



## APPENDIX A

# Practice Consultation Initial Report

### Prepared for the Canadian Nurse Practitioner Initiative

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## Executive Summary

The primary purpose of the Canadian Nurse Practitioner Initiative (CNPI) is to “facilitate sustained integration of the nurse practitioner role in the health system to improve Canadians' access to health services.” Key strategies and recommendations will be developed in five main areas to assist the CNPI meet this goal. These areas are:

- legislation and regulation;
- practice and evaluation;
- health human resource planning;
- education; and
- change management, social marketing and strategic communications.

The focus of this report is on the practice consultation component of the initiative, with particular emphasis on the nurse practitioner (NP) practice in primary health care settings; working relationships among NPs, physicians (MDs), and other health-care professionals; and facilitators and barriers. A wide variety of stakeholders was interviewed across the country by the Manager of Practice and Evaluation between August 2004 and January 2005. Participants interviewed included practising NPs and other members of the interdisciplinary health team, employers / administrators, government representatives, professional organizations and regulatory bodies representing nursing, medicine and pharmacy representatives, and nursing unions. Recent key studies and reports such as the 2003 IBM study titled *Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario* were used as a launching point for the consultations by providing baseline information for the consultations and facilitating questionnaire development.

This report includes an overview and descriptive analysis of the key findings from this initial consultation. The information collected from the consultation was coded, organized under the several major themes, and ranked in descending order of importance based on the number of comments provided. The major themes are as follows.

- Role
- Barriers
- Collaboration
- Outcomes
- Acceptance
- Organization
- Scope
- Other

Themes grouped under the “Other” category included: certification / credentials; mentorship; core competencies of NPs; impact of technology; and the impact of unions on NP practice. The total amount of information collected in this category was small and restricted to certain jurisdictions. Overall, participants across disciplines and across the country provided remarkably similar comments and information.

The majority of the comments provided during the consultation focused on clarifying or explaining the NP role, as well as the roles of other health professionals who may work with the NP. These types of comments were generally consistent across the country, but NPs provided the majority of feedback or data about the NP role. Role clarity is identified in the literature and recent studies as being essential to successful integration of the role. Interestingly, while the nursing component of the role was well understood by many participants (data grouped under the acceptance and outcomes themes demonstrates this), the idea or concern that NPs were perceived as physician-replacements still exists for some. This is a concern because it appeared that some participants felt that the NP role would be eliminated, or that the breadth and depth of the role may be diminished, if more physicians were recruited to their practice settings.

On the other hand, NPs and other professionals such as physicians were able to articulate many aspects of the NP role. Although these descriptions were not all-inclusive, they were generally consistent with jurisdictional NP definitions and descriptions. One aspect of the role, namely the research component, was rarely mentioned by participants. NPs are considered advanced nurse practitioners (ANP) by the Canadian Nurses Association (CNA), and research is one of the five main components or competencies that comprise the ANP role as defined by the CNA. The absence of the research component in the consultation data, particularly in role descriptions provided by NPs, is noteworthy and should be explored further to gain better understanding of the issue.

NP roles were differentiated from other health professional roles by some participants. For example, distinctions were made between NP and several other roles including other registered nurse (RN) roles, physician assistants (PAs) and paramedics. Being able to make these distinctions is important as they help facilitate role clarity for the public and other health professionals with respect to expectations of the NP role, including identification of overlapping or complementary skills. As well, understanding the NP role can facilitate decision-making regarding appropriate skill mix in the practice setting, and also at a much broader system-level with respect to health human resource planning. Finally, participants identified various issues or challenges for role implementation related to geographic location; NPs in the north have fewer limitations placed on their practice than NPs in southern regions of the country. Participants indicated that this occurs regardless of the legal scope of practice of the NP and is specifically related to “political and/or personal turf issues.”

Barriers to NP practice were the second most prevalent theme gleaned from the consultation and were related to boundaries and liability, funding, organizational and structural supports, and legislative and regulatory barriers. Boundary barriers were most commonly cited, and were primarily related to NP role clarity. For example, participants were in some circumstances uncertain as to what to expect from an NP, and on some occasions questioned the educational preparation of NPs. These participants stated that this lack of understanding made NPs feel a lack of trust and respect from their practice team. In addition, the perception that the NP was replacing a physician rather than

providing complementary health services led some physicians to express similar feelings of mistrust and feeling devalued.

Liability issues were linked to boundary barriers, primarily in relation to the perception among other health professionals such as physicians and pharmacists regarding accountability for the practice of the NP. These misperceptions focused predominately on what they saw as the need for monitoring NPs' additional / expanded authorities (e.g., diagnosing and prescribing), and the question of who has ultimate accountability for client / patient care in the event something went wrong. The feelings of mistrust and lack of respect among NPs are a direct outcome of these types of issues and restrictions placed on practice. More education regarding the role, including the accountability of the NP as a self-regulating professional, may in part assuage some of the concerns raised about liability by other members of the health-care team. Consistent, adequate liability protection across the country would also address some of these concerns.

Funding barriers identified were directly related to remuneration, that is, the incongruence between physician fee-for-service (FFS) remuneration and salaried NPs. Barriers included a “quality versus quantity” environment where NPs felt pressured to see more patients at the “expense” of being able to provide adequate nursing care in their interactions with clients. Other participants, because they perceived NPs as physician replacements, stated that NPs were a direct threat to income in a FFS environment. In addition, legislative and regulatory barriers were consistently identified by participants across the country as having a significant impact on NP practice. It was felt by many participants that the legislation and regulation simply has not kept pace with current scope of practice of NPs.

Collaboration was the third most common theme identified in the consultation and was identified by participants as being essential to successful NP role implementation. Participants described their own experiences with collaboration and made suggestions to facilitate it ranging from strategies to support how the work is organized and distributed to having a shared vision, and the need to be flexible and compatible. Mutual respect and trust among the collaborative practice team was deemed essential for success. Challenges to successful collaboration were also identified such as having partners who were willing to collaborate but who are not available, or team members who no longer wished to collaborate with the NP, were also discussed.

Finally, outcome and acceptance themes were identified within the data. Despite issues related to role clarity and barriers to NP practice, and issues affecting collaborative relationships, many participants shared positive comments about NPs. These comments indicated a growing acceptance for the NP role by both the public and other health professionals. It appears that client and physician exposure to the NP role, and physicians not being “forced into” a collaborative relationship, has facilitated acceptance of NPs. This acceptance has also been demonstrated in outcome data provided by participants, and included system-related outcomes such as increased access to health care services and a decline in numbers of emergency room visits.

Physicians working with NPs also cited patient-specific outcomes such as improved teaching, with the result that patients are better empowered to care for themselves and express improved satisfaction with their care. Further, physicians identified personal benefits such as decreased workload, more time to spend with patients, and overall improvement in the quality of care. Many of these physicians also stated that their expectations for the NP role were met. While there are signs of increasing acceptance of the NP role and positive outcomes directly related to the practice of the NP, the need for more education for the public and other health professionals about the NP role at all levels was seen as being critical to further improvements in understanding the role and addressing concerns.

Findings in this initial consultation report resemble findings of other recent reports and studies. This report forms the foundation for additional practice consultations which will be undertaken by the Manager of Practice and Evaluation, CNPI, over the coming year. Further validation of the themes identified in this report and emerging themes will be described in subsequent reports prepared as part of this initiative to facilitate the sustainability of the NP in the Canadian health-care system.

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## 1.0 Introduction

The purpose of Canadian Nurse Practitioner Initiative (CNPI) is to identify strategies in five key areas to optimize the contribution of nurse practitioners in Canada leading to their successful integration in the health care system. These key areas are:

- legislation and regulation;
- practice and evaluation;
- health human resource planning;
- education; and
- change management, social marketing and strategic communications.

This initial consultation report focuses on the nurse practitioner (NP) in primary health care practice and is intended to contribute to the CNPI initiative by providing the reader with a broad overview of perspectives and key themes gleaned from the data gathered about practice and the working relationships among NPs, physicians (MDs), and other health-care professionals. Interviews were conducted by the Manager of Practice and Evaluation of the CNPI across Canada between late August 2004 and early January 2005. The goal was to gain a better understanding of the practice models in which NPs worked and the factors that contribute to successful models. Participants in the consultation included nurse practitioners,<sup>1</sup> physicians who work in collaborative practices with NPs, other members of the multidisciplinary team who work with NPs, administrators who employ NPs, professional / regulatory bodies for RNs and other health professional groups, union representatives, and government. Data was gathered, where possible from all provinces / territories in Canada.<sup>2</sup> This report includes an overview and descriptive analysis of the key findings from this initial consultation. The findings are organized under the several major themes derived from the data collected.

## 2.0 Methodology

The CNPI team agreed to work from already established reviews and reports as the “go forward” point for the initial consultation process. These reports formed the platform from which questions were developed for the cross-country initial practice consultation phase of the CNPI project. *The Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario* (2003, IBM Consulting Services) served as the primary report to facilitate questionnaire development for the consultation. This report is the most recent and extensive study completed in Canada about NP integration. The report contained an extensive appendix that included valid and reliable interview questions and surveys that were used to gather data for the IBM study. Other

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<sup>1</sup> Nurse practitioners interviewed included those formally regulated in those roles, but also RNs practising in NP-like roles who are anticipating formal regulation by their respective college in the coming months.

<sup>2</sup> Exception of NU, YK and NL – other project managers visited these jurisdictions and will provide data in their respective reports.

studies were reviewed for background information prior to the initiation of the practice consultation.

- *The Final Report: The Nature of the Extended/Expanded Nursing Role in Canada* (Centre for Nursing Studies and the Institute for Advancement of Public Policy Inc, 2001)
- *Report on the Evaluation of Implementation of the Nurse Practitioner – Primary Health Care in Newfoundland and Labrador* (Goss Gilroy Inc., Management Consultants, 2001)
- *Barriers to Effective Collaboration Between Nurse Practitioners and Family Physicians: A Discussion Paper* (Jardali, 2003)
- *Advanced Nursing Practice: Opportunities and Challenges in British Columbia* (Schreiber et al, 2003)

Two questions found to be common in these reports and studies were deemed particularly important in furthering the work of the practice component of the CNPI.

- What barriers must be overcome and what facilitators must be encouraged to further integrate NPs into the primary health care setting?
- 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?

These questions were used to form the foundation of all questions used during the practice consultation across the country. (For a list of the specific interview questions see Appendix A.) A number of other key documents were reviewed to facilitate data collection activities and subsequent questionnaire development for the practice consultation. Additional information reviewed included reports and other documents previously prepared by the Canadian Nurses Association (CNA) including position statements, discussion papers, and fact sheets on advanced nursing practice and nurse practitioners.

In planning to conduct the initial practice consultations, the approach and strategy used was intended to be as inclusive of many stakeholder groups, including as many jurisdictional / territorial partners as possible, while respecting the feedback and suggestions from CNA jurisdictional members regarding visitations and consultations. Site visits were organized with the purpose of gaining a better understanding of the practice situations in which NPs work and the factors that contribute to either the success or difficulties of those models. It is recognized that each type of practice setting reflects a wide range of characteristics and may differ from site to site even within the same province / territory or jurisdictional region.

A descriptive case study approach – similar to the IBM study – was used to gather information and was intended to develop a broader understanding of practice models and the barriers and facilitators to NP integration. Generally the visits / meetings were conducted during a one-week visit to each province or territory. The sites were chosen according to three criteria:



- invitation from an NP, administrator, physician or health authority;
- suggestions received from government representatives, nursing associations / regulatory bodies; and
- the CNPI managers' knowledge of the practice site.

Targeted interviews were conducted in each province / territory with the exception of Newfoundland and Labrador, the Yukon Territory and Nunavut. Data from these jurisdictions were gathered by other members of the CNPI team during their visits. (Data from these consultations related to practice are not included in this report. This data is included in the reports prepared by other managers and will be integrated as appropriate into future reports during the next phase of the CNPI practice consultations.)

Interviews and meetings were held with interdisciplinary teams, employers, government, professional organizations / unions representing nursing, medicine and pharmacy. With respect to interdisciplinary teams, efforts were made to interview as many members of the health-care team as possible. For example, interviews were conducted with NPs practising in primary health care settings, and whenever possible interviews also included:

- physicians who work most closely with the NP;
- other physicians if present; and
- other members of the health-care team.

The latter group varied depending on the site, and included administrative staff such as managers, administrators, medical office assistants, and other health professionals such as registered nurses (RNs), licensed practical nurses (LPNs), registered practical nurses (RPNs), social workers, dieticians, and physiotherapists. The types of primary health care practice settings visited included:

- community health centres;
- aboriginal health access centres and aboriginal community health centres;
- emergency department and hospital outpatient clinics;
- fee-for-service physician practices; and
- alternate payment schedule practices (see Appendix B for list of all types of settings).

Interviews were conducted with participants depending on availability during the week of the scheduled CNPI consultation visit. Efforts were made on behalf of the CNPI Manager of Practice and Evaluation to interview as many of these key stakeholders as possible during the week of the visit. Further, to facilitate the interview process, information about the CNPI and copies of the questions to be asked were forwarded to participants prior to the visit. The same questions were asked in every visit and recorded. Field notes were also documented for comments offered other than those generated from the questions. All raw data was entered into a spreadsheet according to the question, aggregated by province, but with specific reference to the person who provided the information removed. The raw data was then themed by a third-party consultant. The Manager for Practice and Evaluation reviewed the themes for their resonance and accuracy. In addition, the authors of this report reviewed the data and analyzed the

themed data to validate common themes.

### 3.0 Findings

The data gathered from the cross-country consultation was coded into themes and sub-themes. This section of the report contains several tables and charts to illustrate the most common themes that emerged from the consultation. Similarities and differences where they occurred among groups of participants such as nurse practitioners, physicians, and employers are identified, and between geographical areas, that is, eastern and western regions of Canada. Care is taken to ensure participant anonymity is maintained.

It is important to note that the data presented in the tables and charts **are counts of the coded themes**. The intention is to give the reader an overview of the most common themes that emerged from the consultation. In some cases, a participant may have provided comments related to only one theme. For example, if a participant provided six distinct comments related to one theme, these comments were coded during the data entry process as six separate entries under that theme. In addition, the reader should note that a single theme could represent a single participant (e.g., an NP or physician) or a group of participants (e.g., a multidisciplinary team interviewed at the same time which was often the norm). Statistical significance of the data was not determined.

To provide context for the findings of the consultation and subsequent discussion, Table 1 shows the number of participants interviewed in each jurisdiction and total number for each geographic region, i.e., western and eastern Canada. The reader should note, as mentioned previously, that **a participant could mean a single individual or group of individuals**. As noted in the table, participants from Nunavut (NU), Yukon (YK) and Newfoundland and Labrador (NL) were not interviewed during this round of consultation by the Manager of Practice and Evaluation. Concurrent interviews were held in these provinces and territories by managers of other portfolios associated with the CNPI initiative, and data collected by these managers are included in their reports. Eventually, all the reports will be merged into one report.

**Table 1 – Number of Participants per Jurisdiction & Geographic Region**

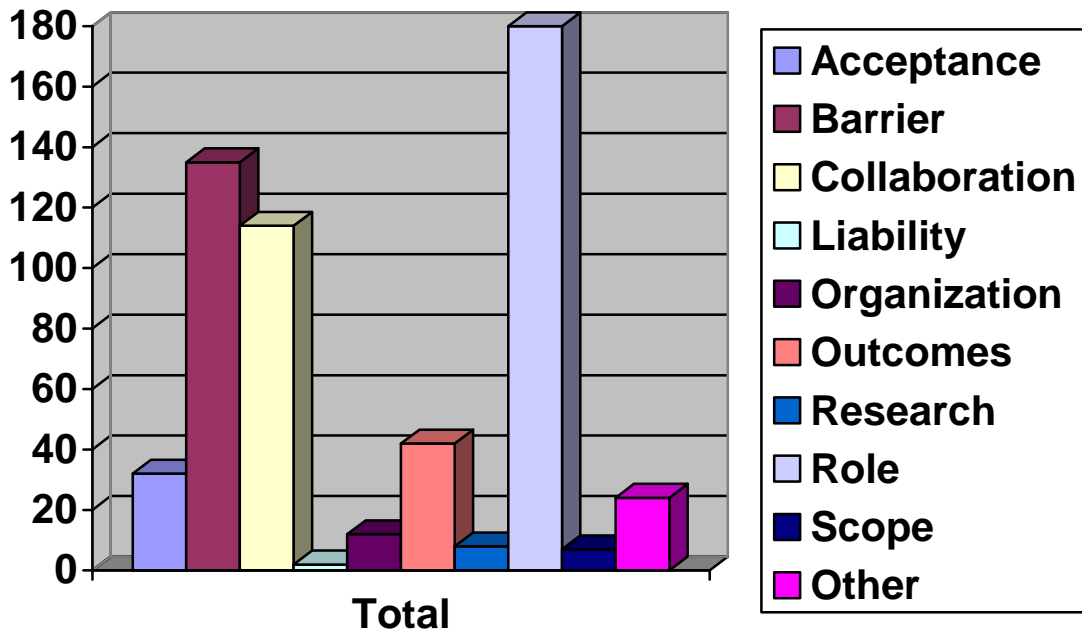
NWT	NU	YK	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
4	0	0	7	2	9	8	12	1	5	11	3	0
Western Canada = 33						Eastern Canada = 30						

Figure 1 shows the major themes that emerged from the consultation. As illustrated in the table, the most frequent areas of discussion or issues raised by participants were, in descending order:

- *Role* – identification or description of the NP practice and, to a lesser degree, the roles of other professionals working with NPs;
- *Barriers* to NP practice and to the implementation of NPs in the practice setting;

- *Collaboration* between NPs and other health professionals;
- *Outcomes* from working with or receiving care from an NP;
- *Acceptance* of NPs by other professionals and the public;
- *Organization* – related issues such as structural and system supports;
- *Liability* – issues related to working with NPs;
- *Research* to evaluate and facilitate sustainability of the NP role; and
- *Scope* of practice challenges.

The remaining feedback represents a wide variety of themes such as *Certification / Credentials, Mentorship, and Core Competencies* of NPs.



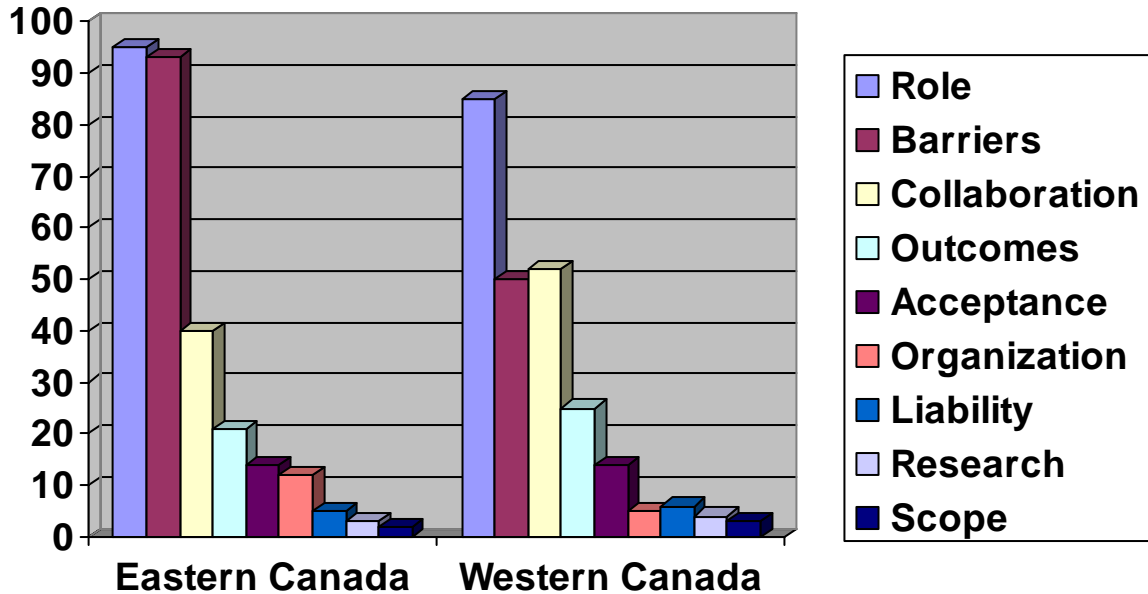
**Figure 1 – Total Major Consultation Themes**

Table 2 illustrates the data grouped by theme as identified in each jurisdiction where interviews were conducted. To help identify trends, Figure 2 shows data grouped by the nine major themes by geographical regions, i.e., western and eastern Canada. These geographical regions are distinguished in Table 1.

**Table 2 – Themes by Jurisdiction**

<b>Themes</b>	<b>NWT</b>	<b>BC</b>	<b>AB</b>	<b>SK</b>	<b>MB</b>	<b>ON</b>	<b>QC</b>	<b>NB</b>	<b>PEI</b>	<b>NS</b>	<b>Tot.</b>	<b>Percent</b>
Role	3	18	4	37	23	7	40	1	7	40	180	32.0%
Barrier	5	10	6	18	11	20	5	7	4	57	143	25.0%
Collaboration	5	29		7	11	22	15	2	3	20	114	20.0%
Outcomes		10		3	10	2		1	3	17	46	8.0%
Acceptance		4		10			2		1	11	28	5.0%
Organization		1		2	2	8				4	17	3.0%
Liability	1	1		4		2				3	11	2.0%
Research		4				3					7	1.0%
Scope		2		2	1	1				1	7	1.0%
Mentor		1			2	1					4	0.7%
Certification/ Credential		1								2	3	0.5%
Core Competency		2				1					3	0.5%
Technology				1		1					2	0.3%
Union			1							1	2	0.3%
Funding					1						1	0.2%
Student				1							1	0.2%
<b>Totals</b>	<b>14</b>	<b>83</b>	<b>11</b>	<b>85</b>	<b>61</b>	<b>68</b>	<b>62</b>	<b>11</b>	<b>18</b>	<b>156</b>	<b>569</b>	<b>100.0%</b>

As noted in Figure 2, with the exception of *Barriers*, jurisdictions are remarkably similar regarding the total number of comments made coded under the various main themes.



**Figure 2 – Nine Major Themes by Geographical Region**

Participants provided the most comments about *Role* in both eastern and western Canada, 95 and 85 comments respectively, for a total of 180 or 32% of all comments. Data collected and coded under this theme was focused on NPs, for example, what they do, who they work with, how they work, issues impacting role implementation, and others aspects of their role. This was common across the country. In reviewing the data, participants in western Canada provided a greater number of comments about roles of other health professionals than participants from eastern Canada. For example, a number of the comments from western Canada related to emerging roles such as physician assistants (PA) and changing roles such as pharmacists, the impact of these roles on the NP role, and an explanation of these roles. These comments were provided primarily by groups representing the interests of these other health professional groups. In eastern Canada, while other roles such as pharmacists and paramedics were discussed, the numbers of comments were few, and no comments were made about PAs. This is probably explained in part by the fact that few if any PAs are practising in eastern Canada, outside of the military, as compared to western Canada.

*Barriers*, the second most common theme (143 or 25% of comments coded), appear to be more heavily weighted or of greater concern in eastern Canada (e.g., 93 comments combined from Ontario and east) than western Canada (e.g., 50 comments combined from Manitoba and west). This finding is of interest because as Table 1

indicates, approximately the same numbers of participants were interviewed from eastern and western Canada.

The third most common theme that emerged from the consultation was *Collaboration* (114 comments or 20% of total comments coded) with eastern provinces providing slightly more comments than western participants, i.e., 62 and 52, respectively. Comments associated with this theme focused primarily on collaboration between NPs and physicians and included what is meant by collaboration, examples of positive collaboration, and issues associated with collaboration. A breakdown of the sub-themes linked with these three key themes is identified later in this section and further discussion of the importance of these themes is found in Section 4.0, Analysis.

Table 3 shows the major themes identified in the consultation linked with participant grouping or type<sup>3</sup>. For example, a total of 16 comments were made by physicians about *Outcomes* related to NP practice, compared to 12 by NPs, and eight by multidisciplinary teams. Given that more NPs were interviewed it is not surprising to see that the total number of comments by this group is higher than all other groups for a total of 226 or 40%.

A total of 142 or 63% of the NP consultation data collected was related to *Barriers* and *Roles*, compared to 111 or 47% for all other groups. As noted in Table 2, 57% of all participants provided comment on or identified issues related to these two themes.

**Table 3 – Major Themes by Participant Grouping**

Themes	NPs	Physicians	Team	Employer	Gov't	Prof. Org.	Other groups
Acceptance	18	1	2	7	0	1	2
Barrier	63	13	2	13	2	19	10
Collaboration	34	16	6	13	2	11	6
Liability	3	0	0	3	1	3	2
Organization	6	1	1	2	0	0	0
Outcomes	12	16	8	2	0	1	0
Research	0	0	0	0	0	1	7
Role	79	14	2	18	1	12	5
Other	11	4	0	2	0	4	2
<b>Total</b>	<b>226</b>	<b>65</b>	<b>21</b>	<b>60</b>	<b>6</b>	<b>51</b>	<b>34</b>

Table 4 breaks down NP data by jurisdiction in an effort to identify similarities and differences where possible. In the east, most feedback was provided about *Barriers* (42) followed closely by *Role* (36) and *Collaboration* (22). Similar trends are noted in western Canada for NPs with the most prevalent themes in descending order as *Role* (43),

<sup>3</sup> Data from QC is not included in this table. A diverse group of approximately 30 stakeholders participated in round table discussions in QC. Data was not recorded in affiliation with the organization / interest represented by the participant.

*Barriers* (21), and *Collaboration* (12). These trends for NPs are consistent with the east and west numbers and trends for all participant groups (Table 3).

**Table 4 – Major Themes by NPs by Jurisdiction**

Themes	BC	SK	MB	WEST Total	ON	NB	NS	PEI	EAST Total
Acceptance		2	6	8	1		9		10
Barrier	2	9	10	21		4	35	3	42
Collaboration	4	2	6	12	3		17	2	22
Liability		1		1		2			2
Organization		1	2	3			3		3
Outcomes	1	2	4	7		1	4		5
Research		0	0	0	0	0	0		0
Role	3	24	16	43	1	1	31	3	36
Other		3	3	6			3	2	5
<b>No. of NPs</b>	<b>1</b>	<b>7</b>	<b>4</b>	<b>12</b>	<b>1</b>	<b>1</b>	<b>7</b>	<b>1</b>	<b>10</b>

To help facilitate understanding of the three key themes that emerged from this initial consultation, sub-themes or further grouping of similar comments were identified for two of the themes– roles and barriers – during the data-entry process. Sub-themes were not identified for the *Collaboration* theme because the vast majority of the 114 comments coded under the theme were related to NP and physician collaboration. The data collected regarding collaboration with other health professionals and administrative staff did not indicate a significant trend. Table 5 shows sub-themes of *Roles* and Table 6 lists sub-themes associated with *Barriers* that were identified by participants. Sub-themes of *Roles* included GP, NP, Scope and other roles (e.g., PAs, pharmacists and paramedics). Comments about the NP role by far exceeded comments related to the other groups.

**Table 5 – Sub-themes of Roles**

Sub-Theme	Totals
General Practitioner	4
Nurse Practitioner	143
Physician Assistant	9
Pharmacists	2
Scope	16
Other	6
<b>Total</b>	<b>180</b>

Sub-themes of *Barriers* are listed in association with participant group. Sub-themes in descending order of popularity were boundaries (50 or 39%), HHR / organizational barriers (21 or 17%), funding and regulation / legislative issues (17 or 13% for each), role (11 or 9%), scope (4 or 3%), and other (8 or 6%). Barriers related to

boundaries were listed more frequently by NPs and other groups (48 or 38%). Physicians listed overall only a small number of barriers (10 or 8% of total sub-themes) related to funding, boundaries, regulation / legislation and role.

**Table 6 – Sub-themes of Barriers by Participant Group**

<b>Barrier</b>	<b>Total</b>	<b>NPs</b>	<b>Physicians</b>	<b>Other<sup>1</sup></b>
Boundaries	50	28	2	20
HHR / Organizational	21	13	3	6
Funding	17	7	3	7
Reg. / Leg.	17	7	2	8
Scope	4	1	1	2
Role	11	5	2	4
Other <sup>2</sup>	8	3	0	5

Other<sup>1</sup> = professional organization, government, and employers.

Other<sup>2</sup> = not coded

## 4.0 Analysis

The findings of the initial practice consultation identified nine main themes that emerged from the data collected. These themes, in descending order of frequency are as follows.

- *Role*
- *Barriers*
- *Collaboration*
- *Outcomes*
- *Acceptance*
- *Organization*
- *Liability*
- *Research*
- *Scope*

Each of these themes is discussed in more detail to identify implications for NP practice, including where appropriate the impact – both opportunities and challenges – on collaborative working relationships, role, and scope of practice. Particular emphasis is placed on the three themes, *Roles*, *Barriers*, and *Collaboration*, which received remarkably more comment or discussion from participants than all other themes combined. It was noted in the findings that participants from both eastern and western Canada weighted these themes similarly given that both groups provided more comments related to these areas than other themes. Further, NPs as compared to other groups of participants appear to weight these three themes more highly.

While comments were grouped under one theme during the data entry process, there is some overlap among themes based on how the data was coded. For example,



descriptions of roles often included barriers to full implementation of the role, yet barriers are also a separate theme. As a result, themes were combined as appropriate to facilitate discussion and analysis of the data collected. For example “roles / scope / research” themes are grouped, “barriers / liability / organizational issues” that were identified as barriers are combined, “collaboration / organization” themes related to collaboration are grouped, and finally “acceptance / outcomes” themes are grouped.

#### **4.1 Role, Scope and Research Themes**

As noted previously *Role* was by far the most common area or theme discussed across the country. This is interesting because role clarity, such as clearly articulating the role and consistency in terminology, is identified in the literature as key to the successful integration of NPs into the health care system. Yet there still remains confusion among nurses, other health professionals, public, government and others about the NP role and its purpose. This theme was consistently noted in all jurisdictions, as one participant stated:

*“Uncertainty currently exists ...as a result, what NPs are going to do must be clearly defined. The need for transparency is crucial.”*

This ongoing need for role clarity perhaps contributed to the fact that the majority of data collected from the consultation was about roles and that NPs in particular provided the most data about their role. The latter may have occurred because NPs are in the best position to describe what they do from a practical perspective, and because NPs recognize the importance of role clarity in facilitating sustainability of their role over time.

The description of the NP role gathered from the consultation data, while not all-inclusive, was consistent with descriptions of the NP role as identified by professional regulatory bodies in Canada. Participants generally described their practice as autonomous, but working in collaboration. They used words like “generalists” to describe themselves and terms like “family practice,” “all types of patients,” “all ages/ all stages,” “birth to geriatric” to describe their patient populations. In some cases, NPs appeared to be more specialized and focused on specific health issues or populations such as mental health, well woman, or diabetes. Given the NP role has only been recently introduced in a number of jurisdictions (e.g., Manitoba, Saskatchewan and the Northwest Territories), many practitioners referred to their practice as evolving. For example, practice may have begun with treating minor conditions such as coughs and colds, and expanded over time to managing chronic diseases and diagnosing hypertension with initiation of medication. In addition, one NP described her practice as follows:

*“We spend 80% of our time in clinical and 20% off service – everything from teaching / research/ administrative tasks.”*

While many other NPs spoke about their role as educator, i.e., patient teaching and health promotion related activities, this quote is the only reference to the research component of the NP role. The CNA (2003) considers NPs to be advanced nurse practitioners (ANPs), and as ANPs they should be engaging in research activities as part of their role. It cannot be concluded that this is the only NP participant in this consultation who engages in research, but it is interesting that it is the only reference to NPs engaging in research as part of their practice role. Therefore, it raises the question as to whether NPs are engaging in research, and if not, why not?

Physician participants working with NPs articulated the NP role as including “acute / episodic care” and “problem patients, routine screening and walk-ins, mental health.” Physicians expressed an appreciation for the NP role in terms of reducing their workload and allowing the physician more time to treat more complex patients, as well as add-on benefits such as patient education. One physician also acknowledged that the workload and responsibility for the NP can be overwhelming.

In some cases, participants distinguished between the NP role and the role of other nurses. This is an important distinction, as it facilitates NP role clarity, helps inform the public, other health professionals and policy-makers about the role, and enables the appropriate integration of NPs into the health care system where they can practise to full scope in conjunction with other health professionals. Examples provided by participants of the differences between the RN and NP are captured in the following statements.

- *“...more comprehensive role, more developed in terms of all clients, current health problems including prevention, patient education, diagnosis, prescription and treatment.”*
- *RNs work from “protocols and delegated medical function whereas the NP will be an independent, autonomous practitioner.”*
- *“NPs exercise more advanced clinical judgment without necessarily performing the more advanced medical procedures and is accountable for her actions...can guide the patient and tell him to come back if necessary (not to go directly to the physician).”*

Although the focus of this project and consultation was specifically related to NP practice models, by virtue of the range of stakeholders who participated in the consultation, information about other roles who either work directly with NPs or who may provide overlapping health services was also shared. The majority of information provided pertained to role description, for example, “physician assistants (PAs) do everything that a physician does,” PA “entry level abilities are generic – so everyone is clear,” and “pharmacist provides direct supervision and delegation to the pharmacy technician.” While this information does not directly impact NPs, it is important to have an appreciation of new and evolving roles particularly because PA certification programs, for example, have been recently accredited by the Canadian Medical Association (CMA), and provinces such as Manitoba have legislation which gives PAs the authority to practise outside of the military setting under the supervision of physicians.

Throughout the consultation process, a number of challenges were identified by participants regarding the NP role including physician replacement issues, rural versus urban issues, and inconsistency in terminology. Participants also suggested ways to enhance NP role implementation. The NP role was initially implemented in Canada in response to physician shortages in the 1970s; this contributed to the creation of a physician-replacement stigma for the NP role. Unfortunately, as a result of this stigma, the nursing aspect of the NP role was undervalued, and when physician supply and demand issues were addressed in the early 1980s, the NP role was no longer supported. The consultation data indicates that to some extent this concept of the NP being a physician-replacement rather than an advanced practice nurse still exists as acknowledgement of the role as nursing is not always evident based on the following participant statements.

- *“...the day we have the benefit of seven practising regular physicians, she [NP] will no longer have a reason to be there.”*
- *“...as the house staff increased, the NP role decreased and there was a turf war.”*
- *“...we are totally consumed in our clinics – physician replacement role, yet our administrators want us to get into health promotion more – we do health promotion during [clinic] visit, yet not recognized as such.”*
- *“Doctors see NPs as physician replacement or in handmaiden assistant role to physician. This is often a response to HR issue of not enough doctors.”*

However, as one NP participant stated, “Initially [NP] saw patients by default – the patient couldn’t see the physician, but could see the NP right away. After [the] initial visit the patients often rebook with the NP.” Although the NP in this case was introduced as a physician replacement, patients liked what they were receiving as confirmed by their choice of practitioner on subsequent visits. To gain a better understanding of the unique role NPs play more research is needed to determine effectiveness of NP practice models and outcomes, as suggested by some participants. This type of research is particularly important to inform policy-makers, some of whom still perceive NPs as physician replacements, as they make funding decisions regarding the appropriate mix of health care providers rather than simply eliminating NP positions when there is a greater supply of physicians.

Other participants in both eastern and western Canada identified rural versus urban issues and inconsistent terminology as impacting on the NP role. The role of the NP is considered to be much broader in the north; because of physician shortages and urgent need for health care, NPs can provide more health services independently whereas the NP in the urban area is far more limited in his or her role and works under tighter protocols. It appears the scope of the role regardless of authority can be impacted simply by location of practice. Other factors impacting practice include legislative/ regulatory barriers, and agreement between NP and MD regarding their respective roles in the health care team. These factors were identified as “limitations” by NPs, and ranged from “lost skills...no suturing” permitted in a specific practice setting, to “prescription authority is holding us back from practising at full scope” to “doctors are very limiting of the NP scope and this comes from the whole issue of turf.” Inconsistent terminology such as

“diagnosis versus assessment” and the variety of titles that are used to describe NPs also create confusion.

Although participants identified these issues as challenges to the implementation of the NP role, facilitators were also identified, under two sub-themes titled “public and professional understanding of the role” and “NP competencies / skills and knowledge.” Participants identified the importance of a better understanding of the NP role among professionals and the public so that they are more knowledgeable about the service NPs provide; in this way expectations can be realistic and achievable. In addition, a physician participant suggested that having good judgment on the complexity of what is happening and insight into one’s own competency is key to successful role implementation. These issues and suggestions will be discussed in more detail later in this section.

## **4.2 *Barriers, Liability, and Organizational Issues / Themes***

As noted previously in this report, stakeholders from across Canada representing a variety of groups recognized numerous barriers to NP practice. In fact, barriers were the second most common theme to emerge from the consultation data. While some challenges were identified in the previous section, specifically related to the NP role, this section focuses on barriers related to boundaries and liability, funding, organizational and structural supports and legislative and regulatory barriers. The reader may note some overlap with the previous discussion, particularly in relation to boundaries.

### **4.2.1 *Boundary Barriers***

Barriers associated with boundaries were related to physicians and other health professionals including other nurses. Barriers associated with physicians centred on “trust” and “value” of both NPs and physicians, and the perception that NPs were “a replacement” “rather than complementary role” to physician practice. NPs from more than one jurisdiction spoke about the stress related to “having your word and expertise believed and taken for value.” Some participants identified tensions with physicians because “they did not understand the role of the NP,” while others stated that physicians felt “threatened” and the NPs were “not acknowledged.” Encroachment on traditional physician scope of practice and acceptance of NP authority to diagnose and prescribe seem to underpin the boundary issues affecting these two groups.

Concepts of “political / personal / turf issues” were consistently identified by multiple stakeholders across the country and were not isolated to physician / NP boundary issues. For example, a variety of stakeholders, including professional associations, government, and practitioners in several jurisdictions (inclusive of those with established and new legislation) specified boundary issues pertaining to NP prescriptive authority and acceptance by pharmacists of that authority. In addition, resistance to the role by other health professionals, usually because it was perceived as a threat to traditional nursing roles, or because the expanded / extended aspects of the NP

role were misunderstood, was cited by participants as creating boundary barriers to practice.

While not prevalent in the practice consultation, a *Liability* theme emerged based on stakeholder comments about liability related in particular to physicians and pharmacists. Stakeholders either stated that liability was a concern or just the opposite. Liability concerns, aside from the NP having adequate liability protection, may be assuaged in part by other health professionals having a better understanding of the NP role and legal authority. If physicians and pharmacists perceive themselves as being accountable for “policing prescriptions” or monitoring NP practice, liability issues will continue to create friction between these providers and ultimately limit the NPs scope of practice. NPs experience these practices as a lack of trust in their professional knowledge, skill and ability. Further it shows a misunderstanding of what NP self-regulation means in Canada.

These boundary barriers are real in many practice settings, to a greater or lesser degree, and ultimately impact health outcomes as they prevent NPs from practising to their full scope and from providing the comprehensive care they are capable of giving to their clients. Participants in eastern Canada indicated that these boundary issues were perpetuated, in part, by the attitudes of the public (the “community is protective of the doctors”) and employers (“the messages we get from our administrators are why would we change things, the doctors are happy”). Although there are numerous boundary issues that need to be addressed, one participant provided the following insight into the issue and incentive to explore these issues further.

*“The nurse practitioner is from nursing and will always remain in nursing. The other professionals do not have to feel their professional integrity is being threatened. NPs themselves also wonder a lot about the role of the family doctor. It has changed considerably over the years. What is his exact role today? It is understandable that it scares him to lose what remains; he has experienced major changes. Young physicians must be trained in the opportunities opened up by NPs because everyone is needed.”*

#### **4.2.2 Health Human Resource / Organizational Issues**

Health human resource (HHR) issues are discussed in detail in the HHR consultation report. However, it is important to acknowledge the HHR barriers and organizational issues that arose from the practice consultation. Recruitment and retention of the most suitable NP for a specific position was flagged as an issue. One participant suggested that, with unionization, the most senior NP gets the position even if not best suited. Organizational barriers were varied, but were identified across the country and ranged from inconsistency as to “who is the collaborating doctor,” “call issues,” “lack of house keeping and support staff,” and limited supplies such as “no telephone or cell phone for the first five months” in practice or “no BP (blood pressure) cuff for ten months for doing house calls.” Having the necessary organizational and structural supports in place is crucial to successful role implementation and demonstrates that the

NP role is valued. Barriers that impede or prevent NPs from being able to fully implement their role can lead to attrition and potential future difficulties with recruitment to a particular practice setting if organizational issues are not addressed. Further discussion of organizational issues in relation to collaboration is addressed later in this report.

### 4.2.3 Funding Barriers

Funding barriers, in particular the physician fee-for-service (FFS) model was seen by stakeholders across the country as being incongruent with the way NPs who are primarily salaried practice. One NP described a “quantity versus quality” dilemma, in that she felt her main stress was lack of time with patients because the FFS practice environment in which she worked focused solely on the number of patients seen. This approach is inconsistent with the way NPs practise and has created conflict in other ways. For example, several participants, including physicians, indicated that NP practice interferes with physician remuneration. One physician stated that “NPs are a threat to income in the FFS environment.” Further, as one NP stated, “How do physicians get paid when the NP sees the patients?” Another participant raised the issue of double billing.

Stakeholders also raised concerns about lack of remuneration for consultation time with NPs, physicians being too busy to consult, and / or a patient having to wait long periods of time before the physician is available to review the case with the NP. Other related funding issues impacting practice are lack of or limited specialist referral fees, and no third-party payments for NP services such as prescriptions.

### 4.2.4 Legislative and Regulatory Barriers

Legislative and regulatory barriers were also identified by participants from across Canada. These barriers have significant impact on the implementation of the NP role and ability of NPs to work to their full scope of practice. Prescriptive authority barriers related to drugs, treatments, and therapeutic substances were prevalent across the country and were identified by many different participants including employers, professional organizations, physicians and nurse practitioners. Federal and provincial legislation / regulation and policy has not kept pace with NP practice and have created barriers or restrictions on scope of practice, client access to health services, and in some situations health and safety issues for NP clients as evidenced by the following statements from employers and professional organizations in three different provinces.

- *“...major barrier to their practice is the Federal Act for Controlled Drug and Substances. They can intubate a neonate, they can place a chest tube, but they can’t order the narcotics that are needed to do these procedures in a responsible manner...”*
- *“...a big issue for the NP is script writing. Does the patient meet the eligibility? i.e., the NP might write a script for home oxygen therapy or anti-embolic*

*stockings, but the home oxygen program does not accept the script from an NP, or the drug store for medical supplies...the federal narcotics act holds back NP practice, the NP can't prescribe a Tylenol #3 because of the codeine content...practice is ahead of the regulations in many such instances...*”

- *“...homeless care – NPs can't sign for welfare for provincial disability support forms – can only be signed by a doctor or counselor. Also vaccines – NPs can't do them, but many of the homeless/street people don't have physicians and are cared for by NPs.”*
- *“...drug and lab tests – has been compromised since the start up because we had lists of meds/tests that we could order. They need constant changing and adding.”*

While some of the issues identified above may be unique to some jurisdictions, such as the need to constantly revise outdated laboratory and drug lists, valuable lessons have been learned and continue to be learned from these experiences to facilitate new ways of regulating NP practice. This is particularly important with respect to prescriptive authority related to narcotics, as the federal government is currently considering granting this authority to NPs through amendments to the Narcotic Control Regulation under the *Controlled Drugs and Substances Act*.

Participants in other jurisdictions identified barriers to practice resulting from statutory committee authority as defined by legislation. For example, several practitioners including NPs and physicians described their frustration with the statutory committee that determines NP prescriptive authority. Participants stated that the committee “is seen as a block to their practice.” For example an NP and physician stated, respectively:

- *“I can't follow with chronic disease management if I can't prescribe the necessary medications. This is a big difference from my practice in [other province]. The role can't be optimized here – especially for chronic disease management– if the committee won't approve the necessary drugs for that care. This is a real barrier to my practice.”*
- *“I am not willing to wait for the committee to approve of medications lists etc. I will find ways around the committee to make it work between my NP and me.”*

Several participants from this jurisdiction identified pharmacists working in the community as a barrier to their practice because NP prescriptions are constantly questioned or “policed”. This is an interesting practice because pharmacists are members of the statutory committee which determines prescriptive authority of the NP. In addition, pharmacists during the consultation in more than one jurisdiction expressed concern about “needing to police NP prescriptions.” As self-regulating professionals NPs are accountable for their practice and for ensuring they prescribe appropriately within their scope of practice. There appears to be a misperception among some pharmacists that their own accountability is heightened when filling prescriptions written by NPs as demonstrated by the more intensive monitoring or “policing” of these prescriptions as compared to the degree of monitoring of prescriptions written by other self-regulating health professionals with a longer history of prescribing.

Other legislative / regulatory / and policy barriers identified by a variety of stakeholders included:

- willingness of specialists to accept NP referrals (funding issue as noted previously);
- private insurance not paying for prescriptions written by NPs;
- provincial drug programs inconsistent with NP prescriptive authority;
- no authority to sign passport applications; and
- “Biggest barriers are limitations to my scope of practice as NPs are not currently regulated in my province.”

The barriers described in this section impinge on the NP scope of practice, limit client access and place them at risk, and can “affect the NP’s self-esteem negatively” resulting in NPs leaving the profession as evidenced by this statement from a regulatory body.

*“Many of the nurses that were NPs have lapsed their NP licensure because of inability to work in the role.”*

### **4.3 Collaboration / Organization Themes**

Collaboration was the third most common theme identified in the consultation and was seen overall as essential by most participants. Participants described their collaborators (e.g., support staff, social worker, psychologist, physician, etc.) and what they collaborate on (e.g., reviewing a case with physician who then prescribes or orders diagnostic tests outside of NP scope). Challenges, as discussed at the end of this section, and tips for successful collaboration were also identified.

A number of tips or suggestions to support and enable a positive collaborative working relationship were shared. Remarkable congruence was found among the comments from the various participants who provided information, including physicians, NPs, government staff, and employers from across the country. Strategies to support and enhance the working relationship ranged from how work is organized such as conducting “group rounds in the morning”, and having “consults as required”, to having a shared vision and similar goals, and being flexible and compatible. Some participants recommended writing out roles and identify preferences, i.e., “what we like to do”. Identification of “complementary skill sets and roles for the team” was also raised.

Mutual respect and trust among the collaborative practice team members was identified as the “foundation of good collaborative practice”, and being “collegial and truthful” was identified as essential for success. A trusting and respectful relationship is critical to success as noted earlier in the roles section of this report; without it the negative impact on collaborative relationship can be detrimental to the NP practice. This is of particular importance in those jurisdictions where formal collaboration is a legal requirement for NP practice. If collaborating partners in these formal agreements no longer wish to be part of the relationship, the NP is placed in a difficult position.



Additionally, if the collaborating physician is not available to consult, as many NPs have recounted, accountability mechanisms need to be in place to address these situations. For example, one NP stated:

*“... there should always be an evaluation of both the NP and the physician; otherwise the physicians are not accountable.”*

## **4.4 Acceptance and Outcome Themes**

Despite the barriers to practice and issues with collaborative relationships that NPs and others identified during the consultation, numerous positive comments were made about NPs and about the contributions they make to client health and the health care system. Comments gathered were grouped under two themes *Acceptance* and *Outcomes*. Acceptance included data that reflected acceptance of the NP role by other health professionals and by the public. Outcomes were categorized as either professional or public outcomes. A discussion of the information collected in association with these themes is included in this section.

### **4.4.1 Acceptance by Other Health Professionals**

Acceptance by other health professionals, particularly physicians, was described by some NPs as initially one of skepticism or uncertainty and by others as immediate acceptance, i.e., “all of the doctors wanted an NP.” Some participants described their working relationships with the team as being in the early stages, but see the acceptance by other team members so far as the “biggest achievement” to date. Participants also identified certain factors which facilitated this acceptance which included having a supportive administrator, and being “treated as a professional – with respect.” Others raised specific physician-related factors in acceptance.

- *“The doctors requested the NP – the NP wasn’t forced on them.”*
- *“They [the doctors] all interviewed the NP.”*
- *“Physicians need comfort with the education of NPs.”*
- *“The doctors in my area were asked – do you want an NP or a PA so they knew the difference and they were thoughtful in their choice.”*
- *“Buy-in by the doctors is key.”*

Finally, one participant shared their experience as follows:

*“[I] am experiencing the physician-NP collaboration and love it. Misconception is slowing everything down. Let’s work together to see how it could be accomplished. More information is needed, actual experience will win out. A special approach has to be developed that will make the physician, who was a skeptic, try this experience and then love it. It is not just at the technical or theoretical level.”*

#### 4.4.2 Acceptance by the Public

A variety of participants, including practitioners and employers, identified a growing public acceptance of the NP role. While the majority of participants who provided this feedback were NPs, perspectives were similar across Canada. Public acceptance appears to have resembled the perception of other health professionals towards NPs, that is, ranging from initial uncertainty and not being sure what to expect from an NP to the community wanting an NP and being clear in their expectations. The NP role is clearly becoming more widely accepted by the public as evidenced by statements such as these.

- *“Understanding of the NP role in the community is improving, the military members are generally very accepting of NP. Once members have been treated by NP they do not want to change. Word-of-mouth has been good.”*
- *We have a very active seniors’ council ... they are very pro-NP / receptive to the concept.”*
- *The philosophy of the students’ health centre is that the people attending the clinic have a choice of provider and many choose to see the NP.”*
- *The patients were very accepting and grateful for the added dimension to their care, mostly positive.”*

Increased exposure to the NP role and statements that were made to the community about “how important it is for the MD to have help” have also aided public acceptance. As one NP stated, this type of messaging is very positive and reassures clients: “...they realize that the MD doesn't need to do everything, that the NP is competent and that they do make a good team.” In addition, as noted earlier many NPs focus on women’s health issues / physicals and this too was identified as a driver for public acceptance by female clients feeling “less intimidated by the NP.” Another NP talked about public acceptance or response to her role:

*“Well, some people consider me a nurse and don't get the expanded scope[idea], I can sense if they are uncomfortable, older people like to see the doctor, younger patients call me doctor.”*

This statement validates the importance of continued public education at the individual level, but also suggests the need for broader educational initiatives at the community, provincial, and national level.

#### 4.4.3 Outcomes (Professional and Public)

The outcomes identified either directly impacted the team / relationship or the public in some way. Physicians and NPs, representing most jurisdictions in Canada identified the most outcomes.

Physicians consistently identified outcomes that had personal benefits such as a reduction in workload, having more time to spend with their patients and an improvement

in their own quality of life. Physicians also commented that their expectations about the NP had been met. Additionally, physicians identified benefits to their patients.

- “...increased quality of care”
- “...thoroughness and teaching is good” and “patients become more empowered to care for themselves and their family”
- “... they [patients] find it easier to run ideas by the NP...patients have a higher comfort level”
- “...patients are happier”

Nurse practitioners also cited many client benefits or outcomes resulting from the introduction of their role. For example, several NPs talked about their practice being different (from physicians) in that they provided “more rounded care for patients.” NPs were focused on “...more education / teaching time with patient, more time dedicated for health prevention/promotion.” Moreover, by co-ordinating care NPs have “improved patient health, [by] plugging into services.” Increased direct access to health care services was consistently identified by NPs as an outcome of their role. For example, one NP stated:

*“The NP role has increased access...already greater than 1,000 patient visits.”*

Other system-related outcomes identified by physicians in at least three jurisdictions were:

- having an NP “...reduced visits to the emergency department”; and
- “... simply having another care provider reduces errors”.

The latter perspective may perhaps be directly related to the reduction in workload that physicians referred to, and more opportunities to case conference. Another participant talked about increased telephone consultation / health questions being directed to NPs. This practice may contribute to reduced numbers of emergency room visits, and may also increase the likelihood of early intervention should it be required.

## **4.5 Other Themes**

Many other themes were also coded from the consultation data collected, although the amount of data was relatively small compared to other themes previously discussed (for a list of all themes, see Table 2, Section 3.0). Perhaps the most significant of the other themes identified are those related to *Mentorship*, *Certification / Credential*, and *Core Competency*. It was identified during the practice consultation that inconsistency or differences in NP credentials and educational preparation have contributed to issues related to role clarity, boundaries, and scope. For example, participants had identified uncertainty about the role as well as their own accountability in relation working with NPs. Problems with the lack of trust and respect as expressed by some NPs are linked to these issues. In an effort to partially address or describe their concerns, participants suggested addressing title inconsistency, examining core competencies for NPs, and

developing mentorship programs and certification programs. These approaches require further exploration to, in part, assuage discomfort of participants and increase interest or desire in working with NPs.

## 5.0 Conclusion

The purpose of this report is to provide an overview of the practice consultation data gathered by the Manager of Practice and Evaluation, CNPI during the late summer 2004 and early winter 2005 regarding NP practice and working relationships with physicians and other health-care professionals. A wide variety of stakeholders was interviewed from across the country. Nine main themes were identified from the consultation data with the most prevalent themes being, in descending order, roles, barriers, collaboration, and outcomes / acceptance.

The most predominant theme extracted from the consultation data was role with an emphasis on role clarity. There appeared to be general consensus among participants across the country about what the NP role is, and how it differs from the roles of other health professionals, and about the challenges and facilitators to successful role implementation. The description of the NP role was generally consistent with jurisdictional definitions of the NP, although it was noted that certain aspects of the role such as the research component were not commonly identified. Participants were able to distinguish between NP roles and other health professional roles and highlighted the importance of articulating the nursing component of the role. In addition, it was identified primarily by NPs that it is the nursing aspect of the role that differentiates NPs from physicians. Although the NP role historically was initiated in response to physician shortages, being able to distinguish today between the nursing aspect of the role and the expanded health services the NP can provide is important, particularly because the consultations indicated that the a perception of NPs as physician replacements was still held by some participants. If NPs are not acknowledged for the unique contribution they bring to the collaborative practice team, their value on the team will be diminished or the role could be eliminated, as it was in the past, if physician recruitment levels increase and if policy-makers do not value the NP role.

Numerous barriers to NP practice were identified by a wide variety of participants. Barriers were more commonly cited in eastern Canada as compared to western Canada, and NPs in general identified more barriers to their practice than any other group. Barriers were diverse and included issues related to boundaries such as between NPs and MDs and other health professionals, issues related to funding arising from primarily salaried NPs working in predominately fee-for-service practice environments, and legislative and regulatory barriers, to name only a few. Boundary issues were the most prevalent and focused on uncertainty about the NP role and related competencies, concerns about encroachment on traditional role / scope of practice of physicians, and a lack of acceptance of the expanded practice component of the NP role (e.g., diagnosing and prescribing of drugs). Many of these concerns have led to both NPs and MDs expressing concerns about feelings of trust, value and respect.

Collaboration was the third most common theme, with no real difference between western and eastern Canada regarding its importance. Information grouped under this theme ranged from descriptions of collaboration or collaborative practice (i.e., the who, what, when, why and how) to challenges to collaboration and to tips on how to enhance successful collaboration. Physician / NP collaboration dominated the information collected and, not surprisingly, the key challenges identified as affecting successful collaboration were trust and respect. Tips for successful collaboration were shared by both physicians and NPs and ranged from tangible organizational supports – such as determining how the work is shared, writing out roles, and identifying preferences – to having a shared vision / similar goals, and being flexible and compatible.

Outcomes and acceptance, respectively, were the fourth and fifth most common themes gathered from the consultation data. While issues remain about the acceptance of the NP role as confirmed by the issues identified under the barriers theme, many participants highlighted a growing acceptance of NPs by other health professionals and particularly by the public. The latter was demonstrated in some jurisdictions by increased client / patient access to health care which participants said was a direct result of the NP's introduction into the community. Physicians shared personal benefits that arose from the NP relationship such as decreased workload and more time with their patients. Participants also highlighted positive outcomes impacting clients / patients including an increased quality of life, and satisfaction with the care received from the NP. While there is increasing acceptance of the role and positive outcomes directly related to the practice of the NP, the need for more education with the public and other health professionals about the NP role at the micro-, meso-, and macro level is essential to increasing understanding of the role and addressing concerns that have been raised about the NP role.

Findings in this initial consultation report resemble findings of other recent reports and studies. For example, the questions used to collect the consultation data for this report were modeled on the recent IBM study on NP integration in Ontario (2003). Many of the findings of this initial consultation report echo the findings in that study. In the next phase of the practice consultation, data from this report and other reports / papers (environmental scans/ literature reviews) commissioned by the CNPI Practice and Evaluation portfolio will be merged and used as foundational and briefing material for upcoming consultations. New data collected will be categorized into themes and analyzed in an effort to validate existing themes and identify new themes that impact the sustainability of the NP role in Canada.

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## **7.0 Appendices**

### **7.1 Appendix A – Survey Tool / Interview Questions**

Dear Participant:

Thank you for your interest in participating in consultations for the Practice and Evaluation portfolio of the Canadian Nurse Practitioner Initiative (CNPI).

As you may know, the purpose of this Initiative is to identify steps to take to optimize the contribution of nurse practitioners in the implementation of them into the Canadian health care system.

There are five component parts of the CNPI:

- Legislations and Regulation;
- Practice and Evaluation;
- Health Human Resource Planning;
- Education; and
- Change Management, Social Marketing and Strategic Communications.

The following questions are developed with the understanding that NPs work in collaborative relationships – although they may have independent and autonomous roles within a collaborative relationship. It is important then to understand the working relationship of NPs with their collaborative partners – physicians, other members of the multidisciplinary team and the administrators that they report to. Specific questions for each of those groups follow.

It would be helpful if you could circulate those questions to those particular members prior to our meeting. You might also ask them that if they are not able to participate in our discussions could they still complete these questions and forward them to me ([rcalnan@cna-aiic.ca](mailto:rcalnan@cna-aiic.ca)). Like all projects, the more data received from the people working in the actual project area, the more likely the data will resonate and reflect the common practice across Canada. It is also hoped that common themes will emerge from the data that will provide the project managers with understanding of major areas to address in the report that will facilitate the implementation of NPs.

Thank you so much for your participation,

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Manager, Practice and Evaluation  
Canadian Nurse Practitioner Initiative  
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## **Questions for NPs and for Collaborative Partners working with NPs**

Group: \_\_\_\_\_ Attendees \_\_\_\_\_

Date: \_\_\_\_\_

### **NP Questions**

What are your main roles here?

- Do you work with all types of patients or do you have a focus on specific patient group(s)?
- What is the impact of focusing on a specific patient group? Practice at full scope?

How do the NP and Physician work together?

In terms of your role here, what has worked well and why?

- What aspects would you change and why?

How would you describe the functioning of the team?

- What contributes to the team working well?
- Not working well?
- Biggest stress points?
- Biggest achievements?

How is this practice different because the NP is here?

- What do you think are the benefits of having an NP here?

Have you introduced any new/innovative practices?

How have patients responded to seeing an NP?

- What feedback, if any, have you received from your patients?
- What are some of the hurdles that they have to overcome to use the services of a NP?

What is the nature of your interaction with the community?

- What is their reaction to having an NP?

What is the level of understanding about the role of the NP in the community?

Thinking back to why you originally decided to practise here, have your expectations been met?

Biggest barriers?



### **Questions for Physicians that work with NPs**

How do you and the NP organize your work?

How is the practice different because the NP is here – what has been the biggest impact of having an NP on you and on the practice?

In terms of the NP role here, what has worked well and why?

- What has not worked well and why?
- What aspects would you change and why?

What contributes to the team working?

- Not working?
- Biggest stress points?
- Biggest achievements

Thinking back to why you originally decided to practice with an NP, have your expectations been met?

What suggestions would you have for other physicians who are considering working with an NP?

### **Questions for other members of the Multidisciplinary team who work with NPs**

1. What is your role here?
2. Approximately how many hours do you work each week?
3. What is the extent of your interaction with the NP?
4. What has been the biggest impact on your practice/work since the NP?
  - a. What are the major benefits of working with an NP?
  - b. What are the major drawbacks of having the NP here?
5. Ideally, what would you do differently in relation to the NP?
6. How has the introduction of the NP influenced access to care?
7. How has the introduction of the NP influenced quality of care?
8. How has the introduction of the NP influenced quality of care?

**Questions for Administrators of CHC/FHN who have NPs on staff**

1. What are the challenges, accomplishments in relation to the NP role?
2. What made you decide to include an NP in this network of care?
3. What aspects would you change and why?
4. How is the NP paid?
5. Is there a need for more NPs here?
6. How has the NP benefited the community?
7. How is the practice organized?
8. How is the program organized?
9. What are the toughest issues to deal with?
10. What information do you need/use/report in relation to the NP in this practice?
11. What do you think should be changed?
12. What factors have facilitated the NP assuming this new role?
13. What barriers have impeded the NP assuming the new role as it was envisioned
14. How has the introduction of the NP influenced access to care?
15. How has the introduction of the NP influenced quality of care?
16. What innovations, if any, has the NP facilitated?
17. Can you provide examples of collaboration/coordination among the team members and the NP?