Canadian Nurse Practitioner Initiative

Nurse Practitioners
Your Partners in Health



Les infirmières et infirmiers praticiens
Des partenaires pour votre santé

Initiative canadienne sur les infirmières et infirmiers praticiens

APPENDIX C

Report on National Roundtable Consultations

June 2005

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Roundtable Consultations Overview

A key activity for the Canadian Nurse Practitioner Initiative (CNPI) is to consult a broad range of key stakeholder groups. An integral part of this consultation process was the seven Round Table Consultations (RTC) held in cities across Canada between April 19 and May 6, 2005. Participants were invited to discuss issues and opportunities outlined in a workbook (Appendix A) that was a summary of literature reviews and comments from an initial round of stakeholder consultations. The purpose of the RTCs was to obtain further input and direction from knowledgeable individuals to resolve issues and identify opportunities.

Participants were selected through a referral process to ensure balanced representation from national/provincial professional organizations, educators, nurse practitioners, physicians, other health professionals and government stakeholder groups.

RTCs were hosted in Edmonton, Alta., Vancouver, B.C., Winnipeg, Man., Toronto, Ont., Montreal, Que., St. John's, Nfld., and Fredericton, N.B.. Every Canadian province and territory was represented and a total of 182 participants were consulted (a list of participants is in Appendix B).

Working in groups of six to eight, participants were asked to review the material in each component section of the workbook and respond to specific questions included in that section. All five CNPI component areas were included in the work book.

- Legislative and Regulatory Framework
- Practice and Evaluation
- Health Human Resource Planning
- Education
- Change Management, Social Marketing and Strategic Communications

Following a background presentation on the Canadian Nurse Practitioner Initiative, the facilitator guided participants through the workbook. Comments, ideas and concerns were noted on flip charts and were used in turn to compile this report (Appendix C for summary chart of "As was said" notes). At every RTC there were at least three CNPI representatives circulating during the consultation.

As a side note, the Quebec RTC attracted a smaller group of participants compared to other cities. This can be attributed in part to the fact that an RTC had already been held in Quebec in January and that there were competing events scheduled for the same day.

Legislation and Regulation

In the first section of the workbook, participants were asked to identify the principles that they believe should underscore a pan-Canadian legislative and regulatory framework as well as the elements to be included in the framework. Because the scope of the legislation and regulation area is so large and because the component areas tend to overlap, some of these elements and issues will be revisited in other sections of this report.

Overall, participants agreed on many principles. There was general consensus that to protect the public broad national NP legislation should exist much the same as there is legislation now for registered nurses' practice. Based on this consensus, many participants felt that the legislation should be non-restrictive to allow for evolution of the profession. Legislation should also set minimum national quality standards. It was considered important to allow for mobility both between jurisdictions and domains of practice. (At one RTC, participants felt that this legislation would allow for mobility to the U.S.) Some participants felt that a strong partnership between provincial and territorial regulatory bodies was necessary to promote consistency in legislation and regulation. Participants mentioned that some existing legislation, such as the *Vital Statistics Act* and the *Public Health Act*, would have to be amended to recognize the role of the NP.

According to most participants, the following elements should be included in the national NP framework:

- Standardized protected title;
- Clear scope of practice (must be enabling and not just list tasks);
- Autonomy;
- Accountability (responsibility),
- Standard educational requirements; and
- National accreditation for entry to practice.

Many issues and concerns were raised during the legislation and regulation discussions.

Transition phase: One area of concern was related to practicing NPs who have no formal NP educational background. Legislation and/or regulations will need to handle this transition phase, possibly as some suggested, through a "grandfather" clause. There are different points of views on how the grandfather clause should be handled: some felt it was a question of getting the nurses who are practising in NP-like roles to sit and pass an exam, while others felt it was a question of those nurses taking the appropriate educational courses and then passing an exam. There was also much debate on the length of time required to implement a grandfather clause. Some felt the transition phase should be shorter rather than longer. There was mention of possible resentment on behalf of the NP community if this implementation phase was followed.

Continuing Education: Many felt that legislation and/or regulations should address a recertification process to ensure a high level of quality in the care provided to Canadians; however, there was little consensus on how often this recertification process should occur. More comments related to this issue are in the Education section of this report.

Collaborations: The issue of "mandatory or optional collaboration" with physicians and other professionals was brought up by a few groups. Some RTC participants felt mandatory collaboration was potentially an element to be considered in the legislation. Other participants, however, felt that mandatory collaboration should not be included in the framework at all. Not making collaboration mandatory, they felt, would allow relationships to be perceived as more professional.

Role Clarification – Specialized versus Primary: Some RTC participants discussed the need to differentiate between the role of a "Specialized NP" or "Primary Care NP". This could be attributed to the fact that there is legislation in some provinces that recognizes these differences in capabilities.

Funding: Sustainability of the profession was also mentioned in these discussions. The need for provincial/territorial support is necessary to achieve success.

Practice and Evaluation

The aim of the Practice and Evaluation section was to identify essential elements to include in the NP role definition and to identify any successful or unsuccessful practice models participants were aware of in the provinces or territories.

Many common elements of the NP role definition were suggested by participants. They felt strongly that the role of an NP was not to fill in for or replace physicians. The key to successful integration is to ensure NPs are seen as equal players in the delivery of health care services and that patients should see the professional that best meets their needs. Common elements for role definition include:

- Education (health promotion and prevention);
- Assessment;
- Diagnosis;
- Treatment;
- Multidisciplinary;
- Accountability;
- Advanced skills acquired from an accredited educational program; and
- Relevant practice and experience.

Other elements of the NP role that were cited in some RTCs, but not all, were research, leadership, mentorship, autonomy and collaboration. Some participants expressed the need to clearly define the terms accountability and autonomy and how they affect the NP role.

NP based in nursing: There was some disagreement among the groups of participants at one RTC about the emphasis that should be put on the RN component in the role definition. Some felt the RN role should be emphasized while others did not.

Practice models: The overall consensus was that successful practice models require an NP to be part of a team. It was stated that an interdisciplinary model that allows for collaboration and consultation was a key success factor. The model must allow for an NP to be involved in the decision-making within the team process and to be seen as an equal member of the team.

Many felt that a community health centre model was the strongest model for participation. A payment model in which providers are salaried or on contract and allows for some flexibility was suggested by most participants. Flexibility in the model would ideally incorporate non-clinical activities such as research, public education and continued education. Furthermore, some participants in one RTC said it would be critical for the NP to understand income generation for the practice.

The need for an evaluation of outcome measures in the practice model was also identified.

Fee-for-service: There was little support for a fee-for-service model, although two groups recognized that there might be some value in it. Many felt that the physician should not be the NP's employer, but as already mentioned, NPs and physicians should collaborate. Patients should be at the centre of any model.

Rural versus urban: The notes indicate that there needs to be some thought to rural versus urban models and how these could and should differ. It was suggested that review of cost effectiveness studies should be carried out.

NP Faculty: At one RTC, the clinical experience of NP faculty was discussed. While this may be outside the scope of the work being completed by the CNPI team, it was interesting to see this issue brought forward. The group wondered if faculty needs to be in active clinical practice to be credible.

Other: Participants in one RTC expressed their belief in the need to differentiate the professional roles of registered nurses, physicians and nurse practitioners clearly. They listed provision of protected provincial funding for NPs as an issue.

Health Human Resource Planning

In this section of the workbook, participants were asked to identify key factors to consider in determining the number of NPs needed across Canada, as part of health human resource (HHR) planning. They were also asked for principles to be applied to funding models that would best support the sustainability of NP positions within interdisciplinary teams.

Participants immediately identified the need for a clear definition of the NP role in order to help determine the planning factors. Moreover, because NPs will be working in teams, participants expressed the need to look at NP human resource needs in coordination with other health care professional human resource needs. This idea builds on other comments such as ensuring that NPs are not physician replacements and that Canadians should be able to see the right health care

professional when needed. Governments were urged to invest in health human resource planning as a whole.

Several common factors in determining the number of NPs needed were identified:

- Wait times;
- Access to care;
- Current and future population demands;
- Funding models;
- Workload; and
- NPs' development (research and continuing education)

Rural versus urban: In two eastern RTCs, participants mentioned the need to consider NPs who work in isolation in rural environments and what human resource support might be provided to them.

Other: At another RTC it was suggested that HHR planning should include ratios of NPs to patients. For example, 1,000 patients to each NP (in a team), was one suggestion, or that every Canadian should be located within 30 minutes of primary care provider.

At another RTC it was suggested that health human resource planners should look at U.S. statistics for trends in NP planning.

Principles to apply to funding models:

The participants' responses illustrated the fact that many different perspectives exist regarding funding. Overall, the idea of working in a team was very much at the forefront of most funding discussions. Most RTCs did not think there was a "one size fits all" model.

Nonetheless, there were three recurring elements in the funding model discussion:

- Salaried and/or contract (but NPs should not be funded under a fee-for-service model);
- Incentive/benefit pay for isolation; and
- Compensation should be provided for continuing education.

NP Accountability: Participants in three RTCs identified the need for NPs to provide value for investment and accountability. They suggested a tool to evaluate outcomes and value-added activities would be helpful.

Unionized: One interesting contrast was that at two RTCs, participants felt that the NP position should not be unionized while in another RTC, people felt NPs should be unionized.

Financial support and funding: Participants in one RTC suggested that compensation for support staff and RNs should be in place. Participants in two RTCs suggested there should be incentives for physicians who collaborate and consult with NPs.

At another RTC, participants felt that NPs should not be employed by physicians As autonomous professionals, NPs should retain control over their own practice.

Education

Participants working on this section addressed the principles and characteristics that they thought would be fundamental to a pan-Canadian NP education. Participants also addressed the issue of standardized exit credentials.

Once again there were many common elements in the core principles that were identified as part of a pan-Canadian NP educational framework. These principles included:

- Interprofessional education;
- Use of varied distance delivery methods that were sensitive to the needs of NP applicants to ensure access to education for rural communities;
- Consistent core curriculum which includes clinical practice and leads to knowledge that can be tested by a national exam;
- Continuing education; and
- Prior learning assessment recognition (PLAR) for nurses working in NP-like roles.

Clinical practice: There were many suggestions for the number of hours and years that need to be invested in clinical practice for entry to practice and for continuing NP practice. At one RTC, participants felt the requirement should be three to five years of clinical practice as an RN prior to acceptance for entry into an NP program and a minimum number of 600 practice hours during the NP program. The minimum number of years required to enter a program suggested was two years.

PLAR: Some suggested that PLAR should be a combination of learning/practice portfolio that is peer-reviewed and includes an employer reference. A written exam could be included.

Replacement of NPs: At two RTCs some thought was given to a replacement program for nurses where there are few NPs/nurses in practice. The feeling was that there should be some sort of circular replacement.

Specialty streams: At one RTC, participants suggested there should be a core NP core curriculum plus specialty streams such as family, neonatal and cardiac streams, for example.

Preceptors: The importance of preceptors and their preparation was discussed in most RTCs. In one RTC, it was suggested that a post-NP fellow-ship/preceptorship be developed.

Educational deductions: In one RTC, participants mentioned that physicians can deduct education costs from their income but NPs cannot. Tax law should be revised so that NPs can also benefit from educational tax deductions.

National Association: In one RTC, it was suggested that a National NP Association should be created.

Shortage: A group in one RTC wondered if the overall shortage of nurses would be a negative factor in the number of nurses entering the NP program.

Standardized exit credentials: Overall the consensus in the RTCs was that the exit credential should be at a master's level degree that requires a minimum number of clinical practice hours. Many also mentioned the need for a national exam for licensing. Continuing education must also be considered, they said, but there was some debate on whether it should be mandatory. A transition period for implementation of mandatory continuing education, a national exam and minimum practice hours will be necessary.

Strategic Communication, Change Management and Social Marketing

Participants were asked to identify three communications issues that need to be addressed to advance CNPI awareness and understanding of the NP role in primary health care. They were also asked to identify specific communications materials and tools that would be helpful to advance awareness and acceptance.

While participants where asked to only identify three issues, many groups created longer lists. These were the most common issues suggested:

- Standardization of title and language;
- Clear and consistent role definition;
- Emphasis should be placed on the value-added role of NP;
- The need for unique communications directed at each identified target group (general public, politicians, health care providers RNs, physicians, pharmacists and others);
- Tactics to deal with resentment, hostility and acceptance of NPs within the health care community; and
- Use of simple clear messaging.

Tools suggested: Several communications tools were suggested. To help advance awareness and acceptance of the NP role, communicators will need to identify champions and highlight NP success stories, either from a collaborative or patient point of view.

Interestingly enough, a few participants felt that NPs should not be perceived as aggressive or force their roles upon other professionals, but should take a much gentler approach to integration. Many felt this approach will depict the NPs' truly professional nature. Many felt that communication strategies need to be proactive and not reactive. Furthermore, the biggest tool that could work in NPs favor is word-of-mouth.

Traditional communications tools and materials were suggested. These include:

- Media relations (print, TV, radio);

- Advertising;
- Internet;
- Tool kits (which would include the success stories and NP profiles, brochures);
- Participation in events and conferences;
- Photo bank; and
- Work with existing organizations to promote NPs.

Some innovative non-traditional ideas suggested include:

- NP documentary – a “day in the life”;
- NP “road show” to Parliament, malls and schools regarding – who is a nurse practitioner?

Thinking ahead: At one RTC participants were forward-thinking and recognized that Canadians will want to know how to access an NP.

Conclusion

Overall, participants were in strong agreement regarding the advancement of the CNPI and its mandate. Discussions were lively and represented many different stakeholder views.

During the RTCs, many of the challenges and opportunities expressed were the same as the ones found in literature reviews and voiced in previous consultations. The main observation from the RTCs is that participants felt the role and scope of the NP needs to be clearly defined in order to advance in all the areas outlined in the CNPI. While defining the role of the NP is critical, many felt that the description should be enabling and not restrictive. Within the role of an NP, terms like autonomy and accountability need to be clearly defined.

There appeared to be no major discrepancies between the different cities and their perspective towards the implementation of a pan-Canadian framework to promote the sustained integration of the role of the NP in primary health care in Canada. What was evident was the difference in the depth of understanding on issues between those provinces that have had legislation for many years versus those that are still in the implementation phases. For example, where NP legislation was in place the RTC discussion went into more detail compared to those provinces or territories where there was no legislation; in the latter, the discussions were less detailed and focused more on the basics of descriptions on NP practice.

Common themes discussed throughout the RTCs include the collaborative and inter-disciplinary role of NPs in the delivery of health care services. Whether in urban or remote/rural settings, participants felt an NP should always be part of a team and not in solo practice.

Some of the more engaging topics included practice models and health human resource funding models. With funding and the lack thereof being an everyday reality, many regions had many opinions on what models and funding factors might work best to sustain a well balanced approach to NP integration. The key to success rests on collaboration. Models should be looked at in conjunction with health care planning and funding to ensure the highest level of quality and long term vision.

The participant evaluation forms indicate that individuals were satisfied with the consultations and felt that many of the issues were well covered during the sessions (Appendix D).

Appendix A

CNPI Round Table Consultation Workbook

Nurse Practitioners
Your Partners in Health

Canadian Nurse Practitioner Initiative

Round Table Consultation

April/May 2005

CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

Table of Contents

Welcome

Welcome to this series of Round Table Consultations organized by the Canadian Nurse Practitioner Initiative (CNPI).

The CNPI is working to develop a pan-Canadian framework to promote the sustained integration of the role of the nurse practitioner (NP) in primary health care across Canada. To achieve this goal, five component areas are being examined:

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

CNPI is committed to wide-ranging stakeholder consultations in the development of this framework. These Round Table Consultations are part of Phase 2 of this initiative. Today is your opportunity to discuss issues that have emerged from the literature reviews and initial consultations completed during Phase 1, and to provide further direction for the five component areas.

Thank you for taking the time out of your busy schedule to participate in these Round Table Consultations. We value your opinions and contributions to advancing the role of the NP across this country.

Marian Knock, RN, MSN, BSN
Executive Director
Canadian Nurse Practitioner Initiative

Notes

Background

First Ministers agree that all Canadians should have access to health care services when and where they need them. (*Health Accord*, September 2004). Nurse practitioners (NPs) can contribute to making this goal a reality. In response to its commitment to provide better access to primary health care for all Canadians, the Government of Canada announced the establishment of the Primary Health Care Transition Fund (PHCTF), an investment of $800 million ending in March 2006.

Through the visionary commitment of the Nurse Practitioner Planning Network, a Canada-wide group representing nursing stakeholders, regulatory bodies, professional associations and governments, a proposal was submitted to the PHCTF. This proposal was accepted and, as a result, $8.9 million was allocated to the Canadian Nurses Association to manage the implementation of the Canadian Nurse Practitioner Initiative (CNPI).

The CNPI was launched in June 2004 and is led by Marian Knock, Executive Director. The governance structure of the CNPI includes an Advisory Committee that is chaired by the Canadian Nurses Association's Executive Director Lucille Auffrey and five Task Forces (Legislation and Regulation; Practice and Evaluation; Health Human Resource Planning; Education; and Strategic Communications, Change Management and Social Marketing). These Task Forces are chaired by CNPI managers.

The CNPI will develop mechanisms and processes to address the varying approaches to integrating and sustaining the role of NPs in primary health care. It is an opportunity for nurses to demonstrate to governments, stakeholders and the general

public their capacity to make a significant contribution to primary health care renewal through the provision of high-quality, cost-effective, primary health care services. Additionally, this initiative will work to address the need for greater consistency in provincial and territorial approaches to NPs by developing the foundation for a shared pan-Canadian understanding of the NP role in primary health care.

For more information, please visit www.cnpi.ca

Please Note:

If there are issues that you know of that are not referenced in this workbook through the literature reviews and summaries, please discuss them in your groups and bring them to our attention during the plenary.

Notes

Notes

Legislation and Regulation

Introduction
The provincial/territorial nursing regulatory bodies have worked successfully together over many years to standardize eligibility criteria for entry to general nursing practice, including the development of core competencies. For NPs, provincial/territorial nursing regulatory bodies have agreed on a set of core competencies. However, agreement is less consistent on issues such as title and title protection, educational requirements for the role, scope of practice, and registration/licensure requirements. A pan-Canadian regulatory and legislative framework would facilitate consistent requirements and standards, support interjurisdictional mobility, and promote public and professional understanding of the NP role.

In Phase 1 of the CNPI, each component commissioned literature reviews and engaged stakeholders in consultations and discussions across Canada. The major findings from these initiatives are summarized below. At the end of the section, questions are posed which have been designed to stimulate discussion on factors that are fundamental to moving ahead with a pan-Canadian framework.

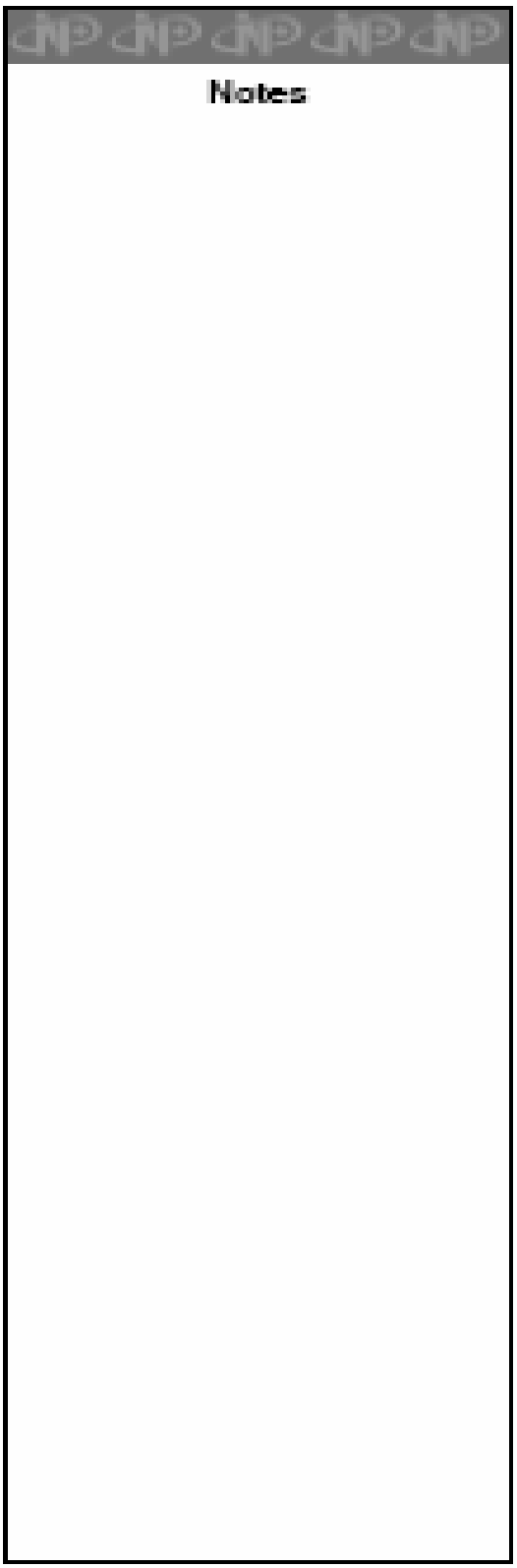
I. Summary of Findings: Literature Reviews
Many inconsistencies were identified in the Canadian and international legislation and regulation. They include:
• title and title protection;
• recognition of overlapping scopes of practice among health professionals;
• variation in entry-to-practice requirements (e.g., education, examination, competency assessment, practice hours, temporary permits);

• continuing competence components;
• scope of practice;
• variation in legislative models (e.g., umbrella or professionspecific legislation);
• inclusion of regulatory components in legislation, regulations and/or bylaws; and
• the definition of nurse practitioner.

The literature review also identified some approaches that could inform the development of a pan-Canadian legislative and regulatory framework for NPs. They include:
• the National Council of State Boards for Nursing *Model Nursing Practice Act;*
• the Pew Task Force recommendations for health professions (1994); and
• the Organization for Economic Co-operation and Development's (OECD's) model for regulatory reform.

II. Stakeholder Consultations
Stakeholders identified significant gaps/inconsistencies/issues in comparing provincial/territorial legislation and regulatory processes. They include:
• diversity of educational approaches;
• variation in definitions and scope of NP practice;
• absence of a clear definition of the NP role;
• overlapping scopes of practice;
• variation in the requirements and mechanisms for consultation with physicians;
• variation in title and title protection;
• the potential of collaborative practice agreements to undermine role autonomy; and
• ongoing evaluation of role effectiveness.

Most stakeholders supported the idea of a pan-Canadian legislative/regulatory framework and identified the following critical elements that should be included:
• clear, enabling definition of the NP role;



Notes

• protection of the NP title;
• scope of practice;
• core set of competencies;
• entry level and continuing competency;
• national examination for initial licensure/registration;
• entry level educational requirements; and
• role evaluation.

III. Major Emerging Issues Influencing Regulation/Legislation

The following issues are emerging:
• timely access to primary health services;
• emphasis on integration and coordination of health services;
• growing acceptance of the NP role by the public and other health care providers;
• educational preparation and registration status for nurses practising in an NP role in primary health care, including those working in remote and under-serviced areas;
• increasing government emphasis on accountability – fiscal responsibility and quality of practice (competency);
• registration/licensure based on competency rather than credentials;
• more sophisticated modalities for competency assessment;
• ease of national and international mobility for choice of work location; and
• changing approaches to regulatory legislation for health professions.

Questions for Discussion

1. What are the underlying principles that you believe should underscore a pan-Canadian legislative and regulatory framework for NPs?

2. Based on these principles, what elements would you suggest for inclusion in a pan-Canadian legislative and regulatory framework for NPs?

Practice and Evaluation

Introduction
The Practice and Evaluation Task Force is examining how best to achieve sustained integration of the role of the NP in primary health care through the practice and evaluation lens.

There is significant congruence between what was learned from the literature review and the consultations. Critical to the work is the recognition that there is a lack of understanding around the role of the NP, as well as the roles of other health professionals in interdisciplinary teams.

While the lack of clarity regarding the NP scope of practice and role continues to be an issue, there are promising signs of greater acceptance by other health professionals as well as patients. Some perceive that working with NPs gives greater flexibility, more time with patients, the ability to see more or different patients and overall improvement in quality of care. Others state that until the scope and role are clarified, the use of NPs will not be fully optimized in the health care system. There is recognition that positive health system outcomes such as increased access to health care services, decreased emergency room visits and improved patient satisfaction are achieved from the integration of NPs.

In Phase 1 of the CNPI work, each component commissioned literature reviews and engaged stakeholders in consultations and discussions across Canada. The major findings from these initiatives are summarized below. At the end of each section, questions are posed which have been designed to stimulate discussion on factors that are fundamental to moving ahead with a pan-Canadian framework.

Notes

Notes

I. Summary of Findings: Literature Review

The NP role:
• ongoing confusion about the scope of practice and role even among NPs;
• inconsistency in role definition across the country;
• role definition critical to integration;
• misperceptions lead to lack of trust particularly around diagnosis and prescribing;
• distinctions are made between NP and several other RN roles, physician assistants and paramedics;
• varying issues relate to the geographic location of the NP's practice. (There is greater openness in the North to the NP's scope of practice than there is in the South).

Barriers to NP practice include:
• boundaries and liability;
• funding and funding models;
• organization and structural supports; and
• legislation and regulation.

II. Stakeholder Consultations

• Role definition is critical to the acceptance and full integration of the NP in primary health care; it provides clarity for future development of the NP's scope and role, and facilitates sustainability over time.
• Barriers and impediments include:
- inconsistency in educational preparation, lack of role definition, lack of trust, and integration of the role within the health delivery system;
- physician fee-for-service payment models are counterproductive to the integration of NPs;
- liability issues regarding the collaborative/autonomous nature of NP practice; and
- lack of policy and health human resource planning.

• Collaboration – is essential to NP integration. This includes: flexibility and compatibility; strategies to support how the work is shared and distributed; and respect and trust among the collaborative practice team.
• Outcomes – although effectiveness has been demonstrated over time and through many and varied studies, the misperceptions about the NP's role and scope contribute to the lack of integration within the health care team.
• Acceptance – clients' and physicians' exposure to NPs has increased acceptance.

Questions for Discussion

1. What are the essential elements that should be included in the role definition of the NP?

2. What can be learned about the practice models in which NPs function in your province/territory? Specifically: which models work best to support the integration of NPs, and why; which models do not work as well, and why?

Notes

Notes

Health Human Resource Planning

Introduction

Addressing the shortages of health professionals has become one of the top priorities for health care renewal in Canada. They have been the subject of federal, provincial/territorial and sub-provincial/territorial reports, health commissions and reviews, and have received considerable media attention.

Health human resource (HHR) planning and management is an important issue for policy makers, health care administrators, professional associations, unions, health services and policy researchers. In the 2003 First Ministers' Accord on Health Care Renewal, the jurisdictional and federal governments made a commitment to work together to enhance HHR planning and management. At their meeting in 2004, the First Ministers reinforced that appropriate planning and management of HHR is key to ensuring that Canadians have access to the health providers they need now and in the future. This includes plans for ensuring the supply of NPs.

In Phase 1 of the CNPI, each component commissioned literature reviews and engaged stakeholders in consultations and discussions across Canada. The major findings from these initiatives are summarized below. At the end of the section, questions are posed which have been designed to stimulate discussion on factors that are fundamental to moving ahead with a pan-Canadian framework. Within the HHR component, two literature reviews were conducted to examine national and international literature on HHR planning related specifically to NPs. Peer-reviewed and grey literature was appraised. The two reviews are *Recruitment andRetention of Primary Health Care Nurse Practitioners in*

Canada, and *Health Human Resources Planning:Modeling Activities for Primary Health Care NursePractitioners.*

I. Summary of Findings: Literature Reviews

• Evidence shows that the NP role in primary health care may be part of the solution to access, wait times, efficiency, effectiveness and costs.
• HHR planning for NPs in Canada is limited by data availability, data quality and timeliness of data collection.
• Limited strategies are in place to coordinate recruitment and retention of NPs in Canada.
• Strategies must be aimed at:
- developing appropriate remuneration and funding models;
- developing national legislative and regulatory frameworks aimed at providing a clear definition of the NP role;
- creating supportive work environments, and encouraging meaningful inter-professional and intra-professional collaboration to improve understanding of the unique contributions NPs make to health care;
- supporting continuing education, particularly in rural, remote or under-serviced areas; and
- providing appropriate compensation.

• Workplace satisfaction depends on autonomy, support, role clarity, collaboration and practising at full scope.

II. Stakeholder Consultations

• There are obstacles to meaningful HHR planning for NPs.
These include:
- lack of uniformity in NP education and competencies affecting the supply of NPs, the demand for services, effective utilization and deployment of NPs;

Notes

Notes

- some NP legislation/regulation may be too restrictive, limiting the utilization and deployment of NPs and affecting their job satisfaction;
- absence of dedicated funding for NP deployment in most provinces/territories;
- remuneration and funding models for NPs vary within and across provinces/territories;
- existing physician fee-for-service payment models are not conducive to collaborative practice with NPs; and
- the approach to determining the number of NPs required to improve access to and quality of health care varies across the country.

Questions for Discussion

1. What key factors should be considered in determining the number of NPs needed across Canada?

2. Given that there are many approaches to health human resource funding models, what principles should be applied to funding models (fee-for-service, salary, contract, etc.) that would best support the sustainability of NP positions within interdisciplinary teams?

Education

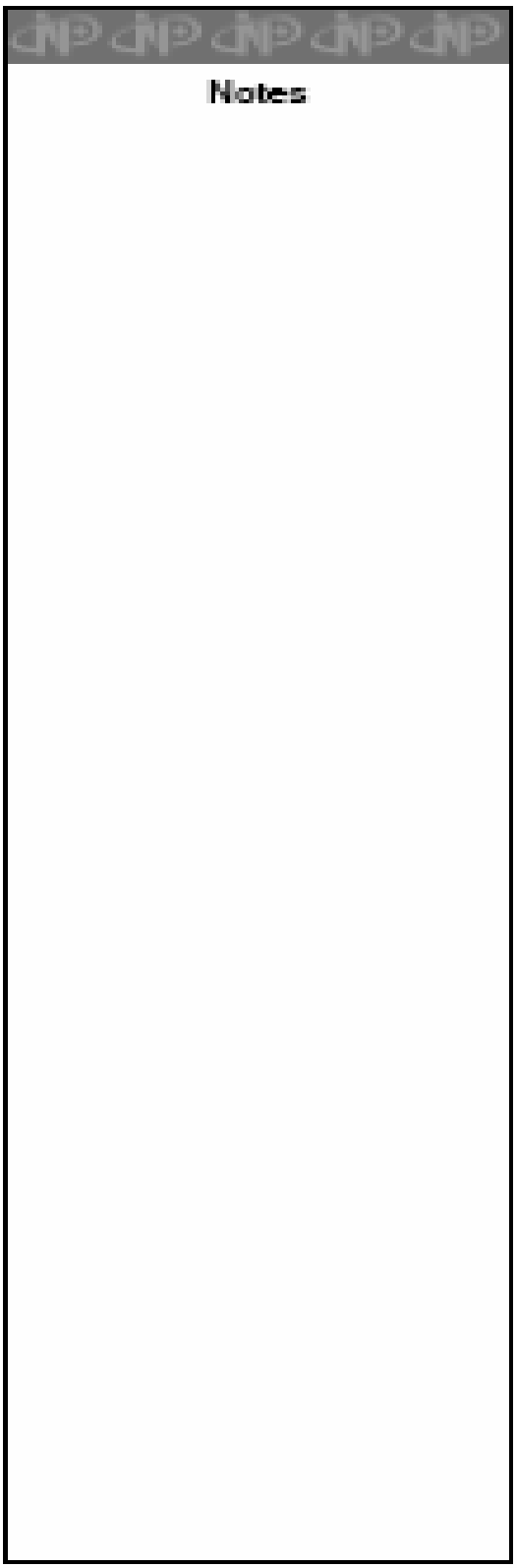
Introduction

NP educational programs have developed over time to meet provincial and territorial needs. This has contributed to the growth of the NP role but has also led to a wide variation in NP educational programs across Canada. As well, there are nurses in NP-like roles across the country who are without formal NP education, particularly in rural and remote areas. There are issues regarding easy access to formal NP education for these nurses, including prior learning assessment and recognition (PLAR). As the NP role evolves in Canada, continuing competence for NPs and re-entry to practice issues need to be addressed.

The objective of the education component of the CNPI is to make recommendations on five aspects of pan-Canadian NP education:
• curriculum and programs;
• educational delivery methods;
• continuing education;
• prior learning assessment and recognition (PLAR); and
• re-entry to practice.

In Phase 1 of the CNPI, each component commissioned literature reviews and engaged a broad range of stakeholders in consultations and discussions across Canada. The major findings from these initiatives are summarized below. At the end of the section, questions are posed which have been designed to stimulate discussion on factors that are fundamental to moving ahead with a pan-Canadian framework.

Within the education component, the literature review was built on the foundational work of the Canadian Nurses



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Association, *Advanced Nursing Practice: A National Framework (2002a)*, as well as the work of the Canadian Association of Schools of Nursing (CASN) in 2003 that resulted in the development of the CASN *National PrimaryHealth Care Nurse Practitioner Education Strategy Framework.*

I. Summary of Findings

• There are inconsistencies in educational programs for NPs across Canada.
• Consensus about NP educational programming will be difficult to achieve because it is complicated by the interdependence and complexity of the factors involved.
• Currently there is little agreement on a standardized exit credential for all NP education programs.
• There is a requirement for standardized credentials to satisfy stakeholder needs.
• Concerns have been expressed about whether there is a need for graduate education, especially in rural and remote NP practice, where recruitment of nurses is difficult.
• A transition period will be needed if changes are made to education, credentials, etc.
• More collaboration is needed between NP educational programs to provide accessibility to the highest quality programs for the greatest number of NP students. Decisions will have to be taken about the type, location and number of these programs.
• Opportunities exist through the development of Centers of Excellence for NP education. Such centers could play key roles in research, development, standardization and delivery of NP educational programs across Canada.
• The profile of NP students may be changing. In the past, most nursing students entered NP programs with extensive practice skills and expertise. Now, more nursing students are moving directly from their bachelor programs into

NP programs. The NP programs may need to be restructured for this different student profile.
• Health professionals need to be educated in a way that promotes collaborative practice.
• Faculty issues include: faculty workload in cost-recovery funding situations, difficulties in recruiting full-time tenuretrack faculty, a lack of doctoral-prepared NPs to act as faculty, and a lack of funding for conversion of courses to online courses. As many as 2,750 new nurse educators will be required to teach the next generation of RNs and NPs, and to conduct the research that will be needed to support their practice. These new faculty will also require significant ongoing clinical experience.
• There is a scarcity of preceptors for NPs.
• There will be a need for increased access to continuing education for practicing NPs. The question is whether continuing education should be mandated as an element of maintaining licensure.

Questions for Discussion

1. What principles and characteristics would need to be foundational to a pan-Canadian NP education (for example, for curricula, educational delivery methods, continuing education, prior learning assessment and recognition, and re-entry to practice)?

2. Should there be a standardized exit credential from all NP educational programs across Canada? If yes, what should that credential be; if no, why not?

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Strategic Communications, Change Management and Social Marketing

Introduction

Strategic communications plays a number of key roles in the CNPI. These include:

• Disseminating information about the CNPI, its goals, activities, progress and its components;

• Developing and implementing a communications strategy aimed at building awareness, understanding and acceptance of the NP role in primary health care across Canada; and

• Developing communications and change management materials explaining the role of the NP in primary health care and system renewal.

Although each of these roles is distinct, they are enmeshed and build one upon the other. Similarly, the result of the work of each component provides information for effective communications as the initiative progresses. It is the integrative effect of these efforts that will give the initiative its momentum and build the foundation needed for acceptance of the NPs role in primary health care across Canada.

Due to the nature of communications, work has proceeded in a slightly different way than in the other four components. A communications framework and strategy was developed, and a series of consultations on the content were held. As part of that work, an analysis of the public environment and context for communications was examined. The decision was also taken to conduct benchmark research with both the

public and physicians to determine their opinions of NPs and the NP role in primary health care. Communications for CNPI are under way and various products are now available on the CNPI website.

I. Summary of Findings: Environmental Scan

• The number one concern of Canadians is health care – access and wait times in particular.
• Many Canadian families do not have access to a family physician.
• Canadians understand that the health care "system" is deteriorating and its sustainability is in question.
• It is generally accepted that the health care "system" has to change if it is to remain viable. The focus of change at this time is on primary health care.
• The integration of nurse practitioners in primary health care is one of the solutions to access and timeliness issues, but the integration of NPs in primary health care is not top of mind as a solution for the public at the present time.
• A *Health Insider* survey (referenced in the Dr. Alba DiCenso /IBM study on nurse practitioners) indicated what the public liked about seeing an NP:
- the amount of time the NP spent with them;
- the quality of care they received from the NP;
- the ease with which they were able to talk to the NP; and
- the information the NP provided about their health condition.

• The report by Dr. Alba DiCenso/IBM on the status of NPs in Ontario, suggests key ways to facilitate the integration of NPs:
- establishment of one recognizable title;
- patient awareness of the NP role;

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- an understanding of the NP role by other health professionals;
- a view by physicians that collaborative practice is 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.

Questions for Discussion

1. What are three communications issues you believe need to be addressed in ongoing communications by CNPI to advance awareness and understanding of the NP role in primary health care?

2. What communications materials/tools would help you advance awareness, understanding and acceptance of the NP role?

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CNPI Round Table Consultations

NOTES

Canada's Nurse Practitioners – Providing accessible, quality care

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Funding for the Canadian Nurse Practitioner Initiative was provided by Health Canada.

Appendix B

Attendance at Round Table Consultations

Appendix B **RTC Attendance List**

Edmonton		
Name	**Title**	**Company**
Susan Balmer	RN. Student NP	Hay River Health
Wendy Gillespie	Pediatric Nurse Practitioner	Calgary Health Region
Louise Jensen	Professor	University of Alberta, Faculty of Nursing
Krista Lachance-Rawson	NP	Cross Cancer Institute
Karen Benwell	NP	
Karen Graham	Nursing Instructor, NP	Aurora College
Rita Wright	Registrar	Alberta Association of Registered Nurses
Jan Fawcett	NP	University of Calgary
Cappy Elkin	Public Rep	
Lloyd Tapper		Northeast Community Health Centre
Christene Evanochko	Neonatal Nurse Practitioner	Stollery Children's Hospital & Royal Alexandra Hospital
Bev Bowden	RN	Stanton Hospital, Emergency Dept.
Joanne Watt	NP	University of Alberta Hospital, Family Medicine Unit
Heather Leslie	Manager, Ambulatory Services	Stanton Territorial Health Authority
Steve Chambers	M.D.	
Gayle Burnett	Senior Health Policy Consultant	Alberta Medical Association
Barbara Waters	CNSI NP, Chronic Disease	Health Canada, FNIHB
Nicolette Doucet	RN	Case Coordinator Home Care
Cathy Giblin	Regional Manager, Nursing Affairs	Capital Health
Teddie Tanguay	NP	Royal Alexandia Hospital - General Systems ICU
Gayle Thompson	NP - Heart Function Clinic	David Thompson Health Region
Glen R. Abernethy	Senior HR Consultant	FIIBS, Government of Northewest Territories
Dana S. Edge	Associate Professor	Faculty of Nursing, University of Calgary
G. J. Heidi Watters	Clinical Nurse Specialist	
Dale Cooney	Deputy Registrar	Alberta College of Pharmacists
Tony Tung	Chair of the Membership Committee	Nurse Practitioner Association of Alberta
Mary Nugent	Nurse Practitioner	Taber Associate Medical Centre

Vancouver		
Name	**Title**	**Company**
Fran Curran		
Patricia Wejr	Policy Analyst	BC Nurses' Union
Karen Kline	Policy Consultant	RNABC
Anne Dietrich Bragg	NP	Yukon-Haines Junction Outpost
Marcia Carr	CNS	Fraser Health - Burnaby Hospital
Bob Lorimer	Principal	Lorimer & Associates
Julie Klippenstein	community NP	Primary Care - Rural Health
Dr. Rita Schreiber		University of Victoria
Lorine Scott	Nurse Clinician	BC Children's Hospital
A. Elizabeth Lindsey		UNBC
Patricia McClelland	RN	
Natasha Prodan-Bhalla	CNS/NP	Providence Health Care, St. Paul's Hospital

Catherine Bradbury	Coordinator of Regulatory Programs	YRNA
Rick Roger		
Victoria Stafford	Lecturer	University of British Columbia, NP Program
Donna Higenbottam	Executive Director	College of Registered Pschiatric Nurses of BC
A.J. Jack Burak	President	Family Physician
Lisa Gaede	M.D.	
Karen Snider	PHC-NP	James Bay Community Project
Peter Boronowski	Physician	College of Family Physicians of Canada
Faith Richardson	Assistant Professor of Nursing	Trinity Western University, Nursing Dept.
Linda Van Pelt	Community NP	CNP Carcross Yukon
Gabrielle Bridle	President	Canadian Practical Nurses Association
Donna Rowland	RN	Yukon Homecare Program
Laurie Dokis	Nurse Consultant	Intertribal Health Authority
Anita Dotts	Project Coordinator	Vancouver Island Health Authority
Ken Foreman	Deputy CEO & Dir. Professional Services	BC Pharmacy Association
Linda Sawchenko	Project Leader	Interior Health
Ms. Diane Clements	Director	Health ServicesNursing Directorate

Winnipeg		
Name	**Title**	**Company**
Bruce Martin	Director of NMU	University of Manitoba
Jone Barry	NP	Loon Lake Primary Care Centre
Maureen Coulthard	Manager, Orthotics Prosthetics	Wascaba Rehab Centre
Patricia Furgal	RN	Sanikiluag Health Centre
Mary-Anne Robinson	Director Primary Care	Winnipeg Regional Health Authority
Nancy Milroy-Swainson	Director, Primary & Continuing Health Care	Health Canada
Sandy May	PHC-NP	North Eastman Health Association
Jane MacDonald	PHC-NP	Aikins Street Community Health Centre
Margaret Rauliuk		
Dr. Rick Hamm		Concordia Health Connections Inc
Sheri Oliver	Project Coordinator	Registered Practical Nurses Association of Ontario
Dr. Larry Reynolds	Dept Head	University of Manitoba
Louise Kowal	NP	Arborfield Health Centre
Sheila Achilles	General Manager, Primary Health	Saskatoon Health Region
Glennys Uzelman	VP Primary Health Services	Prairie North Health Region
Cecile Hunt	VP, Integrated Health Services	Prairie North Health Region
Linda Barlow	Director, Primary Health Care	
Brenda Dawyduk	NP	Burntwood Regional Health Authority
Katie de Leon-Demare	Primary Health Care NP	Winnipeg Health Authority
Sarah Mazhero	Supervisor of Hess Program	

Christine Arcand	NP	Battlefords Family Health Center
Brenda Kirtzinger	Director of Intersectoral Programming	Prairie North Health Region
Lorraine Poirier	Primary Care Nurse	La Ronge Medical Clinic
Joyce Bruce	Faculty	Primary Care Nurse Practitioner Program
Julie Hesketh	Community Integrated Health Services	RHA Central MB Inc
Elsie Duff	NP	Northeastman Health Assoc.
Mr. Bernie Blais	Deputy Minister	Nunavut Ministry of Health and Social Services
Ms. Susan Antosh	President and CEO	Saskatchewan Association of Health Organizations
Ms. Donna Alden-Bugden	NP	Women's Health Clinic/Northern Community Health Care
Toronto		

Name	Title	Company
Leela Subramaniam	PHC-NP	NIC/NP
Janet Cooper	Senior Director, Proffessional Affairs	Canadian Pharmacists Association
Sandra Crawford	PHC-NP	Dilico Ojibway Child & Family Services
Lori Turik	VP	Canadian Association of Chain Drug Stores
Brenda Ceaser	RN	Timmins & District Hospital
Valerie Grdisa	Director, Nurse Practitioner Programs	University of Toronto, Faculty of Nursing
Carol Jacobson	Director, Healty Policy	Ontario Medical Association
Christine Thrasher	Professor	University of Windsor
Joan Edwards	Regional Nursing Officer	First Nations Inuit Healt Branch, Health Canada
Judy Ball	Speech-Language Pathologist	
Willi Kirenko	Chair	Nurse Practitioners' Association of Ontario
Neghesti Gebru		Nursing Instructor/Assistant Professor
Barbara Cantwell	Practice Advisor	College of Dieticians of Ontario
Lori Barbour	Nurse Manager	Baffin Regional Hospital
Faith Donald	Assistant Professor	Ryerson University
Kathleen Whittle	Director, Data and Communications	Canadian Association of Schools of Nursing
Michael Garreau	President	CNSA/AEIC
Ann Palamar	NP-Program Manager	
Joanne Veldhorst	NP	London Inter. Community Health Centre
Karen Antoni	Acute Care NP & President-Elect CAAPN	Hamilton Health Sciences
Cathy Goetz Perry	Executive Director	VON Grey-Bruce
Sharon Goodwin	Sr. Director of Client Services	VON Canada
Shannon Chande	PCNP student at University of Western Ontario	
Susan Boudreau	NP, ER	North Bay General Hospital
Sarah T. Davies	Primary Health Care NP	Hamilton Community Health Centre
Peggy Snyder	Primary Health Care NP	Woolwich Community Health Centre
Jennie Humbert	NP Regional Co-ordinator	University of Ottawa, NP Program
Ann Frances Allen	Manager Policy	College of Nurses of Ontario
Paula Carere	RN(EC)	Langs Farm CHC
Peter Istvan	Director	West Parry Sound Health Centre
Mr. Ben Van Den Assem	Registrar	Department of Health and Social Services Government of Nunavut

St. John's		

Name	Title	Company
Rufina O'Dell	District Coordinator SE Lab and NP	Lab Grenfell Regional Integrated Health Authority
Sandra Duke	ERN/SNP	Geriatric Medicine (Acute)
Wanda Emberley Burke	NP Faculty	Centre for NSG Studies
Mary Manojlovich	Professional Practice Coordinator, Occupational Therapy	Health Care Corporations of St-John's, Dr. L.A. Miller Centre
Mona Clarke	PHS - NP	Dr. Charles Legrow Health Care
Trudy Stuckless	Vice President Professional Standards and Chief Nursing Officer	Central Regional Integrated Health Authority
Debra Barrath	Senior Policy Analyst, Nursing Advisory Services	Nova Scotia Dept of Health
Becky Reid-White	ACEO	Community Health Nursing
Patricia Osmond	Director Nursing POlicy and Professional Practice	Peninsulas Health Care Corporation
Paula Didham	Nurse Educator	Western Regional School of Nursing
Joanne Simms	NP - PHC Adolescent Medicine	Janeway Child Health Centre
Barbara Grandy	M.D.	
Paula Prendergast	Regulatory Policy Consultant	
Patrick King	Exeutive Director	Pharmacy Associatin of NS
C. Renate Bennett	PHC NP	North Queens Health Centre
Catherine Aitken	PHC NP	Springhill Primary Health Care
Kimberley Lamarche	PHC NP	
Nadine Tidd	Prenatal Nutrition Program Worker	Digby County Family Resource Centre
Jocelyn Brown	PHC Coordinator	South Shore District Health Authority
Ruth Martin Niserer	Assistant Professor, Coordinator NP Programs	Dalhousie University
Dwight Ball	Director	Canadian Pharmacists Association
Sandra Moss	Community Health Manager	LeGrow Health Centre
Debbie Oldford	Specialty Nurse Practitioner	Capital District Health Authority
Roger Hamilton	M.D.	
Susan McGowan	PHC-NP	North End CHC
Leanne MacMillan	Staff Lawyer	Nova Scotia Nurses' Union
Andy Moir		
Kelly Power-Kean	PHC-NP	St. Mary's Health Centre
Dawn Frail	Manager, Drug Technology Assessment	Nova Scotia Department of Health
Carolyn Rideout	NP-PHC	
Bernice Martin	Policy Analyst	NS Dept. of Health
Ms. Elizabeth Lundrigan	Nursin Consultant, Advanced Practice & Administration	Association of Registered Nurses of Newfoundland and Labrador

Fredericton		
Name	**Title**	**Company**
Linda Arsenault	Branch Director, VON PEI	
Joanna Montgomery	Nurse in Charge	Deh Cho Health and Social Services
Linda Morris	CNO	
Jacalyn Boone	Nurse Practitioner	Queens North CHC, Minto
Beverly Tedford	Nursing Consultant	Dpt of Health Wellness of NB

Lisa Fréchette	Infirmière praticienne/Nurse Practitioner	St.Joseph's Community Health Centre
Jocelyn Ashton	Nurse Practitioner	Central Miramichi Community Health Clinic
Rose McCloskey	Nursing Professor	University of New Brunswick
David Howe	Family Physician	
Jodi Hall	Education/Practice Consultant	Association of NB LPNs
Phyllis Johnson	Director fo Nursing	Whisperwood Villa
Bill Veniot	Registrar	New Brunswick Pharmaceutical Society
Tracy Horsley	NB Association of Speech-Language Pathologists and Audiologists / Stan Caddisy Centre for Rehabilitation	Stan Cassidy Centre for Rehabilitation Speech-Language
Tom Barry	Family Doctor	NB Medical River-Valley Health
Jeannette LeBlanc	Professeure en sciences infirmières (nursing professor)	Uniersité de Moncton
George Murray	President Elect	Canadian Pharmacists Association
Donna Kidd	Nurse Practitioner	PEI Cancer Treatment Centre
Martha L. Vickers	Nurse Practitioner	Family Practice - Collaborative Practice Pilot Project - Clinique médicale Nepisiguit
Kate Burkholder	Nurse Practitioner	Fundy Health Center
Fonda Kazi	VP Community Health	South East Regional health Authority
Jeana McLeod	Licensed Practical Nurse	Beechwood Health Centre
Marion Clark	Nursing Policy Consultant	PEI Dept. of Health and Social Services
Kelly McDunfield	NP	St. Joseph's Hospital - Community Health Centre
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Denise Malo	Professeure/Directrice adjointe	Dpt des sciences infirmières de l'Université de Sherbrooke
Johanne Desrochers	Administrateur - Programme du Nord et des communautés autochtones - télésanté - Réseau Pédiatrique	Hôpital de Montréal pour enfants du centre universitaire santé McGill
Lynda Lynch	Infirmière éducatrice régionale	Santé Canada (DGSPN1)

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André Grenier	Chef des Opérations	Procter and Gamble Pharmaceuticals
Odette Doyon	Professeure/Directrice du département des soins infirmiers	Université du Québec à Trois-Rivières
Maurice Lamarche	Médecin/MD	
Alexandra Tcheremenska-Greenhill	Director, Office for Leadership in Medicine	Canadian Medical Association
Nathalie Nadeau	Etudiante infirmière practicien specialisee eu cardiologie	CHUM
Josée Dagenais	Infirmière clinicienne spécialiseé	Hôpital Maisonneuve-Rosemont
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Appendix C

Round Table Consultation
As Was Said Notes

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Legislation and Regulation	**Legislation and Regulation**	**Legislation and Regulation**	**Legislation and Regulation**	**Legislation and Regulation**
Q1. What are the **underlying principles** that you believe should underscore a pan-Canadian legislative and regulatory framework for NPs	A strong push for broad legislation (which does not include a list of tasks). Portability was mentioned as a key principle. The importance of building on existing legislation and expanding it to include the role of the NP. Other key principles mentioned included title protection and national standards for education (especially at the entry level).	The need for flexible and broad legislation that takes into consideration Canadians' safety and input. To provide protection to the public, NPs need to have a clear scope of practice (not restrictive and which allows for evolution of the profession) and accountability. The need to incorporate transition strategies in the legislation is also key. Principles such as title protection, continuing competence and portability were also raised.	Participants felt it was necessary to have a harmonizing (umbrella) framework which allows for portability across the country. Emphasis was placed on continuing competence, for example clear consistent entry-level requirements and re-certification processes across the country. Title protection/recognition which includes a clear scope of practice (accountability, autonomy and responsibility) was also highlighted as important.	Portability (including to the US), title protection, continuing competency and a broad scope of practice, definition of the role of the NP were all listed as underlying principles. One contradictory area at this RTC was whether there was a need for 'collaborative practice agreements with MDs'. Another issue discussed was whether there was a need for both a standardized provincial and national exam.

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Legislation and Regulation	**Legislation and Regulation**	**Legislation and Regulation**	**Legislation and Regulation**	**Legislation and Regulation**
Q2. Based on these principles, **what elements would you suggest for inclusion** in a pan-Canadian legislative and regulatory framework for NPs	Standard educational requirements for entry to practice and between institutions, portability, title protection, and a national exam.	Standard education requirements, national accreditation of educational institutions including a national exam, standards for continuing competency, title protection, accountability and a transition phase to accommodate those RNs working in NP like roles.	Title protection, portability, standard educational requirements, standard scope of practice, standards for continuing competency.	Title protection, broad and flexible regulatory frameworks, standards for continuing education, protection of public, portability and a national exam.

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Practice and Evaluation	**Practice and Evaluation**	**Practice and Evaluation**	**Practice and Evaluation**	**Practice and Evaluation**
Q1. What are the essential **elements** that should be included in the **role definition of the NP?**	Participants agreed on the 'autonomous' role of the NP. The NP works in a team and has advanced practice in clinical areas (diagnosis and treatment), research, education, leadership and is an innovator.	Elements defined included advanced skills acquired through an accredited educational program and relevant practice experience to fulfil the role. Emphasis was also put on 'collaboration' although a question was raised as to the difference between 'collaboration' and 'consultation'. The idea of health promotion and prevention were brought to the forefront as well as diagnosis, treatment and prescribing. The role of mentor was also outlined.	Health promotion and prevention are recurring elements. Other elements listed by the participants included assessment, diagnosis and treatment of common/chronic diseases. Many participants also felt that advanced education and the inter (or multi) disciplinary aspect of the role should be highlighted in the definition.	The elements of autonomy, health promotion, prevention, accountability, collaboration and leadership were listed. Some groups mentioned the need to define the educational expectations (Masters degree for example). While some felt it necessary to include the RN component in the role, others felt the RN component should be de-emphasized. One group expressed the need to ensure an NP is not seen as 'solving the issue of the MD shortage'.
Q2. What can be learned about the practice models in which NPs function in your province/territory? Specifically: which models work best to support the	Participants felt it was important for the NP to be part of the team, NPs should be involved in the decision making process and accountable for their actions. However, different setting (urban vs. rural) might dictate different needs or	A collaborative and complimentary model is seen as the best model (community development model). Fee-for-service is not perceived as a good model. Most participants favoured health authority funding for the NP as a	Many participants felt that an integrative/inter-disciplinary model would work best. Participants also suggested a 'client-centered model' where a case management structure was used would be effective. The issue of remuneration	The Community Health Centre model was seen as a successful model. A focus on collaboration/consultation was seen as important (mutual respect). It was emphasized that there was a need to look at rural/remote versus urban needs (one

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Practice and Evaluation	**Practice and Evaluation**	**Practice and Evaluation**	**Practice and Evaluation**	**Practice and Evaluation**
integration of NPs, and why; which models do not work well, and why?	roles. Fee for service or NPs working in solo practice were not popular models.	salaried position. One model suggested is the 'Community health centre model'.	was brought up and most agreed that a fee-for-service was NOT the best approach (lack of trust and support). Many felt the 'buy-in' or support from other professionals such as MDs was necessary to succeed.	model will not fit all). A salaried model was suggested although there is an appeal for fee-for-service in certain areas (NP should have understanding of income generation in the practice). There was also an expressed need for NP autonomy in the model. What would not work: dependency on the number of patients to generate funding, competition amongst providers and hierarchy amongst providers.

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Health HR Planning	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**
Q1. What key factors should be considered in determining the **number of NPs** needed across Canada?	The role of the NP must be clearly stated in order to determine the factors that should be considered. A needs assessment which will evaluate patient wait times and access to care, staff mix where NPs will be employed and current as well as future population health care demands should be done.	There was general consensus that better overall HHR planning needs to be implemented for all health care professionals. Once a clear definition of the NPs role is stated, factors such as demographics, population needs, funding models, workload, mobility and evolving scope of practice must be considered. Some felt community input to HHR planning was necessary.	The group felt that there was a need for an independent review of all health professions to determine HHR needs. HHR planning must be based on population health needs, some of the participants said that a ratio of NPs to patients could be determined such as 1000 patients : 1 NP (in a team) or that every Canadians should be within 30 minutes of a primary care provider. They stated that there was a need to "think upstream". They also stated that there was a need to consider public awareness which will likely create demand. Affordability, the cost of education and team collaboration should also be considered. Other factors listed included the need for	Factors to consider include population needs, other facilities in the area and the range of providers in the community. An interdisciplinary approach to human resource planning is needed. Some felt the number of NPs should be based on community need and MD/NP availability. There is a need to recognize that NPs can manage a majority of primary health care patient needs, therefore do we need more NPs and fewer MDs? Time must be allocated for continuing education, research and evaluation. It may be helpful to look at U.S. statistics.

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Health HR Planning	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**
			pharmacists, family medicine resources, current acceptance of NPs and distribution of work.	
Q2. Given the many approaches to funding models, what **principles should be applied to funding models** (fee-for-service, salary, contract, etc) that would best	This group suggested that the payment model should not include fee-for-service and they expressed the opinion that NPs should not be part of a union. A salary or contractual arrangements are preferable payment models and could include	This group felt there was no 'one-size-fits-all' model. Their request was for flexibility in the funding models. They were not in favour of fee-for-service or volume driven models.	It was suggested that a mixed matrix of funding models should include incentive opportunities. They were not supportive of fee-for-service or unionized funding models. There was support for contractual arrangements that could be	It was stated that there was a need for permanently funded positions (salaried or contractual) that included benefits. Attention must be given to continuing education and funding should be provided as an incentive to encourage RNs

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Health HR Planning	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**
support the sustainability of NP positions within interdisciplinary teams?	potential incentives for rural employment. Many participants mentioned the need for NPs to be able to provide proof of value for investment and accountability.		connected to deliverables such as # of patients, hours of service, etc; salary or capitation was also acceptable as long as there were checks and balances to ensure efficiency and fiscal accountability. Physicians should not gain or lose from involvement of NPs into the practice. Any funding model must support the ethical integrity of NPs.	to become NPs. Many felt that NPs should not be employed by physicians (perceived as too much control). Funding should follow the patient and not the professional. There must be recognition of the ongoing "intellectual" responsibility of the NP role. Fee-for-service was not seen as a favourable model and not even mentioned at most tables.

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Education	**Education**	**Education**	**Education**	**Education**
Q1. What **principles and**	There should be consistent Core curricula at the	Interdisciplinary and new delivery methods for	Principles that were suggested for consideration	Many of the same principles and characteristics

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Education	**Education**	**Education**	**Education**	**Education**
characteristics would need to be foundational to a pan-Canadian NP education (for example, for curricula, educational delivery methods, continuing education, prior learning assessment and recognition, and re-entry to practice)?	national level that will lead to national exam. Minimum hours of clinical practice, delivery methods, prior learning assessment and recognition and partnering with other professions for joint education needs to be considered. The educational standards (both in-class and clinical) must be credible (as viewed by outsiders). Standard entrance requirements must be determined. Funding for education as well as a 'grandfather' perspective must be considered. A replacement program for NPs who return to education should be considered.	education (for example online or rural education) are necessary. There should be a transition period for minimum education requirements which would include PLAR.	included alternative delivery methods, transition period, interdisciplinary education, consistency in educational standards across Canada, a minimum standard of clinical practice hours and funding for education. There was a suggestion for the establishment of a 'Canadian College of Nurse Practitioners'.	mentioned in earlier RTCs such as: interdisciplinary education, alternative delivery methods (distance education), continuing education, re-entry into practice opportunities, common curriculum (including clinical practice) and PLAR were repeated. The provision of funding to cover educational costs (MDs can deduct educational costs but NPs can't) was raised.

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Education	**Education**	**Education**	**Education**	**Education**
Q2. Should there be **standardized exit credential from all NP educational programs** across Canada? If yes, what should it be; if no, why not?	There must be a transition period but the goal would be to work towards a Master-level education and a national exam for licensing. The delivery method needs to be flexible (distance learning for example).	There is a need for a national exam. Continuing education must also be considered.	This group felt a Master's degree was the appropriate standardized exit credential. A few participants at the RTC referred to the need for a national exam.	Both a Master level and national exam should be the standardized exit credential.

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Strategic Communications	**Strategic Communications**	**Strategic Communications**	**Strategic Communications**	**Strategic Communications**
Q1. What are **three communications issues** you believe need to be addressed in ongoing communications by CNPI to **advance awareness and understanding of the NP role in primary health care**?	There is a need to have a standardization of the title and language around the NP; clear (consistent) definition of the NP role, and; an emphasis on the value/care added by the NP.	There is a need for a clear definition of the role of the NP; unique communications strategies directed to specific audiences (public, health care professionals, etc), and; emphasis on value added by the NP (using a non-aggressive but very professional approach to the communication strategies).	There should be standardization of the NP title; clear role definition; identification of target audiences (public, health care professionals, government, etc)	There should be a clear role definition of the NP; emphasis on value added by NP; communications strategies directed to specific audiences (public, health care professionals and government). A push to be proactive rather than reactive with regards to communications issues was also highlighted.

	Edmonton, AB April 19, 2005	Vancouver, BC April 21, 2005	Winnipeg, MB April 26, 2005	Toronto, ON April 28, 2005
Present situation				
Strategic Communications	**Strategic Communications**	**Strategic Communications**	**Strategic Communications**	**Strategic Communications**
Q2. What **communications materials/tools** would help you **advance awareness, understanding and acceptance of the NP role**?	Strategies for media relations, development of a web site and tool kits were identified as useful tools. Other ideas explored included fact sheets that feature NP champions but also 'third party testimonials'. It is important to communicate with nurses about how to become an NP. Long term communications should address the question of 'how to access an NP".	Strategies for media relations (3 minute news clips) and advertising campaigns (bus, newspaper, etc) were identified as useful tools. The use of champions (Physician testimonials and successful collaborations with NPs) would be a good way to demonstrate value.	Strategies for media relations, advertising, tool kits (ppt presentations, Q&A's, fact sheets) were identified as potential tools. Attention should be given to hard-to-reach populations (ex. Aboriginal communities). NPs should be present at conferences (via presentations) and a national 'NP' week was suggested. Word of mouth is an important communication strategy.	Strategies for media relations (production of a documentary on a day in the life of an NP), NP profiles (success stories) and tool kits (pamphlets, etc) were mentioned as tools that could be helpful. Additionally, many felt that a national NP association is needed to give NPs an official voice at the table. Support from other professional associations is also needed.

St. John's, NL May 2, 2005	Fredericton, NB May 4, 2005	Montréal, QC May 6, 2005	Common areas	Issues
Legislation and Regulation	**Legislation and Regulation**	**Legislation and Regulation**	**Legislation and Regulation**	**Legislation and Regulation**
The main principles outlined were the need for portability, broad and flexible legislation (not restrictive), title protection and the need to work towards a national exam and a definition for continuing education. Specifically, it was suggested that periodic reviews of NP practice should occur. Sustainability of and funding for NPs was raised as an important issue. Collaborations with MDs, although not viewed as mandatory, were also deemed to be important.	The need for national standards was expressed, keeping the protection of Canadians in mind. Principles outlined included title protection, role definition (broad rather than restrictive), autonomy, entry qualifications, portability, standardized exam (national exam), portability (both between domains of practice and jurisdictions), and a need to work within existing legislation.	This group focused a lot on the uniqueness of current Quebec legislation (but did agree that national standards might be acceptable). Title protection and role definition were stated as being important. They also favoured mandatory continuing education in order to maintain the NP title. Portability was presented as important. Emerging issues that were flagged included complimentary work with other professionals.	There was general agreement regarding the need for broad national standards that allow flexibility for provincial legislation implementation. Most prefer non-restrictive national standards that address issues such as accountability, autonomy and responsibility. Key elements agreed on included protection of Canadians interests (safety), title protection, portability (mostly between jurisdictions (although portability between the US & Canada was also mentioned) and domains of practice), standard educational requirements (a national exam was mentioned by some of the groups and minimum entry level requirements) and autonomy.	Issues raised included the need for collaboration with MDs or other professionals (collaborative or mandatory?), transition phase (no specifics given although the mention of a grandfather clause was discussed) and continuing education (mandatory or not? - some suggested re-certification every five years)

St. John's, NL May 2, 2005	Fredericton, NB May 4, 2005	Montréal, QC May 6, 2005	Common areas	Issues
Legislation and Regulation	**Legislation and Regulation**	**Legislation and Regulation**	**Legislation and Regulation**	**Legislation and Regulation**
Title protection, a transition phase or grandfather clause for those RNs working in NP like roles, portability, broad and flexible legislation, consistency in continuing education expectations, work towards changing existing legislation.	Title protection, a transition phase or grandfather clause for those RNs working in NP like roles, standard educational requirements, a national exam, portability, standard continuing education and accountability.	No specific comments listed	Title protection, standard educational requirements including continuing education, "grandfathering" mechanisms, national exam, continuing competency requirements	Dealing with transition periods was a cause for concern. Opposing views by participants, some felt the need to have a grandparent clause allowing current NPs to obtain the accreditation, while others felt it is necessary for formal education. There was an acknowledgement that this could be cause for hard feelings.

St. John's, NL May 2, 2005	Fredericton, NB May 4, 2005	Montréal, QC May 6, 2005	Common areas	Issues
Practice and Evaluation	**Practice and Evaluation**	**Practice and Evaluation**	**Practice and Evaluation**	**Practice and Evaluation**
Highlighted elements included autonomy, advanced education (beyond the achievement of a basic nursing degree), accountability, research, work with an interdisciplinary team, and the core competencies (diagnosis, treatment and the ability to prescribe). If NP will be working in various practice areas the standards should then vary accordingly.	The essential elements should include collaboration, consultation, professional autonomy (there is a need for a clear definition of autonomy), education which includes a masters degree, core competencies in primary care (diagnostics testing, prescriptions, prevention and promotion). One group suggested that the role definition should be developed irrespective of provincial regulations. The practice and geographical domains should describe the minimum capabilities and competencies of the NP.	There should be clear differentiation between all the different professions (nurse, nurse practitioner, MD, etc). Québec legislation 90 article 36 provides some of this definition	Autonomous practice, health promotion and prevention, diagnosis, treatment and the ability to prescribe medications, advanced education	the need to define the educational expectations, definition of the importance of the nursing component of the NP role, collaborations versus consultation

St. John's, NL May 2, 2005	Fredericton, NB May 4, 2005	Montréal, QC May 6, 2005	Common areas	Issues
Practice and Evaluation	**Practice and Evaluation**	**Practice and Evaluation**	**Practice and Evaluation**	**Practice and Evaluation**
The collaborative inter-disciplinary model is seen as the gold standard. It was stated that there was a need for flexibility in remuneration for the NP when that remuneration is tied to the physician remuneration method. A broad model based on population needs that would encompass all NP practices is needed.	Fee-for-service was seen as a successful model although it may be seen as barrier to the introduction of NPs. NPs are part of the multidisciplinary team and there is a need for mutual respect and competency. There must be a clear definition of the roles of all the participants to ensure success of any model.	No response noted	The NP should be part of a collaborative multi or interdisciplinary team, the Community Health Clinic model is seen as one of the better models. The fee for service model was not generally supported.	

St. John's, NL May 2, 2005	Fredericton, NB May 4, 2005	Montréal, QC May 6, 2005	Common areas	Issues
Health HR Planning	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**
The population and community needs, existing categories of providers/services must be considered. It is important to have a futuristic view and explore what we expect to be the desired population health outcomes. It is important to ensure that patients will be accessing the appropriate health care provider; this should not be based on MD shortage. Attention should be given to practitioners not being placed in isolated practice. There needs to be a balanced practice (inclusion of clinical, educational, research and other activities) situation.	A clear NP role definition is needed to determine the number of NPs required. Factors to consider include, population health, work setting (rural vs. urban, ER vs. long-term), regional and provincial planning as well as a clear understanding of the availability of other health care professionals.	Key factors include the distribution of the population and their health care needs, which also takes into consideration other health care providers. NP role definition is crucial in determining what impact they will have in meeting needs across Canada.	A clear role definition of an NP is required in order to determine what factors will impact HHR Planning. Assessments including the evaluation of population needs are required. There should be an assessment of other health care professionals in the community and how NPs will fit into the HHR planning mix (not to replace MDs or fill a shortage). A forward looking approach is necessary. Public awareness must also be considered as this might also increase the demand for NPs.	It is necessary to determine population health needs at a community level.

St. John's, NL May 2, 2005	Fredericton, NB May 4, 2005	Montréal, QC May 6, 2005	Common areas	Issues
Health HR Planning	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**	**Health HR Planning**
Capitation and or a salaried model were favoured based on the education and value of the practice. It was stated that there is need for flexibility in the funding model. Some participants felt that unionization of the NP was necessary. It was said that the NP should not employed by the MD. Some participants challenged the CNPI to 'introduce a new funding model'. They stated the funding should be sustainable, not just provided for pilot projects. Participants stated that there was a need to recognize collaboration with MDs and the current fee-for-service system would not achieve this.	There should be structured compensation to allow for consultation and collaboration. Contractual arrangements or salaried positions are the preferred models. The model should reward and recognize situations where there is isolation from urban centres. There should be compensation for continuing education. Quality vs. quantity of practitioners should also be taken into consideration. There should be room for integration with other funding models. Funding for support staff, RNs, computers, etc should also be in place and there should be criteria to measure outcomes, i.e. How will the NP improve patient outcomes?	Salary should be based on the practitioners' qualifications. This should not affect the RNs' salary; a new budget should be created for the new practitioner. Collaboration with other health practitioners also needs to be considered.	Recurring areas that were mentioned: Salary or contract; incentive pay for isolation (rural posts); compensation for continuing education; compensation to encourage collaboration; need for role definition.	

St. John's, NL May 2, 2005	Fredericton, NB May 4, 2005	Montréal, QC May 6, 2005	Common areas	Issues
Education	**Education**	**Education**	**Education**	**Education**
The principles and characteristics that should be considered included the need for interdisciplinary education, alternative delivery methods, standard curriculum (including a minimum number of clinical hours), funding, PLAR and continuing education.	Interdisciplinary education, core curriculum (coordinated clinical training) and consistent entry level requirements were mentioned	Alternative delivery methods, PLAR, continuing education, interdisciplinary education (clinical practice) were listed as key principles.	Alternative delivery methods, interdisciplinary education, minimum clinical practice hours, PLAR were consistently mentioned.	
Master level should be the exit credential. Some participants made mention of a national exam but were not explicit in stating the need for it.	Attainment of a Masters level and national exam were recommended as the standard exit credential. Many participants felt it was important to have a good grasp of the principles and characteristics of the NP before focusing on the necessary exit credentials. It was also stated that it is necessary to set a minimum standard of practice hours.	No specific answers to this question were written in this space but when the group answered the first question they suggested that Masters level and national exam (with OSCE) was the appropriate exit credential.	Most agreed on Masters level and national exam. A transition period for those NPs who do not have a Masters is required.	

St. John's, NL May 2, 2005	Fredericton, NB May 4, 2005	Montréal, QC May 6, 2005	Common areas	Issues	
Strategic Communications	**Strategic Communications**	**Strategic Communications**	**Strategic Communications**	**Strategic Communications**	
There should be a clear role definition of the NP; communications strategies directed to specific audiences, and; strategies to address 'resentment', 'hostility' or 'acceptance' within the health care community.	Communications strategies directed to specific audiences such as the public, politicians and health care professionals (RNs and physicians need to be addressed differently); there needs to be a clear role definition; standardization of terminology such as title, autonomy, collaboration and liability.	Communications should be directed to specific audiences; development of a clear role definition, and; standardization of terminology. There should be a focus on the 'value-added' aspect of the NP role.	The three issues that were emphasized are: standardization of title and language; clear (consistent) definition of role, and; emphasis on value/care added by NP. Many groups identified several target audiences that need to be considered and approached differently. The groups include politicians, general public and health care providers (RNs, MDs, pharmacists and others).		

St. John's, NL May 2, 2005	Fredericton, NB May 4, 2005	Montréal, QC May 6, 2005	Common areas	Issues	
Strategic Communications	**Strategic Communications**	**Strategic Communications**	**Strategic Communications**	**Strategic Communications**	
Internet, strategies for media relations, advertising were all mentioned as tools. A "road show" to various events, associations, high schools was also suggested as useful in reaching a variety of communities. A need for more published 'Canadian' studies on NP practice was also suggested.	Strategies for media relations, NP profiles, testimonials, success stories and the use of the internet were mentioned as tools. Word of mouth also came up as a tool. An NP presence at professional events and conferences was also mentioned as a communication strategy.	Success stories, tool kits, internet and strategies for media relations were viewed as essential tools. Being able to obtain community engagement is key. The strategy should not be aggressive but done with a positive focus and based on the contribution an NP can make to the community.	Traditional tools and materials were suggested such as strategies for media relations, advertising, internet and tool kits. Innovative ideas suggested would be production of an NP documentary. Many felt the tools should be proactive -however, they must be sensitive so as not to be perceived as aggressive. It is also important to have the community and other professionals engaged in the process. This can be done through a 'road show' and an NP presence at various key conferences and events.		1

Appendix D

Round Table Consultation Evaluation

Participant Evaluations of Consultation Sessions
169 evaluation forms collected

Question 1: Has this meeting provided you with a better understanding of the CNPI?

Yes: 163
No: 3
No answer: 3

Overall comments: Participants enjoyed discussions and different points of views presented. Participants felt the information clarified the goals and the objectives of the CNPI. Participants that responded "no" to the question mentioned they were already involved with the CNPI or did not elaborate why.

Question 2: Given today's discussions, are there representatives that should have been present that were not? If so, who*?
(* Participants were not informed of stakeholders that were engaged in past 1:1 consultations with the CNPI prior to the RTCs. An effort was made to approach stakeholders that had not been engaged prior to the RTCs)

Edmonton, Alberta

- Government of Alberta (health and wellness)
- Regional health authorities
- LPN rep
- Patient or Community representative
- College of Physicians and Surgeons of Alberta

Vancouver, British Columbia

- Health authorities (Chief Nursing Officers)
- Government representatives
- Consumer groups
- Other health professionals such as psychologists and physiotherapists
- First nations representative

Winnipeg, Manitoba

- Regulatory body (CRNM)
- Legislators
- College of Physicians and Surgeons
- Patients

Toronto, Ontario

- Social workers
- Public
- Policy makers
- Health unit representatives
- College of Physicians and Surgeons of Ontario
- Foreign trained NPs

St. John's, Newfoundland

- More non-health professionals
- Consumers
- More physicians
- New Brunswick and Newfoundland Nurses Union

- Policy makers
- Educators
- More allied health professionals
- Government representatives

Fredericton, New Brunswick

- More university representatives (that offer Masters program)
- NPs from different work settings
- NANB
- Aboriginal Nurses Association representative
- Patients
- More members of the interdisciplinary health care support services
- Liability issues
- HRDC/ service sociales
- Politicians
- Department of Health
- Specialists

Montréal, Québec

- OIIQ
- Fédération des médecins omnipraticiens du Québec

Question 3: Are there any issues around integration and sustainability of the nurse practitioner that were not covered during the session and should have been? If so, which ones?

Edmonton, Alberta

- Sustainable funding
- Determining practice hours to maintain competency of NP should be based on evidence
- Need for an evidence base towards defining nurse practitioner sensitive outcomes and ideal number of hours to maintain practice competence
- Collaboration
- Supporting NPs in education but being careful we don't support registered nurses as we need RN's in the system as well
- Practice and Evaluation: the need for evaluation parameters was not clearly articulated in the questions
- Public education and scope of practice

Vancouver, British Columbia

- Government commitment and role to the integration and sustainability of NPs into Health Act
- Broader emphasis on role for NP rather than tied to physician
- Implementation strategies
- Transition period (should we, how, what would it look like?)
- Focus on relationships other than NP/physician
- Funding

Winnipeg, Manitoba

- Where will there be funding for NP positions
- Unionization of NPs
- Research and outcomes measures
- Integration of other stakeholder entities
- Retention in the north

Toronto, Ontario

- Acknowledgment of acute NPs and Specialty NPs
- NP practice startup
- NPs working in Family Practice settings have difficulty getting benefits
- Discrepancy of salary and compensation among NP and CNS

St. John's, Newfoundland

- Not enough time to discuss sustainable funding
- Getting into Medical schools across the country to teach new doctors about collaborations
- Funding
- Ensuring this initiative does not fall to the wayside
- Primary health care transition funding utilized – how will initiative move forward
- Work with other disciplines beyond medicine
- Specialty NP
- Evaluation of role

Fredericton, New Brunswick

- Liabilities issues and the CMPA/CNPS liabilities stakeholders
- How to bring doctors and other health professionals into supporting NPs
- CNPI budget information
- CNPI must be utilized down the road
- Physician training on collaboration
- National strategies to sustain integration of the NP in the health care system

Montréal, Québec

- Recognition of experience >20 years versus certification
- Change management = need a plan