REPORT

CANADIAN NURSES ASSOCIATION®

THE CANADIAN NURSE PRACTITIONER INITIATIVE: A 10-YEAR RETROSPECTIVE

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EXECUTIVE SUMMARY

Ten years ago the federal government invested in a pan-Canadian framework to support the integration of the nurse practitioner (NP) role into Canada's health-care system. In 2006, the Canadian Nurse Practitioner Initiative (CNPI) published *Nurse Practitioners: The Time is Now*, a report with 13 recommendations on how to accomplish and sustain this integration. This 10-year retrospective seeks to determine the progress and gaps that have occurred in the wake of those recommendations[1] and to recommend priorities for the continuing integration of the NP role.

Recent findings from the Canadian Institute for Health Information (2015) suggest that significant progress was made over the past 10 years on a number of the CNPI recommendations, including the overall evolution of the NP role.

In terms of employment, the number of licensed NPs in Canada has grown by 300 per cent,[2] with an employment rate of more than 95 per cent. About three out of four NPs work in the family all ages/primary care stream, being deployed across a wide variety of settings and sectors and in various models of care. This strengthening of the NP role is further supported by:

- Significant harmonization and expansion of the scope of practice across jurisdictions
- Pan-Canadian title protection
- A common role description
- Adequate professional liability coverage

All of these improvements were among CNPI's recommendations.

NP education programs have also increased substantially over the last decade. As of 2013-2014, 28 schools[3] across Canada offered at least one NP program (Canadian Association of Schools of Nursing [CASN], 2015). In addition, stakeholders view the standardization of master's education in nursing as significant for the advancement of the NP role.[4]

Other advancements in keeping with CNPI recommendations include the following:

- Canada now has national NP workforce and education data.

[1] In terms of legislation and regulation, practice, education and health human-resources planning.
[2] Increasing from 976 NPs (2006) to 3,966 (2014).
[3] In every province/territory except the Yukon and Nunavut.
[4] Many of CNPI's recommendations on education were captured later in CASN's *Nurse Practitioner Education in Canada: National Framework of Guiding Principles and Essential Components* (2012).

- A number of tools and resources have been developed to support health human resources planning for NPs, including national job boards, fact sheets and position statements.
- Polls suggest an increase in the public's awareness of NPs and in their comfort level with being treated by NPs, in part due to a 2011-2013 NP campaign led by the Canadian Nurses Association (CNA) and its member organizations.

Despite such progress, however, enough gaps remain that we must continue advancing the NP role to improve Canadians' health, well-being and access to cost-effective care. CNA recommends the following pan-Canadian strategies:

- Expand the knowledge and implementation of innovative team-based models that include NPs (who will serve as exemplars).
- Evaluate various team-based models that use NPs, including an assessment of the return on investment.
- Enhance the quality of NP workforce data available at the Canadian Institute for Health Information (CIHI) and NP education data available at CASN.
- Advance the deployment of NP positions in the community to provide primary care to vulnerable populations such as high users, seniors, rural/remote clients, refugees, First Nations, etc.
- Develop a targeted recruitment strategy with incentives to improve the distribution of NPs.
- Harmonize NP remuneration across sectors and provinces/territories that reflect the advanced practice nurse (APN) role.
- Conduct population-health needs-based planning using the Health Human Resources Planning Simulation Model for Nurse Practitioners in Primary Health Care.
- Educate more NPs through a coordinated pan-Canadian strategy.
- Leverage existing tools and resources from the NP campaign to promote greater awareness among decision-makers and the public.
- Improve access to appropriate continuing education for NPs.

As Naylor et al. (2015) frequently mentions in its federal government advisory panel report, *Unleashing Innovation: Excellent Healthcare for Canada*, NPs are underused, despite clear evidence on their benefits to the health system and Canadians.

INTRODUCTION

BACKGROUND

In September 2000, Canada's first ministers acknowledged the need for multi-disciplinary teams and agreed that improving primary health care was crucial to renewing health services. In response, the federal government established an $800 million primary health care transition fund (PHCTF).

From 2000 to 2006, this fund supported provincial/territorial efforts to reform the primary health care system by covering the transitional costs involved with using new approaches. Pan-Canadian initiatives that sought to overcome barriers to the improvement of primary health care were also funded through the PHCTF.

In the 2003 Health Accord, federal/provincial/territorial governments agreed to ensure Canadians receive "the most appropriate care, by the most appropriate providers, in the most appropriate settings" (CNPI, 2006a, p. 10). Their specific target was that "at least 50% of [Canadians] have access to an appropriate health care provider, 24 hours a day, 7 days a week . . . within 8 years" (Government of Canada, 2006, para. 12).

The Canadian Nurse Practitioner Initiative (CNPI) was a direct result of these governmental agreements (i.e., 2000, 2003). As part of their implementation, Health Canada provided CNPI with $8.9 million to develop a framework that would support the sustained integration of the NP role into Canada's health-care system.[5]

CNPI envisioned:

- "A renewed and strengthened primary health care system that optimizes the contributions of nurse practitioners to the health of all Canadians; and
- A system in which nurse practitioners are recognized and utilized across Canada as essential providers of quality health care." (CNPI, 2006a, p. 14)

The goals were:

- "To facilitate sustained integration of the NP role in the health system.
- To develop mechanisms and processes to support the integration and sustainability of the NP role." (CNPI, 2006a, p. 14)

From the beginning, CNPI established consultation and collaboration as foundations for its approach. Doing so was crucial given that "the task required input from stakeholders, including health-care professionals, leaders of health-care professional organizations, regulators, educators, employers, unions, municipal leaders as well as

[5] CNA sponsored and led CNPI, whose mandate spanned 18 months.

federal, provincial and territorial officials" (CNPI, 2006a, p. 11).

Among CNPI's priorities was to develop a consistent definition for the NP role through such collaboration:

> Nurse practitioners are registered nurses with additional educational preparation and experience who possess and demonstrate the competencies required to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice. (CNPI, 2006a, p. 26)

An advisory committee, whose members were from all parts of Canada and represented diverse stakeholder groups,[6] was established to guide the approach to elements of the CNPI work plan. In addition, a task force was created to advise on the scope of work plans for each of the initiative's six components and to review deliverables.[7]

In June 2006, CNPI published *Nurse Practitioners: The Time is Now*, a report with 13 recommendations on how to integrate NPs into the Canadian health-care system. This plan included 84 actions, grouped into seven strategic areas:

- legislation and regulation
- practice
- health human resources planning
- education
- strategic communications, change management and social marketing
- evaluation
- governance

10-YEARS LATER

CNPI's final report provided a roadmap to help integrate and sustain the NP role in Canada. CNA's update to that report in 2009[8] found that more than half of the 84 actions had been fully or partially completed while several others were in progress.

Ten years after *Nurse Practitioners: The Time is Now*, progress and limitations on NP integration continue. In 2015, *Unleashing Innovation: Excellent Healthcare for Canada* (commonly referred to as the Naylor report) frequently mentions how NPs are underused, despite evidence of the benefits they could bring Canadians and the

[6] These groups included nurse practitioners, registered nurses, physicians, educators, employers, unions, pharmacists, regulators, federal, provincial and territorial officials, as well as officials from Health Canada and National Defence.
[7] In case of evaluation, a separate steering committee was also established.
[8] In 2011, CNA also published an action plan: *Collaborative Integration Plan for the Role of Nurse Practitioners in Canada*.

health-care system:

> "The Panel suspects that some of this shortfall could be addressed by greater use of nurse practitioners for primary and specialty care (p. 14).
>
> "Ontario in 2007 created a set of Nurse Practitioner-led Clinics for patients who have trouble finding a family physician. About 25 of these clinics currently provide multi-professional team care to these vulnerable patients. Nurse practitioners also help these patients navigate the healthcare system (p. 61).
>
> "The cash strapped health authority would rather contract the services of a physician that they do not have to pay for out of their own budget rather than develop Nurse Practitioners or Clinical Nurse Specialists who could do the same role for fewer tax payer dollars (p. 88, stakeholder submission).
>
> "But as the case of the nurse practitioner illustrates, even practical and definitive findings do not spark widespread innovation in the absence of winning conditions in the healthcare system (p. 5).
>
> "Canadians still have suboptimal access to ambulatory care — including family doctors, various specialists, nurse practitioners and nurses, non-physician psychotherapists, and physiotherapists" (p. 14).

CNA believes the actions yet to be taken on NP integration in Canada strongly support the case for its continuation. With these actions in mind, this paper will seek to:

- Specify the current implementation status (progress and gaps) of CNPI recommendations in four key strategic areas:
  1. Legislation and regulation
  2. Practice
  3. Health human resources planning
  4. Education
- Recommend priorities for the continued integration of the NP role in Canada

METHODOLOGY

This 10-year retrospective focuses on the major components of the CNPI recommendations. To complete the report, CNA undertook the following activities:

- Hosting a pan-Canadian NP roundtable consultation with key informants (e.g., NPs, national nursing stakeholder organizations, researchers, NP educators, governments, etc.), on November 25, 2015 (see Appendix A for participants)
- Evaluating peer-reviewed and grey literature
- Analyzing 10 years of NP workforce data from CIHI

- Compiling and comparing current NP salaries across Canada
- Analyzing NP education data from CASN
- Comparing the current legislated/regulated scope of practice of NPs across jurisdictions
- Pinpointing federal barriers to NP practice
- Identifying the funding models currently in place for NPs across Canada

FINDINGS

1. LEGISLATION AND REGULATION

To facilitate consistency in federal/provincial/territorial legislative and regulatory approaches, CNPI recommended adopting its *Legislative and Regulatory Framework* (2006c) for NPs in Canada (see Appendix B).

Successes

Since the release of CNPI's final report, many aspects of its recommendations on legislation and regulation have been achieved:

- The "nurse practitioner" definition was integrated into the policy documents of CNA and its jurisdictional associations.
- All jurisdictions have NP legislation and regulations in place.
- The title "nurse practitioner" is now protected in all Canadian jurisdictions.

However, additional designations still in use in certain jurisdictions could still be addressed. For example, in Ontario, NPs can also use "RN extended class" (RN(EC)) and, in Manitoba, "registered nurse (extended practice)" (RN(EP)) and "registered nurse (nurse practitioner)" (RN(NP)). NPs have noted how such designations can cause confusion, particularly for the public.

CNPI's initial core competency framework was revised in 2010, in collaboration with provincial/territorial nursing regulators (outside Quebec).

Several types or streams of NPs are in place across the provinces and territories. As Table 1 shows, the Family/Primary Care – All Ages stream predominates, with 75 per cent of NPs licensed as of September 2015 (Table 1).[9]

[9] Because this is the first time such data has been captured and reported, a 10-year comparison is not possible.

Table 1. Number of NPs by Province and Stream in Canada, September 2015[10,11,12]

Province/Territory	Type/Stream	Number
British Columbia	Family – All Ages Adult Pediatric	307 28 13
Alberta	Family – All Ages Adult Child Neonatal	164 177 41 20
Saskatchewan	Primary Care – All Ages Adult Pediatric Neonatal	197 3 1 7
Manitoba	Primary Care – All Ages Adult Pediatric	142 11 5
Ontario	Primary Health Care Adult Pediatric Anesthesia	1,959 512 215 Not Reported
Quebec	Primary Care Cardiology Nephrology Neonatology	247 30 14 17
New Brunswick	Primary Care – All Ages	98
Nova Scotia	Family – All Ages Adult Pediatric Neonatal	89 50 4 9
Prince Edward Island	Family – All Ages	26
Newfoundland and Labrador	Family – All Ages	115

[10] Except for Alberta, Nova Scotia, and Newfoundland and Labrador, whose NP numbers are as of October 2015.
[11] NPs may be registered in more than one specialty.
[12] Adapted from Spence, Agnew, & Fahey-Walsh, 2015, pp. 8-9. Copyright 2015 by the Nurse Practitioners' Association of Ontario.

Province/Territory	Type/Stream	Number
	Adult Pediatric	18 3
Northwest Territories/ Nunavut	Primary Health Care – All Ages	53
Yukon	Family – All Ages	5

In terms of registration requirements, the Nurse Practitioner's Association of Ontario (NPAO) has mentioned common prerequisites among the jurisdictions, including:

- Being registered as an RN in the respective jurisdiction
- Graduating from a recognized/approved NP program
- Passing the approved exam

As well, some jurisdictions have other requirements. For example, Alberta requires NP applicants to have 4,500 hours of experience as an RN, while B.C. and Quebec require them to pass the Objective Structured Clinical Examination (OSCE) in addition to the Canadian Nurse Practitioner Exam.

The development of the Canadian Nurse Practitioner Exam: Family/All Ages (CNPE: F/AA) was one of CNPI's first major achievements. It continues to serve the profession well and is used in all 10 provinces.[13] (The Yukon registers NPs after they have been registered elsewhere in Canada.)

Some jurisdictions (e.g., B.C.) recognize more than one exam for a stream. Most jurisdictions with an adult stream use the American Academy of Nurse Practitioners Certification program's Adult-Gerontology Primary Care Nurse Practitioner Certification Exam (Canadian Council of Registered Nurse Regulators [CCRNR], 2016). All jurisdictions who license pediatric NPs now use the Pediatric Nursing Certification Board's (PNCB's) Primary Care Pediatric Nurse Practitioner Certification Exam (CCRNR, 2015). U.S.-based exams will likely continue given the small number of these specialty NPs in Canada, which make developing Canadian exams impractical. However, using American exams raises questions as to whether NPs are being prepared for U.S. or Canadian practice, which differ in their health systems and legislation/regulation. All Canadian jurisdictions who license neonatal NPs are using the Ordre des infirmières et des infirmiers du Québec (OIIQ) OSCE exam. (See Table 2 for complete list).

[13] See http://www.ccrnr.ca/familyall-ages.html

Table 2. Approved NP Exams by Province and Stream/Type

Jurisdiction	CNPE: Family/All Ages	Adult (ANCC* or AANP*)	Pediatric (PNCB)	Family (ANCC or AANP)	Neonatal (OIIQ)	Other
B.C.	✓	✓	✓	✓		
Alta.	✓	✓	✓		✓	
Sask.	✓				✓	
Man.	✓	✓	✓			
Ont.	✓	✓	✓			
Que.					✓	✓
N.B.	✓					
N.S.	✓	✓	✓		✓	
P.E.I.	✓					
N.L.	✓					
N.W.T./ Nunavut	✓					

* ANCC = American Nurses Credentialing Center; AANP = American Academy of Nurse Practitioners

The requirement that NPs have a formal collaborative practice agreement with a physician remains in Quebec, Nova Scotia, New Brunswick, Prince Edward Island, and Newfoundland and Labrador (Spence, Agnew, & Fahey-Walsh, 2015).

There has been a significant harmonization and expansion of the NP scope of practice across jurisdictions, as CNPI recommended. According to research conducted for NPAO (Spence, Agnew, & Fahey-Walsh, 2015), all jurisdictions have authorized NPs to independently:

- perform comprehensive health assessments
- make and communicate a medical diagnosis ("diagnostic impression" in Quebec)
- order laboratory tests
- order and interpret diagnostic imaging tests (with some exceptions for CT scans and MRIs)
- prescribe controlled drugs and substances (in progress in B.C., Ontario; with limits in the Yukon)
- independently refer to a specialist physician (only by primary care NPs in Quebec)

- prescribe massage therapy, acupuncture and physiotherapy (except Quebec)
- prescribe orthotics, mobility aids and compression stockings
- order home oxygen and insulin syringes/blood glucose monitors (except Quebec)
- order incontinence/ostomy supplies

There has also been change in several jurisdictions on including NPs in legislation related to hospitals, workers' compensation and motor vehicles. For example, as of September 2015, NPs in the Yukon, B.C., Manitoba, Ontario, and Newfoundland and Labrador can admit, treat and discharge hospital patients (Spence, Agnew, & Fahey-Walsh, 2015). NPs are also authorized to complete medical exams for drivers in the Northwest Territories, Nunavut, B.C., Saskatchewan, Manitoba, Ontario, New Brunswick, and Newfoundland and Labrador.

Table 3 provides an inventory of the authority NPs have been given with regard to completing forms for workers' compensation and short-term or other disabilities.

Table 3. NP Authority for Workers' Compensation, Short-Term Disability or Other Forms, as of September 2015[14]

Province/Territory	Workers' Compensation	Short-Term Disability Form	Other Disability Forms
B.C.		✓*	
Alta.			
Sask.	✓		
Man.		✓**	
Ont.	✓		
Que.		✓ (some limits)	
N.B.	✓	✓	✓ (EI forms)
N.S.	✓		
P.E.I.		✓	
N.L.		✓	
N.W.T./ Nunavut		✓	
Yukon			

* Insurance companies make independent decisions about accepting forms completed by NPs.
** Manitoba Public Insurance, Manitoba Hydro and Manitoba Infrastructure accept NPs' authority to complete physical examination reports. Third party insurance companies make independent decisions about accepting forms completed by NPs.

[14] Adapted from Spence, Agnew, & Fahey-Walsh, 2015. Copyright NPAO, 2015.

Opportunities for Further Advancement

Standardizing the NP role across jurisdictions is essential for developing its full potential and providing the most cost-effective care for Canadians. It will lead to greater clarity about the role for the public, for decision- and policy-makers, and for other health-care team members (while promoting acceptance). By enabling continued compliance with the interprovincial Agreement on Internal Trade, standardization will also support workforce mobility for meeting population health needs. While a high degree of commonality exists across the provinces and territories, some differences could still be harmonized, such as hospital admitting and discharging.

In addition, significant barriers to NP practice remain within federal legislation. Examples include:

- Disability benefits under Employment Insurance and Canada Pension Plan policies, which do not specifically authorize NPs to complete the medical report section of the application forms
- The *Food and Drugs Act* and its regulations, which do not allow NPs to distribute drug samples to their clients

The legislations in question affect both the broad population and its different segments. For example:

- Persons in specific professions/trades
- Veterans and RCMP personnel
- Other public servants

Appendix C provides a full inventory and description of federal legislation and its impact on different groups.

A number of legislative/regulatory opportunities exist to more fully integrate NPs into the Canadian health system across Canada. These include:

- Removing federal barriers to NP practice
- Continuing to amend provincial/territorial legislation to optimize the NP role
- Enabling NPs to complete medical exams for drivers
- Standardizing the NP designation across Canada
- Eliminating the requirement for a formal collaborative agreement with a physician

2. PRACTICE

CNPI's recommendations, in *Practice Framework for Nurse Practitioners in Canada* (2006b), sought to facilitate consistency in federal/provincial/territorial approaches to NP practice (see recommendations in Appendix D).

Successes

In terms of progress, the NP role description CNPI developed in its practice framework is still in use across the country today. In 2008, CNA also sought to further clarify the NP role in its revision of *Advanced Nursing Practice: A National Framework*: "The NP is an advanced practice nursing role that requires competencies in change management, research, leadership, collaboration and, of course, clinical competence" (CNPI, 2006a). However, at the NP roundtable CNA hosted in November 2015, NPs said they have very little opportunity to engage in research. Their practice arrangements and employment conditions make it hard to fulfil advanced practice dimensions beyond providing clinical care.

Since CNPI, there has been an explosion of the types and number of models of care that include NPs, suggesting improved access to care for Canadians. A fall 2015 survey of NP associations in Canada by the NP council at the Canadian Association of Advanced Practice Nurses (CAAPN) found models of care that include:

- long-term care
- primary-care multidisciplinary networks/teams
- mobile health units/clinics
- school health
- emergency departments
- home care
- quick-care clinics
- multidisciplinary specialty clinics (e.g., cardiac, nephrology)
- community health centres
- rehabilitation centres
- NP-led clinics
- family doctor offices
- public health units
- hospitals
- private clinics
- educational institutions
- street health

This increase in the settings and sectors where NPs are deployed was reinforced by participants at CNA's roundtable, who saw this as a success in the advancement of the NP role over the last 10 years. However, with the types of models being so varied across the country, they said integrating NPs into them depends very much on the funding model. Scaling-up models of care that include NPs was also identified as a priority action. Appendix E shows the CAAPN NP council inventory of models of care in 2015 and their associated funding structures.

Other successes in NP practice that roundtable participants identified include:

- The extent to which the language of policy work includes NPs
- That the language being used in policy, such as "primary care provider" or "most responsible practitioner," is more inclusive of NPs
- More NPs taking leadership roles
- More areas of NP expertise: e.g., methadone, refugee health, population diversity
- Greater public recognition of the NP role
- Improvement in physicians' acceptance of the NP role

Regarding such acceptance, when CNPI began, physicians deemed liability a significant barrier to any collaborative work they might undertake with NPs (and other health-care providers). In response, CNPI brought together the Canadian Medical Protective Association (CMPA) and the Canadian Nurses Protective Society (CNPS) to develop a joint position statement (CMPA & CNPS, 2013 [later revised]). Today, while all NPs must have at least $5 million of liability coverage, as CNPI recommended, most NPs' have more. CNPS (n.d.-a) provides "up to $10 million per claim for professional negligence relating to care provided in Canada" through civil litigation and "up to $1 million per occurrence" for criminal investigations and prosecutions or statutory offences as beneficiaries of CNPS coverage. NPs who are members of the following associations and colleges qualify:[15]

- CARNA
- CRNM
- ARNNL
- CRNNS
- SRNA
- NPAO
- CRNBC
- NANB
- RNANT/NU
- ARNPEI
- YRNA

As of January 2015, NPs in B.C., Quebec and Ontario who are not members of these associations and colleges can register individually to become a CNPS beneficiary.

[15] See list of acronyms.

RNAO members qualify for professional liability coverage up to $10 million per claim through the Liberty Mutual Insurance Company. This amount covers "claims or legal actions for professional negligence arising from the provision of a professional nursing service [and includes] the payment of settlement or court-imposed damages, costs, legal expenses and fees as per the terms and conditions of the policy. [It also provides up to $1 million for] criminal investigations and prosecutions, statutory offences, public inquiries, inquests and fatality inquiries and non-party proceeding" (RNAO, n.d.).

The main difference between the CNPS and the Liberty Mutual programs is that CNPS provides "occurrence-based professional liability protection and legal assistance" (CNPS, n.d.-b). Such protection enables beneficiaries to receive benefits without imposed time limits.

In Quebec, the NP professional liability limit for each loss and insurance period is $5 million. This protection is provided by La Capitale General Insurance Inc., which has partnered with OIIQ to offer a professional liability insurance program to its members.

With today's insurance programs, it would appear that liability protection is no longer a barrier to physicians' acceptance of the NP role.

Opportunities for Further Advancement

A number of ways exist to further integrate NP practice harmoniously into Canada's health system. These opportunities include:

- Expanding team-based care models that include NPs
- Scaling up innovative NP models, such as the Manitoba Mobile Clinics
- Encouraging team-based funding models that support the inclusion of NPs
- Evaluating team-based models that use NPs for such items as return on investment
- Offering protected time and/or funding for advanced practice nurse activities such as research and continuing education
- Establishing an NP mentorship program

3. EDUCATION

CNPI's recommendations in *Education Framework for Nurse Practitioners in Canada* (n.d.-a) sought to bring more consistency to federal/provincial/territorial educational approaches (see the framework's summary of actions in Appendix F).

Successes

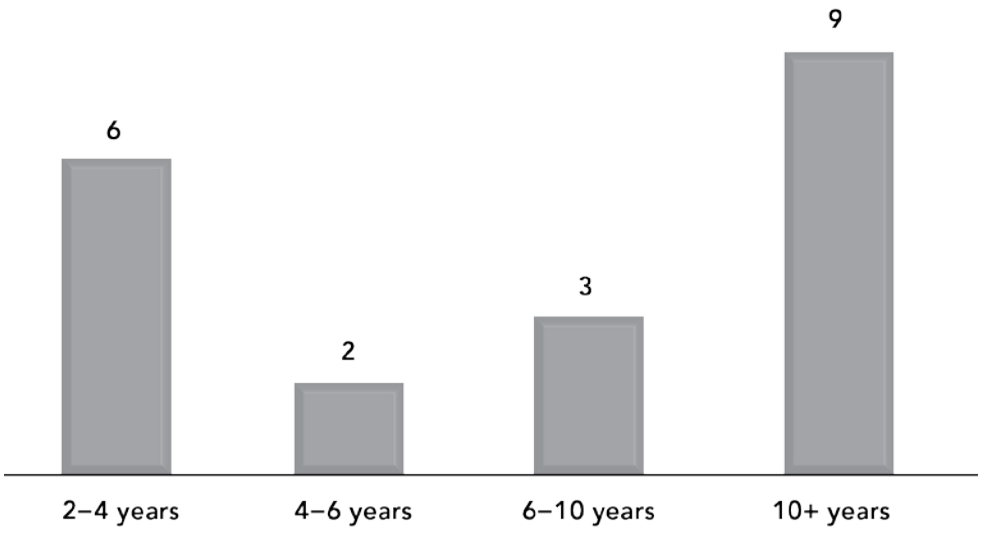
Significant progress has been made on adopting CNPI's educational recommendations. More recently, CASN led the development of a collaborative

national NP education framework that included guiding principles and essential elements. This framework (CASN, 2012) shares many CNPI components, although the extent that educational programs are complying with its recommendations has not been determined.

CASN's 2011 national survey of practices and programs found that all schools were meeting or exceeding the mandatory minimum clinical hours CNPI recommended. While NP courses had a high degree of commonality of across programs, there was room for greater alignment. Most used a combination of distance learning and onsite education. One program distance learning only, and four programs were offered entirely on site (CASN, 2011).

NP education continues to be offered at post-RN, master's, and post-master's levels with the majority at the master's level (CASN, 2011). Over the last 10 years, the number of NP programs has increased (see Figure 1). As of the 2013-2014 academic year, there are 28 NP programs across the country, with at least one in every province or territory except the Yukon and Nunavut. This expansion suggests a recent resurgence in provincial/territorial government interest in NPs.

Figure 1. Age of NP Programs in Canada[16]



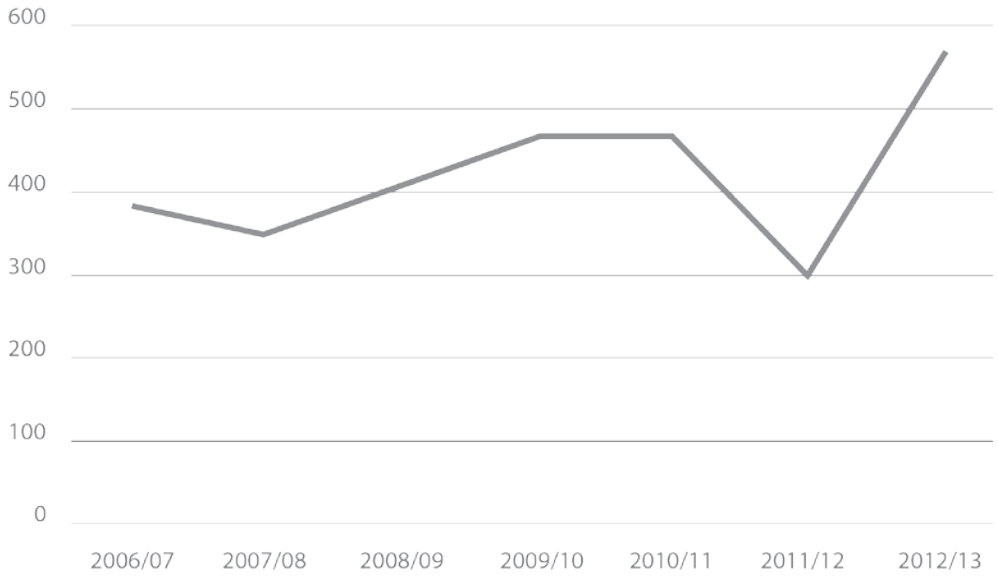
Source: NP Forum Environmental Scan 2011

Figure 2 shows the number of admissions to NP programs which, apart from 2012-2013, has been between 350-450 since 2006-2007. While the reasons for the coexistence of stable admission numbers and more programs are unknown (and warrant further investigation), the following seem most probable:

[16] Adapted from CASN (2011).

- NP programs are small in size and/or have become smaller as the number of programs has increased.
- NP programs have become more evenly distributed across the country.
- Challenges exist with expanding the size of NP programs.

Figure 2. NP Admissions 2006-2013[17]



The 2012-2013 spike in admissions should mean more NP graduates in 2014, 2015 and 2016, though whether this increase will continue still remains to be seen.

Participants at CNA's 2015 NP roundtable identified the standardization of master's education as one of the successes in advancing the NP role over the last 10 years. It has particularly helped with the public's understanding of role. They also noted, anecdotally, that more NPs have doctorates. While CIHI was not able to verify the number of NPs with doctorates (the national NP workforce data does not include education data), knowing this would help us understand how many NPs have the capacity to be faculty which, in turn, will affect the further growth of NP education programs. It would also be helpful to know how many NPs with doctorates are now in faculty roles.

[17] Adapted from CASN (2015).

Opportunities for Further Advancement

Though CASN has not yet begun to accredit NP education programs, as CNPI recommended, it has recognized the value of doing so:

> Accreditation promotes excellence and is recognized worldwide as an important, objective method to assess professional education programs. Accreditation identifies strengths and opportunities for improvement that can guide decision making. The process provides administrators and faculty with information regarding areas that require development, modification and/or resources. (CASN, n.d.)

Accreditation remains an opportunity for strengthening the academic quality of Canada's NP education programs.

In CASN (2011) survey of NP educational programs found that the most common challenge was a lack of qualified faculty. Respondents identified a total of 164 faculty members teaching in NP programs, 18.3 per cent (30 of 164) of which held a PhD.

This same CASN survey said there was a need for NP clinical preceptorship and more clinical placement opportunities, which participants at CNA's 2015 NP roundtable also echoed.

In terms of continuing education for NPs, CNPI's recommendations are seen as less successful. Consistent funding support, protected release time and access to appropriate continuing education continue to be issues. Access was one of the top six priorities for action identified at the CNA NP roundtable.

A number of educational opportunities exist to further integrate NPs into Canada's health system in a harmonized manner. These include:

- Increasing NP clinical placement opportunities
- Establishing an NP clinical preceptorship model
- Improving access to appropriate NP continuing education
- Assessing the compliance of NP programs with the *Nurse Practitioner Education in Canada* national framework (CASN, 2012).
- Supporting CASN in accrediting NP programs
- Educating more NPs through a coordinated pan-Canadian strategy

4. HEALTH HUMAN RESOURCES

Several CNPI health human resources (HHR) recommendations are available in Appendix G.

Successes

One of the greatest HHR successes, which began during CNPI (but has since evolved), is the development of data to support HHR planning. This advancement occurred when CIHI expanded its nursing databases to include NP workforce data — data CIHI continues to report annually.

CASN also collects NP education data as part of an annual student and faculty survey. NP education statistics, which CASN publishes in *Registered Nurses Education in Canada Statistics* each year, provides information on NP programs, admissions and graduates (parts of which we outlined in our section on education).

In regard to centralizing NP employment opportunities, several NP job boards are available to facilitate recruitment and employment, including NursingCareersCanada.ca from CNA and NPCanada.ca. A quick review of these websites shows several vacant NP positions, especially in rural and remote areas of Canada, which a number of NPs at CNA's 2015 roundtable validated.

The most recent workforce statistics (CIHI, 2015) show there has been a 300 per cent increase in the number of licensed NPs over the past 10 years.[18] However, NPs only represent 1.4 per cent of the RN/NP workforce. More than 95 per cent of NPs are employed as of 2014 — with between 77 and 80 per cent working full time, a trend that has remained consistent over the past 10 years. The average age of NPs (45 years) has also remained steady for a decade (CNA & CIHI, 2005; CIHI, 2015).

Subsequent to CNPI, CNA developed evidence-based fact sheets on NPs in long-term care (LTC), emergency departments, and rural and remote communities.[19] The intent was to advance the deployment of NPs in these areas across the country.

Between 2011 and 2013 CNA led an NP campaign with several of its jurisdictional members. The goal was to raise demand and support for NPs by creating greater awareness about the role.

Primary audiences included the general public, federal/provincial/territorial politicians, government decision-makers, the media, CNA jurisdictional members, Canadian NPs and NP associations. The campaigns radio and print ads, social media and government relations initiatives were rolled out in three phases across the country:

- Phase 1: Ottawa and New Brunswick
- Phase 2: Newfoundland and Labrador, Alberta, Saskatchewan and B.C.
- Phase 3: Prince Edward Island, Nova Scotia, the Yukon and Ontario

[18] Increasing from 976 NPs (2006) to 3,966 (2014).
[19] CNA updated two fact sheets (LTC, emergency) in 2013 and its NP position statement in 2009.

Surveys showed overall that the campaign succeeded in improving the public's comfort level with being treated by an NP. Phase 1 surveys showed that a higher percentage of respondents were comfortable being referred to an NP when concerns were general or moderate. Phase 2 and 3 surveys showed that a higher percentage of those exposed to the ads were comfortable being treated by an NP, either for general health-care needs or for symptoms they were moderately concerned about.

Opportunities for Further Advancement

A more even distribution of NPs in terms of place of work and rural versus urban settings is an area worth advancing. While a significant shift in NPs' place of work has occurred over the past 10 years, it's been moving in the wrong direction. Between 2005 and 2014, the percentage of NPs working in community health went from 58.3 per cent down to 32.2 per cent. Access to primary care services may also not have improved as much as many think, even though the number of NPs has risen by 300 per cent (CIHI, 2015). In addition, there has been a reduction in NPs working in rural areas in the past decade, from 29 to 18 per cent. The health needs of Canadians living in rural and remote areas are some of the greatest in the country (see figures 3 and 4).

During CNPI, leading HHR researchers developed and tested a planning simulation model based on population health needs in three provinces (Ont., N.L and Alta.). At that time, results showed that plans to train, educate and supply a certain number of NPs for their proposed scope of practice in the health system would fall short (CNPI, n.d.-b). It appears none of the provincial/territorial governments have since conducted HHR planning based on population health needs, even though the model and training was provided to those governments who showed interest during CNPI.

NP remuneration varies across the country as well as across sectors within provinces or territories and, in general, do not reflect the value of an advanced nursing practice role. Many NPs have said they have not had a wage increase in many years. Participants at the CNA 2015 NP roundtable saw remuneration an area for improvement, noting that RNs often have higher incomes than NPs (see Appendix G).

A number of variables suggest that Canada could educate more NPs to meet the health needs of our populations, especially the most vulnerable. These variables include:

- Canada ranking last among 11 OECD countries (2013) in timely access to primary health care providers
- Our rising rates of chronic disease, including cancer, heart disease, dementia, diabetes, and others
- Our aging population
- A high number of NP vacancies

- That 95 per cent of NPs are employed
- The relatively low number of NPs in the nursing workforce
- Having fairly constant NP admission numbers

Educating more NPs would require having a coordinated pan-Canadian strategy among schools, governments and employers. The HHR planning model mentioned earlier (CNPI, n.d.-b) could help with such an initiative.

There are a number of HHR opportunities to further fully integrate NPs into the Canadian health system in a harmonized manner across Canada. These include:

- Enhancing the NP education data available at CASN to specify NP education levels
- Enhancing the NP workforce data available at CIHI (specifically, the types/streams of NPs and their education levels)
- Positioning NPs in community to provide primary care to support vulnerable populations, including:
  - high users
  - rural/remote
  - First Nations
  - seniors
  - refugees
  - others
- Harmonizing remuneration across sectors and provinces/territories to reflect an APN role
- Implementing a targeted recruitment strategy with incentives to improve the distribution of NPs
- Conducting population health needs-based planning using the Health Human Resources Planning Simulation Model for Nurse Practitioners in Primary Health Care
- Leveraging tools and resources from CNA's national NP campaign to promote greater awareness among decision-makers and the public

Figure 3: Place of Work Among NPs in Canada, 2005 and 2014

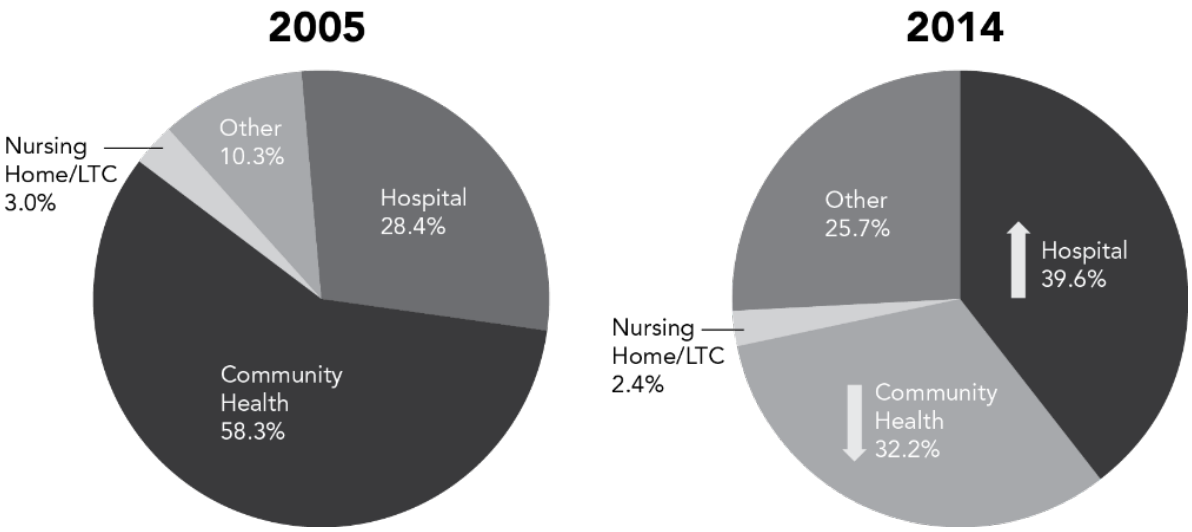
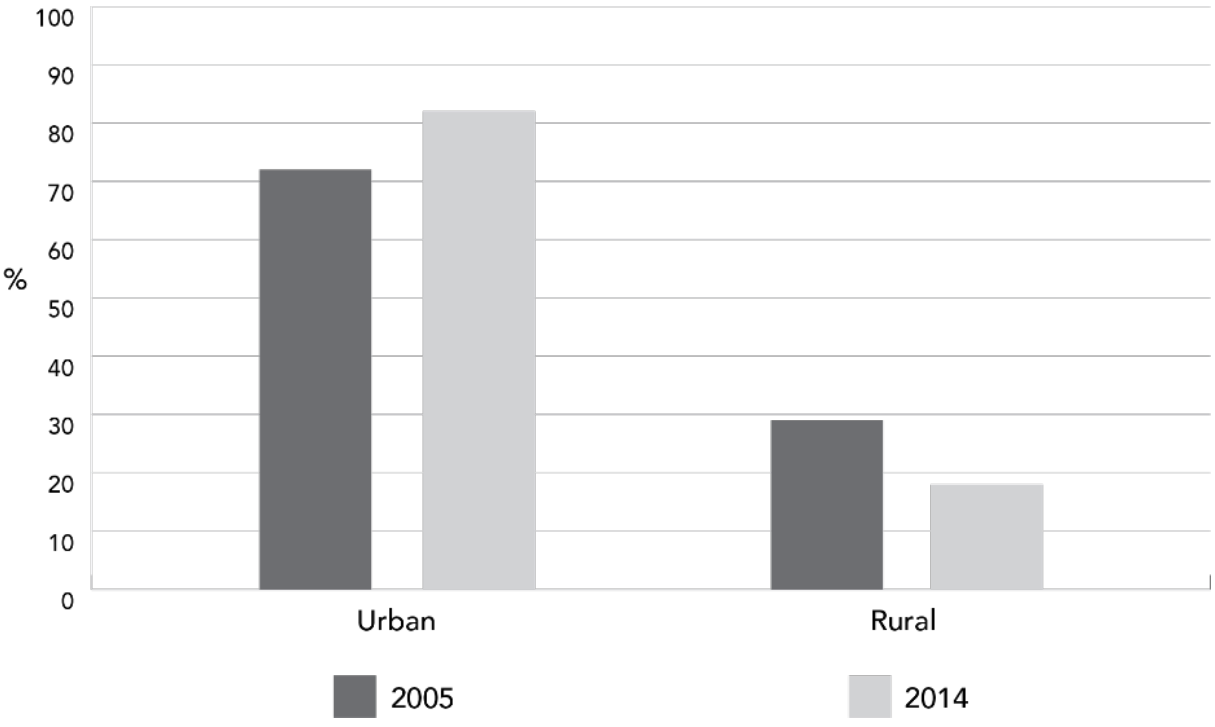


Figure 4: NP Rural and Urban Divide in Canada, 2005 and 2014



SUMMARY OF OPPORTUNITIES

The following summary shows key opportunities that will further advance the NP role in Canada to strengthen primary health care and improve the health of all Canadians.

- Remove the requirement for a formal collaborative agreement with physicians
- Eliminate federal barriers to NP practice
- Continue to amend provincial/territorial legislation that limits optimization of the NP role in the health system
- Enable NPs to complete medical exams for drivers
- Standardize NP designation across Canada
- Scale up team-based models that include NPs
- Scale up innovative NP models, such as Manitoba Mobile Clinics
- Encourage team-based funding models that support the inclusion of NPs
- Evaluate various team-based models that use NPs, including an assessment of return on investment
- Offer protected time and/or funding for advanced practice nurse activities such as research and continuing education
- Establish an NP mentorship program
- Increase NP clinical placement opportunities
- Establish an NP clinical preceptorship model
- Improve access to appropriate NP continuing education
- Assess the compliance of NP education programs with CASN's *Nurse Practitioner Education in Canada* framework (2012)
- Support CASN to accredit NP programs
- Enhance the quality of NP education data available at CASN
- Educate more NPs through a coordinated pan-Canadian strategy
- Enhance NP workforce data available at CIHI (specifically, the types/streams of NPs)
- Position NPs in community to provide primary care to support vulnerable populations:
    - high users
    - rural/remote
    - First Nations
    - seniors
    - refugees
    - others
- Harmonize NP remuneration across sectors and provinces/territories to reflect the APN role

- Implement a targeted recruitment strategy with incentives to improve the distribution of NPs
- Conduct population-health needs-based planning using the Health Human Resources Planning Simulation Model for Nurse Practitioners in Primary Health Care
- Leverage tools and resources from CNA's national NP campaign to promote greater awareness among decision-makers and the public

RECOMMENDATIONS

The following pan-Canadian strategies are recommended for the continued integration of the NP role:

- Expand the knowledge and implementation of innovative team-based models that include NPs (who will serve as exemplars).
- Evaluate various team-based models that use NPs, including an assessment of return on investment.
- Enhance the quality of NP workforce data available at CIHI and NP education data available at CASN.
- Advance the deployment of NP positions in the community to provide primary care that supports vulnerable populations such as high users, seniors, rural/remote, refugees, First Nations and others.
- Develop a targeted recruitment strategy with incentives to improve the distribution of NPs.
- Harmonize NP remuneration across sectors and provinces/territories to reflect the APN role.
- Conduct population-health needs-based planning using the Health Human Resources Planning Simulation Model for Nurse Practitioners in Primary Health Care.
- Educate more NPs through a coordinated pan-Canadian strategy.
- Leverage existing tools and resources from the NP campaign to promote greater awareness among decision-makers and the public.
- Improve access to appropriate NP continuing education for NPs.

CONCLUSION

While NPs are more common in Canada today than they were 10 years ago, problems related to the NP role persist (in varying degrees) among the provinces and territories and the country as a whole. Jurisdictions are at various stages in their efforts to

integrate NPs in the delivery of health care.

Given the significant challenges facing the health-care system, and the shift toward interprofessional care, it is important to use health-care professionals to their full potential, at the right time and place. NPs are already valued as a cost-effective solution to more timely access to quality health care, no matter where it is delivered. With an aging population and rising rates of chronic disease, we can and now should advance the NP role further.

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LIST OF ACRONYMS

ARNNL	Association of Registered Nurses of Newfoundland and Labrador
ARNPEI	Association of Registered Nurses of Prince Edward Island
CAAPN	Canadian Association of Advanced Practice Nurses
CARNA	College and Association of Registered Nurses of Alberta
CASN	Canadian Association of Schools of Nursing
CCRNR	Canadian Council of Registered Nurse Regulators
CIHI	Canadian Institute for Health Information
CRNBC	College of Registered Nurses of British Columbia
CRNM	College of Registered Nurses of Manitoba
CRNNS	College of Registered Nurses of Nova Scotia
NANB	Nurses Association of New Brunswick
NPAO	Nurse Practitioners Association of Ontario
NPOS	Nurse Practitioners of Saskatchewan
RNANT/NU	Registered Nurses Association of Northwest Territories and Nunavut
RNAO	Registered Nurses' Association of Ontario
SRNA	Saskatchewan Registered Nurses' Association
YRNA	Yukon Registered Nurses Association

APPENDIX A

CNA NP ROUNDTABLE PARTICIPANTS — NOVEMBER 12, 2015

Nurse Practitioners	Affiliation
Theresa Agnew, Primary Health Care NP	Executive Director, Nurse Practitioners' Association of Ontario
Deanna J. Barlow, NP	President, Nurse Practitioners of Saskatchewan
Laurie Brehaut, NP (P.E.I.)	
Sophie Charland, Primary Care NP (Quebec)	
Cindy Fehr, NP (Manitoba)	
Kathleen Fyvie, NP (B.C.)	
Lee Holliday, NP (Yukon)	
Jason Ings, NP (Alberta)	
Maureen Klenk, NP	Past President, Canadian Association of Advanced Practice Nurses
Aimee Mains, NP (Saskatchewan)	
Raleen Murphy, NP (N.L.)	
Kimberly Newton, NP (Nova Scotia)	
Janet Weber, Primary Health Care NP (N.B.)	
APN	
Kate Burkholder, NP Council Chair	Canadian Assn. of Advanced Practice Nurses
Jennifer Fournier, Board Member	Canadian Assn. of Advanced Practice Nurses
Melanie McCarthy, Secretary	Canadian Assn. of Advanced Practice Nurses
University	
Esther Sangster-Gormly, Assoc. Professor	University of Victoria
Ruth Martin-Misener, Professor	Dalhousie University
Government	
Barbara Foster	Health Canada
Beverly Griffiths, Director of Acute Health Services, N.L. Provincial Chief Nurse	N.L. Department of Health and Community Services
Jacques Néron	Health Canada
CNA	
Lisa Little, Facilitator	
Josette Roussel, Senior Nurse Advisor	

APPENDIX B

LEGISLATION AND REGULATION RECOMMENDATION

Adopt CNPI's *Legislative and Regulatory Framework* to facilitate consistency in federal/provincial/territorial legislative and regulatory approaches.

Element	Action
Principles	Adopt the 10 underlying principles as the basis for NP legislative and regulatory processes.
Scope of Practice	Enact and implement a broad scope of practice for NPs based on pan-Canadian core competencies.
Definition of the NP Role	Adopt CNPI's NP definition.
Title Protection	Protect the NP title and designation in legislation in all Canadian jurisdictions.
Core Competencies	Adopt CNA's Canadian Nurse Practitioner Core Competency Framework.
Registration/Licensure	• Develop and implement a framework to facilitate the practice of extended/expanded role registered nurses. • Adopt the standardized requirements for registration/licensure of NPs. • Adopt the Canadian Nurse Practitioner Examination, Family/All Ages. • Establish consensus on standardized mechanisms to support the practice of RNs in the extended/expanded role.
Quality Assurance	Adopt CNPI's Competence Assessment Framework for Nurse Practitioners in Canada.
Liability	Adopt a requirement for $5 million in liability protection (minimum) for NPs in Canada.
Application to Other Statutes	Amend existing federal/provincial/territorial statutes to be consistent with NP practice.
Data Systems	Expand the national RN database (CIHI) to include

Element	Action
	relevant information on NPs.
Public Involvement	Include public membership/participation on all nursing regulatory boards/councils and their statutory committees. Engage the public and other stakeholders in the development of legislative and regulatory processes for NPs. Provide information about the NP role to consumers.
Mobility	Develop and implement a mutual recognition agreement for NPs. Reduce unnecessary barriers to Canadian and internationally educated NPs applying for registration/licensure.
Evaluation of Regulatory Effectiveness	Develop and adopt a pan-Canadian evaluation framework to assess the effectiveness of NP regulatory mechanisms and processes.

APPENDIX C

FEDERAL BARRIERS TO NP PRACTICE

Broad Population

Legislation	Who is Affected	Description
Canada Labour Code (ss. 132, 204, 205.1, 206, 206.3, 206.4, 207.2, 239)	Employees who: • are pregnant or nursing • have a family member with a serious medical condition • have a critically ill child • have an illness or injury	Medical examination and certification forms. Except under special circumstances, the definition of medical practitioner appears to be limited to physicians. (Employment Insurance Act: For compassionate care benefits — another medical practitioner, such as an NP, can sign the medical certificate when: the gravely ill family member is in a geographic location where access to a medical doctor is limited or not possible — and a medical doctor has authorized the other medical practitioner to treat the ill family member.)
Employment Insurance Act (ss. 23.1, 23.2, 152.06, 152.061, 41.2)	Individual persons/claimants of benefits	Medical examination and certification forms. Except under special circumstances, the definition of medical practitioner appears to be limited to physicians. Special circumstances where treatment by a medical doctor is not readily available, a medical practitioner can be

Legislation	Who is Affected	Description
		designated by the medical doctor.
Employment Insurance Regulations (s. 63)	Insured persons seeking benefits under indemnity plan	Mentions only care by a physician.
Income Tax Act (ss. 63, 118.2, 118.3, 118.6, 146.4)	Insured persons: • incapable of caring for children due to mental/physical infirmity and confinement • with impairments undergoing therapy • who are a beneficiary and need a medical doctor to certify their state of health	Deductibles for therapies under the care of medical doctors (and certain other health-care professions; no mention of NPs or RNs in these sections of the act). Other health-care professionals noted: psychologist, optometrist, speech/language pathologist, audiologist, physiotherapist, occupational therapist. For disability savings plans, a medical doctor must certify a beneficiary's state of health.
Income Tax Regulations (ss. 8302, 8503, 8517)	Individual person	Elections for retirement benefits dependent on certification by physicians only.
Quarantine Act (s. 22)	Travellers (the public) believed by a quarantine officer to have or possibly have a communicable disease may be required to undergo a medical examination.	Medical exams by medical practitioners. Definition restricts this to those licensed to practise medicine.
Refugee Appeal Division Rules (ss. 67, 68)	Individual applicant who wants to change the date/time of a hearing for medical reasons	Medical certificates can be provided by "qualified medical practitioners." Definition unclear but appears to restrict this function to physicians.
Refugee Protection Division	Individual claimant who	Medical certificates can be

Legislation	Who is Affected	Description
Rules (ss. 8, 54, 65)	applies for an extension of time for medical reasons to provide a Basis of Claim form Individual applicant who wants to change the date/time of a hearing for medical reasons	provided by "qualified medical practitioners." Definition unclear but appears to restrict this function to physicians.

Persons in Specific Professions/Trades

Legislation	Who is Affected	Description
Aeronautics Act (s. 6.5)	Flight crew members, air traffic controllers (or other holders of a Canadian aviation document that imposes standards of medical or optometric fitness)	Medical examination and certification. Only physicians and optometrists are specifically listed.
Canada-Nova Scotia Offshore Marine Installations and Structures Occupational Health and Safety Transitional Regulations* *See also: Canada-Newfoundland and Labrador Offshore Marine Installations and Structures Occupational Health and Safety Transitional Regulations (ss. 134, 281) On Board Trains Occupational Safety and Health Regulations (s. 7.19) Maritime Occupational Health and Safety Regulations (s. 254) Canada Occupational	Employees (re: fitness to work with hazardous substances)	Medical examination and certification. Only physicians are specified.

Legislation	Who is Affected	Description
Health and Safety Regulations (s. 10.7) Aviation Occupational Health and Safety Regulations (s. 5.7) Oil and Gas Occupational Safety and Health Regulations (s. 11.22)		
Canada Occupational Health and Safety Regulations (s.18.7)	Employees (divers)	Medical examination and certification. Only physicians are specified.
Canada Oil and Gas Diving Regulations (ss. 27, 64, 67)* *See also: Canada-Newfoundland and Labrador Offshore Area Diving Operations Safety Transitional Regulations (ss. 26(b)(ii), 62(b)(ii), 66(5), 66(6)(c)) Canada-Nova Scotia Offshore Area Diving Operations Safety Transitional Regulations (ss. 26(b)(ii), 62(b)(ii), 66(5), 66(6)(c))	Divers/diving supervisors Pilots (of atmospheric diving systems, such as a one-person submarine)	Medical examination and certification. Only physicians are specified.
Canada Shipping Act (s. 90)	Employees (re: must not be a hazard to maritime safety, such as an operator of a vessel, etc.)	Medical examination and certification. Only physicians and optometrists are specifically listed.
Canadian Aviation Regulations (s. 404, 604)	Pilots Passengers unable to sit upright	Medical examination and certification. Only physicians can provide medical exams and

Legislation	Who is Affected	Description
		certify passenger medical requests.
Coal Mining Occupational Health and Safety Regulations (ss. 64, 142)	Hoist operator	Medical exams and certification. Only physicians can certify an operator.
Dairy Products Regulations (s. 11.1)	Employees engaged in the preparation of an exposed dairy product	Medical certification only by physicians.
Food and Drugs Regulations (B. 24.300, B.24.301)	Seller of a food represented for use in a very low-energy diet	Written order only from a physician for food represented for use in very low energy diets.
General Pilotage Regulations (ss. 2, 3, 4)	Pilots (and applicants for pilotage duties)	Medical exams and certification can be conducted only by physicians
Railway Safety Act (s. 35)	Employees (for positions critical to safe railway operations)	Medical exams by physicians-only allowed under the law.

Veterans and RCMP Personnel

Legislation	Who is Affected	Description
Returned Soldiers' Insurance Regulations (ss. 8, 9)	Insured veterans	Medical exams for disability benefits to be carried out by physicians only.
Veterans Health Care Regulations (ss. 25, 30)	Veterans and their families	Therapeutic duties for clients and travel compensation for relatives' visits are only within a physician's purview.
Veterans Insurance Regulations (Schedule 10)	Insured veterans	Medical exams for disability benefits can only be undertaken by physicians.
Royal Canadian Mounted Police Superannuation Regulations (s. 26.2)	Members of the force/ contributors	Medical exams can only be undertaken by physicians.

Other Public Servants

Legislation Title	Who impacted	Description
Counting of Service by Former Members of the Senate or House of Commons Regulations (s. 6)	Public service employees (e.g., members of Parliament)/ contributors	Medical exams conducted only by physicians.
Government Employees Compensation Regulations (s. 3)	Public service employees and their families	Medical certification by physicians only to allow for compensation to employees or their dependents.

Public Service Superannuation Regulations (s. 43)	Public service employees/ contributors	Medical exams by physicians only allowed under the law.

APPENDIX D

PRACTICE RECOMMENDATION

Adopt CNPI's *Practice Framework for Nurse Practitioners in Canada* to facilitate consistency in federal/provincial/territorial approaches to practice.

Element	Action
Advanced Nursing Practice	Revise CNA's advanced nursing practice framework to reflect and clarify the NP role.
Role Description	Adopt the CNPI nurse practitioner role description.
Liability	Establish a national voluntary database to track claims and payments made against health-care providers, including NPs. Provincial/territorial governments cover the costs of professional practice and liability protection.
Collaboration and Consultation	Incorporate the seven elements deemed essential for optimum collaboration into all practice arrangements, including existing agreements.
Interprofessional Practice	Develop and implement clear policy direction for models of interprofessional primary health care service-delivery and a supportive change-management strategy.

APPENDIX E

INVENTORY OF CARE AND FUNDING MODELS

Province	Model of Care	Funding Model/No. of NPs
N.W.T. and Nunavut	Majority of work is in family clinics, hospitals and health centres. One NP hired by mining company.	48 salaried (government)
British Columbia	Primary care NPs work in multidisciplinary Ministry of Health (MOH)-salaried clinic settings providing primary care to specific marginalized populations. • HIV/AIDS, mental health and addictions, well women and children affected by substance abuse or violence, geriatric/frail elderly, First Nations, youth • Mobile health units providing primary health care access for remote and/or marginalized populations • NP-physician-shared coverage of residential care homes Primary care NPs in MOH-salaried multidisciplinary general primary health care practices (includes fee-for-service practices that include salaried NPs) NPs working in multidisciplinary	Health authority (HA)-salaried models where the HA receives full funding for NP positions (salary, benefits and overhead/admin., support/professional development) from the MOH. NP4BC-salaried model where HA receives partial funding for NP positions (salary, benefits only. HA global budget must cover overhead/admin., professional development) No capitation model[20] is available for NPs, although physicians access this funding to employ NPs. Shadow billing — Physician employers bill MSP for NP employee's work to cover NP salary. Private pay (uncommon) — patients pay NPs for services not eligible for MSP reimbursement.

[20] Capitation is a payment arrangement for health-care service providers such as physicians or NPs. It pays a physician or group of physicians a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

Province	Model of Care	Funding Model/No. of NPs
	MOH- salaried health authority (HA) clinics providing secondary level care to address specific health challenges. • Heart function clinics, transplant clinic, chronic pain clinic, trauma follow up clinic, rapid access clinics (internal medicine) Primary care NPs in multi-disciplinary private pay and/or private pay/MSP-billing clinic settings providing primary care across the lifespan • Copeman Healthcare Clinic NP is paid by the clinic. Shadow billing may also occur in this type of setting. NPs in multidisciplinary MOH-salaried acute care settings providing specialized tertiary care to specific patient populations • Cardiac surgery, thoracic surgery, hemodialysis, general surgery, multi-system trauma, nephrology, oncology, specialized pediatric populations, emergency/urgent care	
Alberta	Majority of primary care is provided via primary care networks (PCN) located across the province.	Dominant funding model is through Alberta Health Services (AHS). Most NPs are employed by AHS and work in acute care. Two years ago an initiative was developed to roll out family care centres (FCCs), with AHS paying NPs a salary to provide primary care. After the initial plan to have

Province	Model of Care	Funding Model/No. of NPs
		145 FCCs, the government opened just three, then cancelled the program. Few NPs are employed in a primary care network (PCN) due to the lack of a funding model. NPs working in a PCN cannot generate revenue for the organization but must be paid through the operations budget. Because the NP salary is a cost for the PCN, it would rather hire a physician.
Saskatchewan	RN(NP)s are registered to practise in adult, neonatal and primary health care. The roles are incorporated into primary health care (PHC), emergency departments, geriatric services, chronic disease management, women's health, youth shelters, long-term care, rehabilitation, neonatal intensive care units and school health (NPOS, 2016). RN(NP)s are under contract in the northern part of the province with some of the grand councils. Some RN(NP)s are employed outside of the regional HAs in private/affiliate programs such as Eden Care and/or other long-term care (LTC) positions.	Regional health authorities (RHAs) fund most positions throughout the province. A few RN(NP) positions are not funded this way but are instead paid for by specialists, who incorporate or work with them in their practice. RN(NP)s are not fee-for-service positions.
Manitoba	Approximately 145 NPs are registered with CRNM. Each of the five regional health authorities have NPs. NPs work in variety of settings with the majority in primary care (access clinics, quick-care clinics,	Manitoba Health provides the funding for most NP salaries, for both independent positions and collaborative teams (run by RHAs or attached to private physician clinics).

Province	Model of Care	Funding Model/No. of NPs
	private and regional care clinics, mobile clinics), some in emergency care and specialty hospital care (cardiac care, pediatrics), and some in long-term care centres. NPs are registered as family NPs and then specialize based on their population, i.e., adult, family, pediatrics, gerontology.	
Ontario	NPs work in a variety of models and settings including hospitals, family health teams, nurse practitioner-led clinics, community health centres, public health units, long-term care facilities, family doctor offices, community care access centres, etc. There is specialty certification for PHC, adult and pediatric NPs.	Funding models vary. NPs cannot bill the province (OHIP) for services provided to clients. Most are salaried positions funded by the Ministry of Health and Long-Term Care. NPs in acute care are often funded from a hospital global budget. Some are employed directly by physicians in their solo practices, who pay from their salary or fee-for-service revenue.
Newfoundland and Labrador	NPs work in a variety of models: PHC, acute care, critical care and in specialty programs (e.g., bariatric surgery program, HIV clinic). Work in a multitude of settings: clinics, hospital, family doctor offices, out-patient, community, rural and remote travel along coastal N.L.	Private off-shore companies employ a small number of NPs. One NP may be funded by a private family doctor's office. The provincial department of justice employs two NPs, but most are employed through RHAs. One NP is self-employed and charges patients directly.
New Brunswick	All NPs are licensed as PHC-All Ages. There are no acute care NPs or midwives. One NP is approved through	NPs are mostly funded by the health department and are employed by one of two RHAs in community health centres, ERs,

Province	Model of Care	Funding Model/No. of NPs
	NANB and the chief nursing officer to open a private clinic. NANB has evaluated and confirmed that it is consistent with the PHC scope. Other organizations: • First Nations — funded by the bands • Canadian Armed Forces — Department of National Defence • Universities — NP's primary role is as educator • Correctional services • Private sector employers • Irving Oil Company – PHC-NP position posted • Research grants • Methadone clinic • NP private practice	public health, nursing homes (through the Department of Social Development), mental health, methadone clinics, physician offices, First Nations, and university clinics. In April 2015, the Department of Health announced a pilot project whereby a physician may hire an NP and be reimbursed for each client NP visit at half the usual rate. Under this plan, NPs do not belong to a union and must negotiate all their benefits.
Prince Edward Island	Two NPs working in a fee-for-service practice. Hired privately by physicians, these NPs are unable to bill medicare directly. Therefore, the physician bills for the work the NP does. Most NPs are working in general family all-ages practices, collaboratively, with family physicians. There are a few new pilot projects getting started. An NP has been hired to work in the diabetes program mainly providing care to unaffiliated patients. Another is working temporarily with OB/GYNs providing prenatal care for unaffiliated patients.	One NP has been hired through private funding to work in a clinic operated through CHANCES Family Centre. NPs are hired by the provincial government and salaried as per the P.E.I. Nurses' Union collective agreement.

Province	Model of Care	Funding Model/No. of NPs
	One NP works in the P.E.I. Cancer Treatment Centre.	
Nova Scotia	47 NPs in adult care Three NPs in child care Seven NPs in neonatal care 89 Family/All Ages NPs — In general terms, they are working in primary care clinics/practices, a couple in community emergency centres, one in ER and some in both long-term and primary care.	Most NP's are employees of the provincial HA, with funding from the Department of Health and Wellness. NPs shadow bill and, as salaried employees, are not permitted to bill for their services. While NPs can by employed privately, the physician they work for needs to be an active participant in the care of the patient, with a few exceptions (paps, immunizations, flu vaccines and injections). One NP is self-employed and works in medical esthetics. One NP is a government employee and with benefits, WCB, insurance, etc.).
Yukon	Three practising NPs from Nova Scotia Two NPs work in collaboration with medical clinics. • One NP is in a three-year pilot project • Two NPs were responsible for ensuring they had appropriate malpractice insurance, covering their positions with locums for vacations, etc.	

APPENDIX F

EDUCATION RECOMMENDATION

Adopt CNPI's *Education Framework for Nurse Practitioners in Canada* to facilitate consistency in federal/provincial/territorial education approaches.

Element	Action
Guiding Philosophy, Assumptions and Values	Reflect the guiding philosophy, assumptions and values found in the *Education Framework for Nurse Practitioners in Canada.*
Entry to Nurse Practitioner Educational Programs	
Entry Requirements	Establish admission criteria that include active RN designation and a minimum of two years of full-time equivalent clinical nursing experience.
Prior Learning Assessment and Recognition (PLAR)	Adopt and apply the principles found in Prior Learning Assessment and Recognition for Nurse Practitioner Education and Regulation in Canada.
Transfer of Credits	Establish a pan-Canadian approach to transfer of credits. Allow for the transfer of credits between educational institutions subject to maximums established by the institutions.
Curriculum Alignment and Linkages	
Program Philosophy	Develop philosophy, mission and goal statements that are aligned with pan-Canadian frameworks governing NP education and periodically assess and review them.
Program Accreditation	Establish and promote participation in a pan-Canadian accreditation process for NP educational programs. Develop linkages between accreditation and approval processes.
Stakeholder Needs	Be responsive to broadly defined, evidence-based stakeholder needs.
Nurse Practitioner Core	Be consistent with the *Canadian Nurse Practitioner Core*

Element	Action
Competencies and Curriculum Design	*Competency Framework* and the standards inherent in the NP program approval process.
Exit Credential Standardization	Adopt the master's degree (MN/MScN) as the required exit credential ideally by 2010 but no later than 2015.
Bridging Mechanisms for NP Educational Programs	Develop and institute bridging mechanisms to support program transition to a graduate degree (MN/MScN) as the standardized exit credential.
Bridging Mechanisms for Individuals	Develop and institute bridging mechanisms to support an individual's transition to a graduate degree.
Nurse Practitioner Education Delivery	
Faculty	Where practical, designate PhD-prepared practising NPs to teach NP-specific courses. Where limited: facilitate access to PhD preparation; engage qualified master's-prepared NPs or non-NPs; and/or use team teaching or shared resource models.
Faculty/Student Ratios	Recognize NP faculty clinical hours as teaching hours. Establish and monitor guidelines governing NP educational program faculty/student ratios.
Clinical Practice Hours	Establish 700 hours as the standard minimum number of clinical practice hours.
Clinical Preceptors	Require clinical preceptors to be an NP, or an advanced practice nurse or equivalent subject matter expert in a relevant professional discipline with a sound understanding of the NP role. Initiate a coordinated effort to sustain and increase the supply of available preceptors. Develop preceptor preparation programs.
Distance Education	Develop pan-Canadian standards for NP distance education. Develop and deliver distance education courses for NPs.
Collaborative Programming	Develop innovative approaches to support collaborative programming and pursue and implement funding for collaborative programming approaches.

Element	Action
Interprofessional Teaching and Learning	Develop and offer interprofessional courses.
Evaluation and Testing of Nurse Practitioner Students	Implement evidence-based student evaluation and testing methodologies.
	Establish a pan-Canadian resource bank, including approaches and tools.
Licensure to Practice	Implement cross-jurisdictional collaboration among schools and regulatory bodies to ensure that the licensure-to-practice process for NP students is supported by NP educational program content and teaching and learning processes.
Transition to the Workplace	
Facilitating Transition	Develop and implement processes and structures to facilitate the transition of NPs from their educational programs to the workplace and from novice to expert.
Mentorship	Establish mentorship and a mentorship culture as standard features of the NP learning experience.
	Develop pan-Canadian mentorship tools and promote their use across all NP educational programs and in the workplace.
Continuous Learning and Competency	Create and support a culture of continuous learning among students and practicing NPs.
	Remove potential barriers to continuing education, including funding, time off, and access to learning opportunities.
Re-entry to Practice	Develop refresher training programs as required for re-entry to practice.

APPENDIX G

HEALTH HUMAN RESOURCES RECOMMENDATIONS

Conduct needs-based HHRP for NPs using a pan-Canadian, interprofessional approach that is based on a conceptual framework. To support this planning, use the Health Human Resources Planning Simulation Model for Nurse Practitioners in Primary Health Care.[21]
Develop and implement clear policy direction for models of interprofessional primary health care service delivery and a supportive change management strategy.
Adopt funding models for primary health care services that reflect a needs-based system (including health status) that supports interprofessional practice and incorporates population health outcomes.
Remunerate NPs to reflect their scope of practice, responsibility and accountability, and standardize the remuneration to address: • Salary/benefit discrepancies (within provinces and territories) • Yearly cost-of-living expenses • Incentives and supports to recruit NPs to difficult-to-recruit areas • Additional overhead/operating/infrastructure expenses
Utilize NPs across all health-care settings in urban and rural/remote/isolated areas. NP practice should be a blend of individual and family visits, population health activities, and other advanced practice activities (research, leadership, collaboration and change agent).
Create healthy work environments for NPs that support positive client, provider and system outcomes.

[21] See CNPI (n.d.-b).

APPENDIX H

ANNUAL NP REMUNERATION (AS OF JUNE 2015)[22]

Province	Min. Salary	Max. Salary	Effective Date	Steps	Unionized	Avg. Hours	Source
B.C.	$93,327	$102,667			No		Interior Health (one region)
Alta.	$97,635	$127,250	Apr. 1/14	11	No[23]	2,022.75[24]	Alis.alberta.ca Alberta Health Services (AHS)
Sask.	$92,821	$111,023	Apr. 1/13	5	Most in SUN or CUPE	1,948	SUN
Man.	$90,108	$111,137	Apr. 1/15	5	All in MNU	2,015	
Ont.	See next chart			8	Low % in ONA	1,950	
Quebec	$53,100	$94,683	Apr 1/14	18	Most in FIQ and two other unions	1,885	FIQ
N.B.	$82,420	$100,308	Jul. 1/14	6	Most in NBNU	1,957	NBNU
N.S.	$89,391	$108,166	Nov. 1/13	7	Most in NSNU	2,080	NSNU
P.E.I.	$88,140	$99,586	Apr. 1/15	6	All in PEINU	1,950	PEINU
N.L.	$72,481	$89,680	Jul. 1/15	6	All in NLNU	1,950	NLNU
N.W.T./ Nunavut	$98,807	$120,900			No	1,950	CFNU

[22] The average NP annual salary if they worked a full FTE (1.0) was $116,000 in 2014.
[23] Legislated as ineligible to unionize.
[24] Per 1.0 FTE

ONTARIO NP SALARIES

Facility	Minimum	Maximum	Increase?	Source
FHT[25]	$78,054	$89,203	Frozen @ 2006	MOHLTC
NPLC	$74,038	$89,203	Frozen @ 2006	MOHLTC
CHC	$74,038	$92,200*	Almost all @ 2006; three ≥92,000	AOHC
AHAC	$74,038	$92,200	A few @ 2009	AOHC
ONA: Lakeridge	$111,813	$116,785	1.4-3%/yr.*	ONA
ONA: Southlake	$94,653	$118,521	1.4-3%/yr.*	ONA
Public Health Units	$91,396	$118,735		ONA
ONA: CCAC	$99,468	$122,280	3% in 2 yrs.*	ONA

*Average NP in primary care: at or <$89,203. Espanola and area FHT NP salary range: $79,911-$89,154 (ONA represents the NPs). Central Toronto CHC: NP salary range: $74,038-$89,203 (ONA website). The average NP salary in hospital: $107,000 per annum. Average NP in CCAC $112,000.

[25] **Legend**: Family Health Team (FHT); Nurse Practitioner Led Clinic (NPLC); Community Health Centre (CHC); Aboriginal Health Access Centre (AHAC); Community Care Access Centre (CCAC); Ontario Nurses Association (ONA); Ministry of Health and Long-Term Care (MOHLTC); Association of Ontario Health Centres (AOHC)