2018

Comprehensive Evaluation of the Nurse Practitioner Role in Newfoundland & Labrador - Executive Summary

Association of
Registered Nurses
of Newfoundland
and Labrador

Table of Contents

Acknowledgements

The evaluation was undertaken by Dr. Christine Way, Dr. Kathy Watkins and Dr. Colleen Hanrahan on behalf of ARNNL.

To request a copy of the full report, please contact ARNNL at info@arnnl.ca.

55 Military Road | St. John's | NL | Canada | A1C2C5 | Tel: (709) 753-6040 | 1 (800) 563-3200 | Fax: (709) 753-4940 | info@arnnl.ca ARNNL.CA

Preamble by ARNNL

The Association of Registered Nurses of Newfoundland and Labrador (ARNNL) is the regulatory body for all Registered Nurses (RNs) and Nurse Practitioners (NPs) in the province. ARNNL's professional association role is to promote activities to advance healthy public policy. ARNNL advances nursing excellence for public protection and optimal health of the Newfoundland and Labrador population. ARNNL exists so that there will be: Public Confidence in Self-Regulation; Accountable Professionals; and Evolution of the Profession. There are approximately 6500 registered nurses and nurse practitioners registered and/or licensed in NL.

Nurse Practitioner Practice in NL

NPs are "*registered nurses who have the education, experience and competence to provide comprehensive health assessment, to diagnose, to treat and manage acute and chronic illness within a holistic model of care.*" (Canadian Nurses Association [CNA], 2010 as cited in ARNNL, 2013). NP practice was initially established in NL in 1998 to support increased access to health care providers, particularly in remote and rural areas of the province. At that time, ten NPs were granted interim licenses by ARNNL. In 1999, NL became the second jurisdiction in Canada to fully enact legislation to support implementation of the NP role. By the end of that licensure year, there were 19 fully licensed NPs practicing in the province.

NP regulation and practice has evolved in the 20 years since the role was established. Initially NPs in NL were educated at the diploma level through the Centre for Nursing Studies. NPs are now required to complete graduate-level education. Although RNs may choose from any number of accredited NP education programs, Memorial University School of Nursing (MUNSON) is the sole educator of NPs in this province. MUNSON offers two NP education options: Master of Nursing-NP Degree (MN-NP) and Post-Master's NP Graduate Diploma. The current number of seats in the MN-NP program is 12 per year; however, MUNSON projects the number of seats to increase to 16 per year in 2019. The current number of seats in the Post-Master's NP Graduate Diploma program varies each year according to applicants and available space.

NPs in this province initially practiced as either Primary Health Care NPs or NP-Specialists. Today, NPs practice within one of the three streams: family/all-ages, adult and pediatric (neonatology being a subspecialty of the pediatric stream) in all areas of the province including rural, urban and remote. The NP role is well-established in diverse practice settings including specialty units in acute care (intensive care, urology, surgery, medicine, etc.), pediatrics, emergency departments, outpatients, community clinics, family practice clinics, NP-led clinics, addiction centers, justice (correctional centers), tertiary care, long-term care, private agencies and self-employment.

There is ongoing interest and demand to establish the NP role within new areas in the health care system, and in communities and programs, as evidenced by the continued growth in the number of NPs (ARNNL, 2017). At the time of this evaluation study, there were 149 NPs licensed in NL. Statistics from the Canadian Institute of Health Information (CIHI) showed that in 2017, NL had a ratio of 31 NPs per 100,000 population; the second highest ratio in Canada behind only the Northwest Territories and Nunavut (69, combined) (CIHI, 2018). At the time of the release of this report, there were 174 NPs licensed to practice in NL.

Implementation of government policies designed to improve access to primary health care services announced in Budget 2018, will require a stable and consistent supply of health professionals who can deliver these services to the population. A sufficient supply of NPs along with the ability to recruit and retain NPs to these positions will be key to the success of this new primary health care model. Government strategies offering financial assistance for NP education such as the NP Bursary Program which provides funding in exchange for a service commitment, are designed to help ensure that a continued supply of NPs is available.

ARNNL..CA 55 Military Road | St. John's | NL | Canada | A1C2C5 | Tel: (709) 753-6040 | 1 (800) 563-3200 | Fax: (709) 753-4940 | info@arnnl.ca

Research shows that the public support the NP role and are satisfied with their care. A random sample of the public from this province showed that 92% of those who had received care from an NP gave a rating of eight or higher (on a scale of 1-10) for their satisfaction with their care. Additionally, 88% of those who had never seen an NP reported they would do so in the future if the opportunity was available (ARNNL, 2018). Evidence from other studies support the finding that there is a high level of satisfaction with care provided by NPs (College of Registered Nurses of Nova Scotia [CRNNS], 2016; Nanos, 2016; Canadian Federation of Nurses Unions [CFNU], 2018).

The NP role has been studied in other provinces, mainly Ontario, however there are no recent studies completed in this province. To date, only one evaluative study had been completed on the implementation of the NP role in NL (Goss Gilroy Inc., 2001). NP practice has changed considerably in the seventeen years since the initial evaluation was completed. Hence, provincial data to guide further implementation and optimal utilization of NPs are needed.

The Current Evaluation

ARNNL proposed to evaluate NP practice in NL in an effort to address these information deficits and to look for input on opportunities for further advancement and integration in the interest of the public. Funding was provided by the Department of Health and Community Services (DHCS) to conduct an independent evaluation of the NP role in this province. An NP Evaluation Advisory Committee (NPEAC) was established to guide the evaluation. The NPEAC was comprised of members with experience in evaluation and/or expertise in NP scope of practice, and stakeholder groups such as NL Medical Association, NL Pharmacy Board, NL Centre for Health Information (NLCHI) and employers. The committee developed a conceptual framework to inform the evaluation and identified the following objectives:

1. identifying the characteristics of NP practice within various practice settings;
2. determining the implementation process in both public and private organizations to create and develop a new NP role;
3. identifying factors that influence the integration of the NP role into various practice settings within both public and private organizations;
4. determining the impact of the NP role on the health care system; and
5. determining the future direction for the NP role.

The primary focus of the evaluation was to identify the processes for implementation and degree of integration of NPs within the health care system. The proposed outcome of the evaluation was to support optimal implementation and integration of NPs by identifying strategies to address barriers and enhance facilitators identified by the project participants. Examining the impact of NPs through patient/client satisfaction and/or health system impacts was determined to be beyond the scope of this evaluation as other sources or methods were underway to gather this information (e.g., Canadian Federation of Nurses Unions, Regional Health Authority (RHA), etc.). As such, data collection was focused on obtaining the perspectives of NPs and key stakeholders that engage with NPs within the NL healthcare system (e.g., managers/administrators, interprofessional team members, etc.).

The evaluation was undertaken by a group of seasoned researchers: Dr. Christine Way, Dr. Kathy Watkins and Dr. Colleen Hanrahan. The study provided quantitative and qualitative data and the report identified both action items recommended by the participants and overarching recommendations by the researchers. These recommendations and action items were further supported in the literature.

55 Military Road | St. John's | NL | Canada | A1C2C5 | Tel: (709) 753-6040 | 1 (800) 563-3200 | Fax: (709) 753-4940 | info@arnnl.ca ARNNL.CA

Executive Summary

Nurse Practitioners (NPs) have been regulated in Newfoundland and Labrador (NL) under the *Registered Nurses Act* since 1998. Currently, there are 149 NPs practising in various locations and practice settings in the province. As regulator, the Association of Registered Nurses of NL (ARNNL) was interested in identifying strategies for optimizing NP role implementation and integration. The NP Evaluation Advisory Committee (NPEAC) developed an NP Evaluation Framework to inform a comprehensive evaluation of the role within the NL health care system (HCS).

Purpose

The current Evaluation was undertaken by a group of seasoned researchers tasked with documenting the current status of NP role implementation and integration in NL and its impact at provider, practice, organizational and system levels. The primary purpose was to explore ways of enhancing optimal NP role integration and identifying priority areas for future roles. A secondary purpose was to identify strategies to advance the NP role by addressing barriers to/facilitators of implementation and integration. The NP Evaluation Framework informed all phases of the project. Specific objectives of the Evaluation were to document/inform: 1) characteristics of NP practice within practice settings; 2) implementation process used in public and private organizations to create and develop new NP roles; 3) factors influencing the integration of NP roles within practice settings of both public and private organizations; 4) impact of NP role on the health care system; and 5) future directions for the NP role.

Methods

This Evaluation was conducted in five phases. Phase 1: 1) search of MEDLINE, EMBASE, CINAHL, Cochrane Library, Google Scholar, and relevant publicly available documents at federal/provincial/territorial (F/P/T) levels focusing on NP role implementation and integration; 2) survey instruments and interview/focus group guides development. Phase 2: 1) schedule/ conduct interviews/focus groups with key stakeholders (NPs, physicians [MDs], registered nurses [RNs], social workers [SWs], pharmacists, managers/senior administrators [M/As], NP educators, and representatives from government and regulators/associations/ bargaining units); 2) distribute surveys via Survey Monkey to target groups (NPs, MDs & RNs); and 3) initiate preliminary analysis of qualitative data. Phase 3: 1) summary of qualitative interview/focus group data and major theme generation; 2) collate/analyze closed-ended survey questions and summarize/content analyze open-ended survey questions; 3) comparative analysis of qualitative and survey findings; and 4) identify action items reflecting stakeholder suggestions about potential solutions to modify/eliminate key issues/barriers. Phase 4: 1) draft interim report of the findings for the ARNNL; 2) review of research evidence/theoretical papers/discussion briefs; and 3) search for meaningful linkages between relevant literature and Evaluation findings. Phase 5: 1) discussion writing – synthesizing Evaluation findings with relevant literature; 2) reach conclusions and create overarching recommendations; and 3) revise interim report..

Results

Data collection for this Evaluation occurred between April 30 and August 31, 2017. Surveys were completed by NPs (n = 88), RNs (n = 31) and MDs (n = 40). A total of 61 key stakeholders participated through either focus groups (n = 13) or individual interviews (n = 15).

A brief overview is presented on Evaluation findings. The presentation is organized according to key targets of the NP role (funding models, implementation process, integration, impact and future directions) defining the objectives for this Evaluation.

ARNNL..CA 55 Military Road | St. John's | NL | Canada | A1C2C5 | Tel: (709) 753-6040 | 1 (800) 563-3200 | Fax: (709) 753-4940 | info@arnnl.ca

Funding Models

Sub-optimal funding for NP positions within all sectors of the HCS surfaced as a major concern for most stakeholders. With the majority of NPs employed by regional health authorities (RHAs), most positions are funded through global budgets for nursing services. There are no dedicated funds earmarked for NP positions. As such, M/As often struggle to find funding for new positions and/or sustain existing ones. The Department of Health and Community Services (DHCS) must approve funds for new NP positions being proposed by RHAs to address service needs. This is a tedious and time-intensive process. An important action item supported by most stakeholders is to have protected funding for all NP positions and identify alternate funding models to ensure role sustainability.

Implementation

An important focus of this Evaluation was to document how key stakeholders were viewing implementation processes (decision to introduce NP role to completion of orientation) within particular organizations/RHAs and/ or provincial-wide initiatives. The findings suggest that most stakeholders were of the opinion that there is limited systematic planning for introducing new NPs into the NL HCS. Contracted prior planning efforts (e.g., informal needs assessments, limited stakeholder involvement, etc.) and inadequate role development activities (e.g., inadequate/absent position descriptions, orientation and mentorship time/programs for NPs, limited resources, unprepared/uniformed managers, limited communications with/involvement of team members, inadequate guides for role enactment, etc.) translated into preventable challenges for interprofessional (IP) teams members (e.g., issues with role clarity, overlapping roles, power struggles/resistance, reduced NP confidence, autonomous practice or working to full scope, etc.) and the public (e.g., limited role knowledge/awareness, initial resistance, etc.). Participants found it difficult to comment on how well the role was being implemented as intended due to restrictive prior planning and absence of formal monitoring mechanisms to evaluate it. There was general consensus among stakeholders on actions required to address identified gaps/deficiencies in the implementation process with most stressing the need for: 1) unified approaches to provincial policy/standards, operational plans (practice models), securing supportive resources (including funding), increasing knowledge/ awareness of the NP role/scope of practice; and 2) greater planning (including formal consultations with all relevant parties) for successful formation of IP collaborative teams and incorporation of NP roles within them.

Integration

Another focus of this Evaluation was to determine stakeholder perceptions of NP role integration (*completion of orientation and mentorship to the present*) into various practice settings within the NL HCS. The findings capture stakeholder experiences with NP role integration and factors influencing (enablers/barriers) role integration. Experiences with NP role integration reflect a continuation of issues noted with prior planning for role introduction (e.g., role ambiguity, limited understanding about/opportunity for full scope of practice, inadequate knowledge about/preparation for intended models of IP collaborative practice, limited M/A knowledge/ ability to lead/monitor IP team work, etc.). Besides these issues, critical requirements for effective role integration were noted: 1) continuing education/professional development to help maintain NPs competencies; 2) education/ training for all team members to acquire/master requisite collaborative skills and foster a culture of collaboration; and 3) adjustment of basic curriculum content/clinical practicums to better prepare NPs for workplace challenges.

Barriers to/facilitators of NP integration were intertwined with how stakeholders experienced the role. Identified factors were seen as barriers or facilitators depending on the context and level of experience with the NP role. Important influencing factors included: 1) public/HCP understandings/familiarity; 2) public/HCP resistance/ acceptance; 3) employer/RHA support for M/As and NPs; 4) quality working relations/level of collaboration; 5) HHR planning (retention/ recruitment/succession planning); and 6) communications/consultations about and supportive funding for achieving integrated care and NP integration within IP teams.

55 Military Road | St. John's | NL | Canada | A1C2C5 | Tel: (709) 753-6040 | 1 (800) 563-3200 | Fax: (709) 753-4940 | info@arnnl.ca ARNNL.CA

There was also general consensus among stakeholders on priority target areas requiring action to ensure effective NP role integration and movement towards achieving the integrated care mandate. Critical action items include: 1) establish forums for stakeholders to discuss appropriate collaborative models, effective strategies for implementing collaborative practice principles, and psychometrics for monitoring collaborative practice; 2) develop communication strategies to clarify NP role dimensions and expected advanced practice competencies for all key stakeholders (RHAs/employers, associations/regulators, RNs and NPs); and 3) develop an organized approach to educating management, all HCPs and the public about the NP role.

Impact of NP Role

An important objective of the current Evaluation was to document stakeholders' perceptions of the overall contributions of the NP role to the NL HCS. Most stakeholders perceived that NPs were having a positive impact on: 1) care delivery (i.e., more holistic, comprehensive, coordinated, consistent, continuity & patient-centered); 2) team functioning (promoting a collaborative approach and enhancing nursing care through leadership, expert knowledge, and effective communication); and 3) health/system outcomes (access, timeliness & efficiency). Nevertheless, a few stakeholders (especially medical associations and MD survey participants) tended to be more guarded with their responses and wanted more evidence to support NPs effectiveness. Most stakeholders were unaware of local research projects, except for the current Evaluation, focusing on role impacts and recognized the need for a more robust data collection process.

Action items suggested for the NP role impact tended to reveal more discrepancies among stakeholders than those for other objectives. An action item more supported by M/As and N/Ps is to have integrated HHR planning models for all HCP groups to effectively plan for integrated models of care. The suggestion was also made that NPs should be considered as a special subgroup when planning for the RN workforce. Additional action items supported by most stakeholders include: 1) formal evaluation of the ongoing impact of the NP role in all practice settings; 2) develop and implement formal mechanisms (IP collaborative education) directed towards increasing MD knowledge about the NP role and enhancing more positive working relations among NPs and MDs.

Future Directions

A final objective of this Evaluation was to explore stakeholders' perspectives on possible future directions for the NP role in the NL HCS. Of specific interest was determining what actions could/should be taken in the education, practice, HHR, independent practice and research arenas that would ensure future success of the NP role. The dominant themes populating this objective reiterate those identified in previous objectives. To summarize, most stakeholders supported the following priority areas: 1) collect research evidence to monitor the impact of the NP role (e.g., patient outcomes/team functioning/system effectiveness/efficiency, etc.) and use this data to inform decision-making (e.g., funding allocation, selecting alternate models of care with NPs as integral members of IP teams and/or NP-led services, patient-centered care delivery models, etc.); 2) adopt funding models and remuneration schemes that support IP collaborative teams and enable NP autonomous, full scope and independent practice; 3) develop strategic planning initiatives that optimize NP role implementation and integration by engaging all key stakeholders and decision-makers in ongoing communications focused on HHR planning, NP role expansion and optimal utilization, and identifying supportive infrastructure requirements for NPs; 4) amend existing legislation/regulations to effect policy change around NP autonomous practice and role integration (i.e., remove veto powers of CPSNL/NLPB over NP standards and the mandatory requirement for collaborating physician agreements); 5) launch well-organized awareness campaigns to educate the public and all stakeholders on how the NP role differs from other nursing roles and physician roles; 6) engage relevant stakeholders (e.g., Chief Nurses, NE, DHCS, etc.) in ongoing discussion focused on revising/expanding NP Education programs to enhance alignment with provincial population health/service needs (e.g., include curricula content/preceptorship experiences that ensures graduates have requisite competencies; allocate seats for qualified RNs working in high service needs areas within RHAs to help with recruiting/retaining challenges; ensure funding support via bursaries, etc.).

ARNNL..CA 55 Military Road | St. John's | NL | Canada | A1C2C5 | Tel: (709) 753-6040 | 1 (800) 563-3200 | Fax: (709) 753-4940 | info@arnnl.ca

It is important to emphasize that not all stakeholders supported the premise that NPs could/ should play an enhanced role in the HCS and/or be better utilized for improving system efficiency, patient outcomes and patient access to quality, coordinated care services in PHC settings. Physicians and medical groups were more inclined to assume a restrictive stance by de-emphasizing the importance of the NP role, favouring less independence and autonomous practice for NPs, and expressing reservations about the quality and intensity of NP education. It is apparent that more work is required on establishing lines of communication at regulatory/ association levels to enable more effective and insightful interactions among the nursing and medical professions in order to generate agreement on expectations for the NP role within the NL HCS. Certainly, there is consensus among all stakeholders that actions are required on IP collaborative team functioning and how best to interphase the skill sets of all team members. All stakeholders (NP, M/As, NE, SWs, MDs and representatives from the DHCS and regulators/ associations/bargaining units) highlighted the importance of IP teamwork and the need to identify the singular and collective contributions of all team members to realize the goals set for integrated care in this province.

Conclusion

The current Evaluation represents a first step in an important agenda directed towards understanding how best to optimize utilization of the NP role in the NL HCS. A mixed methods design was used to gather information from a cross-section of stakeholders/decision-makers situated in key regions of the province. The findings provide meaningful insights into the current status on NP role implementation and integration, factors influencing effective role integration and priority areas requiring future consideration and timely actions. The findings are informed by and concur with existing research evidence on the NP role and required actions that must be taken to advance the role and ensure that it is strategically placed within the future health care system. To help move this agenda forward in the province the Evaluation team developed a list of key recommendations grounded in stakeholder identified priority areas for action.

55 Military Road | St. John's | NL | Canada | A1C2C5 | Tel: (709) 753-6040 | 1 (800) 563-3200 | Fax: (709) 753-4940 | info@arnnl.ca ARNNL.CA

Recommendations

1. Develop alternate funding models to support IP collaborative team-based practice in all practice settings where NPs are fully integrated as part of the team. Importantly, dedicated, sustainable funding should be secured to support the introduction and integration of NPs positions within IP collaborative teams.

2. Promote greater utilization of NPs throughout the health care system to address challenges in service provision in primary health care (inefficiencies/disparities with equal access to quality/coordinated/ comprehensive health care), transitioning between levels of care, and service provision in other health care settings (e.g., LTC, acute care). What is needed to ensure effective and meaningful NP utilization is contingent upon the presence of a supportive infrastructure for enabling full scope enactment, adequate resources for addressing population health needs, and appropriate funding models. The overarching conclusion is that the health care system, especially in primary care settings, could benefit (improved capacity and optimal use of scarce HHRs) from increased utilization of nursing resources in IP and nurse-led teams.

3. Develop a standardized approach (e.g., PEPPA model) to NP implementation and integration to ensure that those in leadership positions, particularly nursing, in the provincial government, RHAs, ARNNL and education are working towards the same goals and outcomes.

4. Develop and launch a provincial campaign to increase public, nursing, physician, other health care provider, management/administration and DHCS awareness/understanding of the NP role and scope of practice and how NPs could be used to enhance access to quality/coordinated/comprehensive health care in all settings.

5. Explore further why physicians are not as positive about the contributions (e.g., enhanced access to care, timeliness of care, coordination of care and quality of care, etc.) of NPs in the NL health care system as NPs, RNs and managers.

6. Develop a provincial approach to IP education that would ensure all members of IP collaborative teams and associated managers have a clear understanding of NP roles and all HCP roles, as well as each other's scope of practice, responsibilities and accountabilities. Equally important is education and training on how to engage in collaborative practice and work effectively together as a team.

7. Implement an evaluation and monitoring template that uses IP team- and NP-specific indicators to assess their separate and interactive effects on health and system outcomes in all health care sectors.

8. Develop mechanisms to ensure that all levels of leadership (e.g., practice, organizational, F/P/T) have the requisite knowledge, skills, abilities and supportive resources (within/external to immediate employers/ associations/regulators) to lead NP implementation and integration.

9. Amend legislation, associated regulations and standards of practice to remove barriers to full NP role enactment in all practice settings.

10. Develop an HHR strategy that views NPs as a critical sub-group within the nursing profession. This approach will ensure better identification of current and future NP requirements within/across all health care sectors.

ARNNL..CA 55 Military Road | St. John's | NL | Canada | A1C2C5 | Tel: (709) 753-6040 | 1 (800) 563-3200 | Fax: (709) 753-4940 | info@arnnl.ca

List of Abbreviations

ACNP	Acute Care Nurse Practitioner
AHP	Allied Health Professional
APC	Advanced Practice Competency
APN	Advanced Practice Nursing
ARNNL	Association of Registered Nurses of Newfoundland and Labrador
CCAPNR	Canadian Centre for Advanced Practice Nursing Research
CCRNR	Canadian Council of Registered Nurse Regulators
CAN	Canadian Nurses Association
CNS	Centre for Nursing Studies
CPSNL	College of Physicians and Surgeons of Newfoundland and Labrador
DHCS	Department of Health and Community Services, Government of Newfoundland and Labrador
F/P/T	Federal/Provincial/Territorial
HCP	Health Care Provider
HCS	Health Care System
HHR	Health Human Resources
IAPP	The Institute for the Advancement of Public Policy
ICP	Integrated Care Programs
IP	Interprofessional
LPN	Licensed Practical Nurse
LTC	Long-Term Care
M/As	Managers and Senior Administrators
MD	Physician
NE	Nursing Education
NL	Newfoundland and Labrador
NLASW	NL Association of Social Workers
NLCHI	NL Centre for Health Information
NLMA	NL Medical Association
NLNPA	NL Nurse Practitioner Association
NLPB	NL Pharmacy Board
NP	Nurse Practitioner
NPAC	Nurse Practitioner Association of Canada
NPEAC	Nurse Practitioner Evaluation Advisory Committee
PANL	Pharmacists' Association of Newfoundland and Labrador
PCA	Personal Care Attendant
PEPPA	Participatory, Evidenced-Based, Patient-Focused Process for Advanced Practice Nursing
PHC	Primary Health Care
PHCNP	Primary Health Care Nurse Practitioner
RAU	Regulators, Professional Associations and Collective Bargaining Agents for NPs, physicians, pharmacists, social workers and allied health professionals in NL
RCT	Randomized Control Trial
RHA	Regional Health Authority
RN	Registered Nurse
RNUNL	Registered Nurses' Union Newfoundland and Labrador
SW	Social Worker

55 Military Road | St. John's | NL | Canada | A1C2C5 | Tel: (709) 753-6040 | 1 (800) 563-3200 | Fax: (709) 753-4940 | info@arnnl.ca ARNNL.CA

55 Military Road
St. John's
NL | Canada
A1C 2C5
Tel (709) 753-6040
1 (800) 563-3200 (NL only)
Fax (709) 753-4940
info@arnnl.ca
arnnl.ca