the key data that support the recommendations. Many of the recommendations are based on multi-variate analysis which looks at the relationships between variables and it is, therefore, difficult to identify one particular variable that explains each recommendation.

## Accountability for Implementation of Recommendations

1. The Joint Provincial Nursing Committee (JPNC) to prioritize, develop a timetable, and assign responsibility for the implementation of the recommendations contained in this report.
2. The Nursing Secretariat to be accountable for facilitating an evaluation in two years time to examine the extent to which the recommendations in this report are implemented and the impact of that implementation.

## Shared Vision and Role Alignment

3. MoHLTC, Council of Ontario University Programs in Nursing (COUPN), stakeholder organizations and associations to develop a joint statement related to the vision for NPs in the province. This vision statement should be broadly disseminated to health organizations, providers and the public. (See Site Visit Summary, Chapter 6.)
4. MoHLTC to encourage organizations with funded NP positions to articulate their mission, vision and team strategy. This could be a requirement in the proposal process for sites to have a funded NP. (See Site Visit Summary, Chapter 6.)
5. Educational institutions, with the support of MoHLTC, to plan opportunities for NPs, physicians and other allied health care professionals to learn about respective roles during professional training. (See Analysis of NP and MD Surveys, Chapter 5, Exhibit 53, Site Visit Summary, Chapter 6.)
6. COUPN, with the support of MoHLTC, to plan for internship opportunities for NPs that build on the basic NP education and recognize the transition from novice to expert. These opportunities should also recognize the differences in skills and experiences across practice settings. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 42,52 and 55, Site Visit Summary, Chapter 6.)

## NP Role Clarity

7. MoHLTC to require that funding proposals for NP positions include a needs assessment and clear definition and description of the proposed NP role at that site. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 35, 61, 130, and 139, Site Visit Summary, Chapter 6.)
8. MoHLTC, in collaboration with stakeholder groups, to develop an orientation package for sites funded for an NP. The package could include specific information about NP skill sets and guidelines for education and orientation to the NP role for all members of the health care team. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 35, 49, 73, 130, 135 and 139, Site Visit Summary, Chapter 6.)
9. NPs to be included by the funded sites in defining their role and level of autonomy, taking into consideration their skills and experience as part of the introduction of the NP into the practice setting. (See Site Visit Summary, Chapter 6.)

10. NP role definition to be reviewed and updated by sites funded for an NP on an annual basis or as needed to ensure patient needs, other team members' roles and practice focus are aligned. (See NP and MD Surveys, Chapter 5, Exhibits 21, 130, 135, 137 and 139, Site Visit Summary, Chapter 6.)

## Team Dynamics

11. MoHLTC to work with stakeholders to create a venue/forum for sharing best practices related to team collaboration in sites funded for an NP. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 101, 102 and 110, Site Visit Summary, Chapter 6.)
12. MoHLTC to remunerate MDs for consultation and collaboration with the NP unless the funding mechanism of a setting (e.g., CHC) already includes this remuneration. The MoHLTC and OMA should work to determine the most appropriate rate to be paid to physicians for formal and informal collaboration and consultation with the NP. (See Analysis of NP and MD Surveys, Chapter 5, Exhibit 86, Site Visit Summary, Chapter 6.)
13. MoHLTC and hospitals to review the impact of NPs on emergency department volumes and the associated impact on MD positions funded through Alternate Payment Plans. (See Analysis of NP and MD Surveys, Chapter 5, Exhibit 121, Site Visit Summary, Chapter 6.)
14. Practices creating an NP role for the first time to be given one-time funding from the MoHLTC to support the costs associated with orientation, role definition, team building exercises and conflict resolution. Knowledge created through this process should be transferred when other NPs/team members join the practice. (See Key Findings of Analysis of NP and MD Surveys, Chapter 5, Site Visit Summary, Chapter 6.)

## Resources

15. To facilitate planning and monitoring, the MoHLTC to develop with the program areas and selected stakeholders, standard information collection and reporting mechanisms regarding NP human resources and activity. This information could be used to facilitate planning for resource allocation, NP education and to support the development of performance measures. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 55 and 110, Site Visit Summary, Chapter 6.)
16. MoHLTC to identify a co-ordinating body for NP human resources planning and monitoring. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 12 and 13.)
17. MoHLTC to develop a centralized process to maintain current information about funded NP positions. (See Key Findings of Analysis of NP and MD Surveys, Chapter 5.)
18. In relation to NP salary and benefits: (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 40, 41, 55, 86, 110, 126 and 127.)
  - a. MoHLTC to oversee the development of a policy for a stable funding mechanism for NP positions.
  - b. In conjunction with selected stakeholders, MoHLTC to develop guidelines for sites to use in relation to salary equity.
  - c. MoHLTC to develop a plan to align salaries between newly funded positions and current positions.
  - d. MoHLTC to develop a long-term plan for funding to account for cost of living and other increases.
  - e. MoHLTC to re-examine the amount allocated to sites for overhead costs to ensure comprehensive and appropriate coverage.
19. MoHLTC and selected partners to develop NP activity benchmarking and disseminate this information to sites with funded NP positions. ( See Analysis of NP and MD Surveys, Chapter 5, Exhibits 21 and 34.)

## NP Scope of Practice

20. MoHLTC to consult with medical and nursing associations in relation to billing rules within Ontario's Schedule of Benefits related to the issue of allowing a specialist to be paid when a referral comes from an NP. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 31, 32 and 62, Site Visit Summary, Chapter 6.)
21. Consistent with the RHPA, MoHLTC to consult with nursing and medical associations and regulatory bodies to develop a review process related to approved drugs NPs can prescribe and laboratory tests that NPs can order. This is intended to improve and streamline the process and ensure inclusion of tests and drugs to manage conditions within the NP's scope of practice. (See Site Visit Summary, Chapter 6.)
22. Nursing associations to develop a process to ensure the timely dissemination of information to NPs about updates to the list of approved drugs. This list to categorize drugs by name and classification. (See Site Visit Summary, Chapter 6.)
23. MoHLTC, with the appropriate stakeholders and institutions, to develop a process that facilitates the flow of information between care sectors (e.g., hospital, long-term care facility) and allows for NP involvement in patient care as it relates to continuity. (See Site Visit Summary, Chapter 6.)
24. Nursing and medical associations to disseminate information to NPs, physicians and interested stakeholders about current NP liability coverage and implications for each professional group. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 33, 34 and 131 to 133, Site Visit Summary, Chapter 6.)
25. In the Fall of 2002, relevant stakeholders, including nursing and medical associations, respective protective agencies and MoHLTC began a collaborative review of the restrictions related to NP liability protection that was resolved in June 2003. It is recommended that the implementation of the outcomes of this review be monitored by the involved stakeholders. (See page 18 and 37, Analysis of NP and MD Surveys, Chapter 5, Exhibits 33, 34 and 131 to 133.)

## Recommendations – System Integration of the NP

26. MoHLTC, in collaboration with NP stakeholder groups, to develop a public education program about NPs and their role in primary health care. This program will include guidelines and best practices for community education programs about the NP role. (See Analysis of NP and MD Surveys, Chapter 5, Exhibits 101 and 102, Site Visit Summary, Chapter 6.)
27. MoHLTC and NP stakeholder groups to facilitate the development of a best practices information clearing house related to community/organization/health setting education and/or orientation to the NP role. This information should be integrated with other initiatives related to best practices for primary health care delivery. (See Key Findings of Analysis of NP and MD Surveys, Site Visit Summary, Chapter 6.)
28. MoHLTC and the Council of Ontario University Programs in Nursing (COUPN) to review strategies for increasing the educational preparedness of the NPs including longer clinical practice, addition of an internship year, raising the level of the PHCNP educational program to a Master's level, increasing the length of the educational program, and increasing the emphasis on and access to continuing education. (See Analysis of MD and NP Surveys, Chapter 5, Exhibits 42 and 55, Site Visit Summary, Chapter 6.)
29. MoHLTC and COUPN, in consultation with nursing associations, to develop an educational strategy that would respond to the basic and on-going education needs of NPs related to specific primary health care clinical practice areas. (See Analysis of MD and NP Surveys, Chapter 5, Exhibits 42 and 55.)





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