FULFILLING NURSE PRACTITIONERS' UNTAPPED POTENTIAL IN CANADA'S HEALTH CARE SYSTEM:

Results from the CFNU Pan-Canadian Nurse Practitioner Retention & Recruitment Study

June 2018

Greg Bennett/Ontario Nurses' Association

CFNU

CANADIAN FEDERATION OF NURSES UNIONS

CANADIAN FEDERATION OF NURSES UNIONS (CFNU)

We are Canada's nurses.

We represent close to 200,000 frontline care providers and nursing students working in hospitals, long-term care facilities, community health care and our homes. We speak to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.

Greg Bennett/Ontario Nurses' Association

THE CFNU PAN-CANADIAN NURSE PRACTITIONER RETENTION & RECRUITMENT PROJECT

CONTENTS

MESSAGE FROM LINDA SILAS CFNU PRESIDENT

For over a decade in Canada we have been hearing a familiar refrain: there is a need for fundamental reform of our health care system to meet the challenges ahead. Our population is aging rapidly, our acute and long-term care facilities are stretched to capacity, and there is a pressing need to increase care options within the community through the extension and expansion of primary care, home care, long-term care, and mental health services. About one in six Canadians do not have a regular health care provider, and certain groups, including Indigenous peoples and seniors, continue to experience higher rates of chronic diseases. Meanwhile, escalating costs, access issues and health personnel shortages mean wait times continue to be top of mind for Canadians.

Nurse Practitioners (NPs) represent an innovative opportunity for Canada to address its growing health care needs, especially within underserved populations, communities and settings. NPs are uniquely suited to help address these issues, in part because they go beyond traditional medical care models to provide holistic health promotion and illness prevention. Decades of rigorous evidence shows that NPs improve access to personalized, cost-effective, high-quality care that reduces wait times and costs throughout the broader health system. Integrating NPs contributes to the management of chronic disease and improves health outcomes and interprofessional collaboration. Expanding NP care will help meet the growing needs of our communities while saving our system precious health care dollars.

Surveys show that the public is also receptive to the expansion of NP care. Although NPs have practiced in Canada for decades, many Canadians may still be unsure about their role. NPs can provide a diagnosis, order and interpret diagnostic tests, communicate results, recommend or prescribe treatment, as well as consult and refer to other health care providers, including specialists. Like the other three million Canadians who have entrusted their family's care to an NP, I am personally very satisfied with the care I have received from my NP for the past 14 years. I really couldn't ask for better, higher-quality primary care services.

Recognizing the value NPs can provide to patients and our health care system, governments across Canada have taken some steps to address the barriers to NP practice by expanding their scope of practice, and introducing successful initiatives such as Manitoba's Mobile Clinics, in which NPs and Registered Nurses (RNs) provide on-the-spot primary care for people living in smaller, underserved communities. Ontario's use of NP-led clinics and the community health centre model are also leading practices that should be implemented nation-wide.

However, barriers to the optimal use of NPs remain. These include government legislative/regulatory/policy barriers, financing, funding and reimbursement issues, opposition from certain interest groups, or challenges in uptake at the organizational level.

Within the past decade, some provinces have seen the introduction of new categories of health care professionals, for example, unregulated physician assistants (PAs). PAs practice under the direction of an individual physician and have a specific and limited capacity, unlike NPs who are autonomous health care professionals with a broad scope of practice. NPs also benefit from more formal education and experience prior to practising (see Table 4). Given this, and Canada's significant historic investments in existing NPs, Canada would be best served by fully leveraging NPs to meet the comprehensive, complex and growing health needs of Canada's underserved populations, communities and settings.

NPs are the solution to Canada's long-standing shortage of primary care providers, access and wait times issues. To realize the full potential of NPs, governments need to address the remaining barriers to NP practice, such as outdated funding models, inappropriate remuneration, the lack of interprofessional collaboration and

legislative/regulatory policy. As it stands, these barriers are preventing NPs from fully realizing their capacity. To improve our health system's efficiency and effectiveness, we need to invest in NPs and expand their role within Canada's health system.

Although there has been some progress over the past decade in this direction, the supply of NPs in Canada remains very small. From 2004-2006 Health Canada invested close to $9 million in the Canadian Nurse Practitioner Initiative, which was tasked with the challenge of integrating NPs into Canada's health system. The Initiative helped increase the number of NPs who are registered to practice from about 1,000 in 2005 to 5,274 today. However, with a ratio of only about 14 NPs per 100,000 population (one fifth the supply in the U.S.), and more than half of all NPs concentrated in Ontario, most people in Canada don't have the option of NP care. The number of NPs is still undoubtedly insufficient to meet the growing needs of Canada's population.

In an effort to understand why Canada has failed to take advantage of NPs' full potential, the CFNU commissioned this study exploring barriers to retention and recruitment and the expansion of NPs within our health care system. The project included an online bilingual pan-Canadian survey, email surveys for Principal Nursing Advisors and nurses' unions, an analysis of data from CFNU's annual contract comparison documents, CIHI/CFNU geo-mapping of access to primary care providers, and a comprehensive literature review. Based on these elements, a thematic analysis and recommendations have been developed. An Advisory Committee, with representation of NPs from across Canada, worked with the CFNU in developing this report.

The survey is the largest NP survey of its kind ever undertaken in Canada, achieving a 22% pan-Canadian response rate, including NP representation from all provinces and territories, except Yukon. A total of 1,160 responses were received, comprised of 1,038 English and 122 French. The survey results suggest that NPs have solutions to improve our health care system. They know what works and what doesn't in terms of optimizing their role to improve health and health system outcomes.

The survey results highlight the experience of NPs in our health care system from a health human resources perspective. Among the notable findings from our survey, NPs are not compensated appropriately. Governments need to consider NPs' formal education and experience, their scope of practice, professional responsibilities, as well as their role as autonomous health care providers in determining appropriate compensation.

There is also frustration with the lack of understanding of NP scope of practice. Even though they are autonomous practitioners, some managers don't understand the full capabilities of NPs. For example, one NP commented that her role was determined by her manager, who "tells us what we can and can't do based on funding for supplies." What emerges from both the survey results and the literature review is the lack of legislation/regulations and comprehensive team-based funding models to permit NPs to work to their full scope of practice. This is one of the issues we address in the report recommendations.

RECOMMENDATIONS

REMUNERATION

- That within two years the provinces/territories harmonize NPs' salaries across all health care settings.
- That employers enhance NPs' benefit packages to include premiums for on-call work (standby and call-back), mentoring & preceptorships and improve the sustainability of employment relationships through the provision/expansion of NP pensions, health benefits, vacations and other leave provisions (e.g. for professional development), as well as compensation for WSIB, malpractice, liability costs and access to funding for innovative and responsive professional development and continuing education opportunities.

FUNDING MODELS

That federal/provincial/territorial governments, within the next year:

- Adopt/implement sustainable funding models to reflect population health needs, support interprofessional collaboration, enable optimal scope of practice for all providers, and involve NPs in the development, implementation and evaluation of their role;
- Adopt a mechanism — inclusive of governments, employers, unions, associations and NPs — to overcome barriers to NP practice;
- Expand or create NP-led clinics.

HEALTH HUMAN RESOURCES PLANNING

That federal/provincial/territorial governments:

- Fund permanent employment positions for NPs in a variety of settings to meet the health needs of underserved populations;
- Provide targeted funding for isolation/housing allowance of NPs in rural/remote/isolated and Indigenous communities and work with Indigenous communities to expand and recruit NPs and work with schools of nursing on programs that prepare NPs to work in these areas;
- Amend legislation/regulations/policies to allow NPs to work to their optimal scope;
- Implement quality frameworks (e.g., PEPPA) to better integrate NPs into the health care system.

RECOMMENDATION FOR UNIONS

- When working in a unionized environment, ensure there are opportunities for NPs to provide input into collective bargaining, support for ongoing retention and recruitment programs, etc.

One of the findings of direct concern to the CFNU was the perception, expressed in the survey, that nurses unions should do more to fully understand NP practice, responsibilities and worklife. To this end, the CFNU recommends including NPs in bargaining unit scope and actively engaging with NPs to hear, and act, on their issues. This paper serves as a step in this direction.

As our population rapidly ages, the need for community-based care by autonomous practitioners to manage acute and chronic conditions will only increase. Now is the time for governments across the country to plan for tomorrow's health human resource needs so that we ensure we benefit fully from the value NPs can provide to patients and our health care system. Just as we are all working towards better access and reduced costs for prescription drugs through a national pharmacare program, better access to health care depends upon capitalizing on the significant value-added benefits that NPs offer Canada's health care system.

On behalf of all CFNU Member Organizations — United Nurses of Alberta (UNA), Saskatchewan Union of Nurses (SUN), Manitoba Nurses Union (MNU), Ontario Nurses' Association (ONA), New Brunswick Nurses Union (NBNU), Nova Scotia Nurses' Union (NSNU), Prince Edward Island Nurses' Union (PEINU), Registered Nurses' Union Newfoundland & Labrador (RNUNL) and the Canadian Nursing Students' Association (CNSA)— we thank the Advisory Committee, Principal Nursing Advisors and our research and communications team. We look forward to working with all governments to implement these recommendations and make our health care more accessible and effective by expanding access to Nurse Practitioners across Canada.

Sincerely,

Linda Silas, CFNU President

CONTEXT & OVERVIEW

Nurse Practitioners (NPs) help to improve timely access to individualized, high-quality, cost-effective care, resulting in shorter wait times, reduced costs, prevented (re)admissions and better interprofessional collaboration.[1,2,3,4]

WHAT IS A NURSE PRACTITIONER?

Nurse Practitioners (NPs) are Registered Nurses with additional graduate or post-graduate education and clinical practice experience, who are educated in both nursing theory and medical skills. They provide health care in every province/territory in Canada.*

They possess the knowledge and skills to:

- Make a diagnosis, identify a disease, disorder or condition
- Order and interpret diagnostic tests
- Communicate the diagnosis and test results to the patient and to other health care professionals
- Recommend or prescribe treatment—including drugs—and specific procedures

NPs work in a wide variety of health care settings, within the community in home care, long-term care, public health care and primary health care, as well as in hospitals, etc.

* The Canadian Nurses Association (2016). *The Nurse Practitioner Position Statement.*

Integrating NPs has been shown to improve patient and system outcomes and contribute to high-quality chronic disease management, helping to improve the health status of individuals on several measures.[5,6,7,8,9,10] In fact, research indicates that health outcomes are as good as, or better than, comparators.[11,12]

For those who have been patients/clients of NPs, the evidence suggests a high level of satisfaction with the care provided and confidence in NPs' ability to look after them.[13] This finding was echoed in a Canada-wide public opinion poll which found that 93% of Canadians are confident that NPs can meet their day-to-day health needs.[14] However, despite public confidence, a lack of public awareness regarding the role of NPs remains among the public.

In spite of the wealth of evidence pointing to the benefits of investing in the expansion of NP positions to increase access to quality and cost-effective care for patients across Canada, and the willingness of the Canadian public to opt for NP care, barriers to full implementation of the NP role persist in Canada. Although there has been some progress in the expansion of NPs over the past decade, the supply of NPs in Canada remains very small in most provinces. Currently, more than half (57%) of Canada's 5,274 NPs are found in Ontario.[15]

When referring to NPs and their utilization in primary health care, there is considerable work to do in Canada and around the world. A recent Organization of Economic Cooperation and Development (OECD) working paper suggests that there are similar barriers to NPs in most countries, including opposition from certain stakeholders and vested interests (e.g., the medical workforce), government legislative/regulatory/policy barriers, financing and reimbursement issues, and challenges in uptake at the organizational level.[16]

When compared to the United States (U.S.), where the number of NPs has more than doubled since 2007, Canada is lagging behind in realizing the potential of NPs to help alleviate wait times. In the U.S. there are now 248,000 NPs licensed to practice,[17] a ratio of one NP for every 1,314 people. In Canada, with a supply of only 5, 274 NPs, the ratio is one NP for every 6,994 people (or about 14 NPs per 100,000 population).[18]

The CFNU Pan-Canadian NP Retention & Recruitment Project was undertaken between November 2017 and June 2018 to help develop recommendations for the expansion of NPs within Canada's health care system to improve timely access to health care for all those living in Canada. The project included an online bilingual pan-Canadian survey with responses from every province and territory, except Yukon, email surveys soliciting specific information from Principal Nursing Advisors and nurses' unions, an analysis of data from the CFNU's annual contract comparison documents, CIHI/CFNU geo-mapping of access to primary care providers, and a comprehensive literature review (peer-reviewed and grey literature over a 5-year period) with a thematic analysis of data and recommendations based on the results of the project.

The survey — the largest NP survey of its kind ever undertaken in Canada — achieved a 22% pan-Canadian response rate with NP representation from all provinces and territories, except Yukon. A total of 1,160 responses were received, comprised of 1,038 English and 122 French.

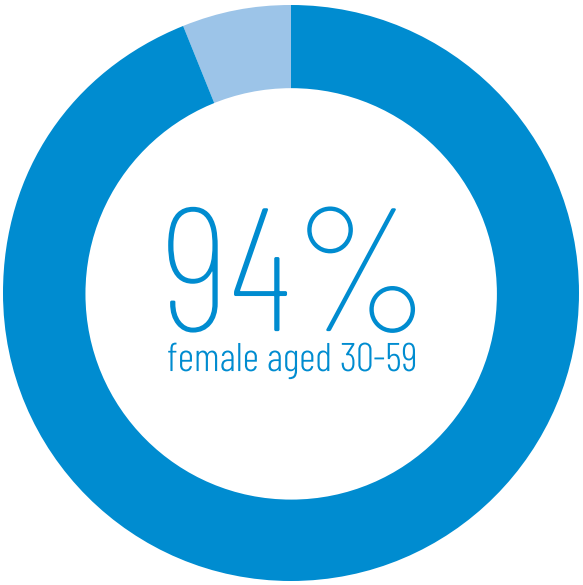
Table 1 indicates the response count and what this represents in terms of the proportion of supply based on the Canadian Institute for Health Information's 2017 NP supply figures by province/territory and nationally.

TABLE 1 – NP Survey Response Count/Rates

PROVINCE/TERRITORY	RESPONSE COUNT	RESPONSE RATE (%)
British Columbia	62	14.8
Alberta	143	29.7
Saskatchewan	76	35.2
Manitoba	71	39.9
Ontario	447	14.8
Quebec	107	24.8
New Brunswick	35	28.0
Nova Scotia	37	22.7
Prince Edward Island	12	50.0
Newfoundland and Labrador	61	37.0
Northwest Territories and Nunavut	6	14.6
Other (outside Canada (2); did not indicate their province/territory)	103	
TOTAL	**1,160**	**22%**

Source: CFNU Pan-Canadian NP Survey (2017-2018).

DEMOGRAPHIC PROFILE

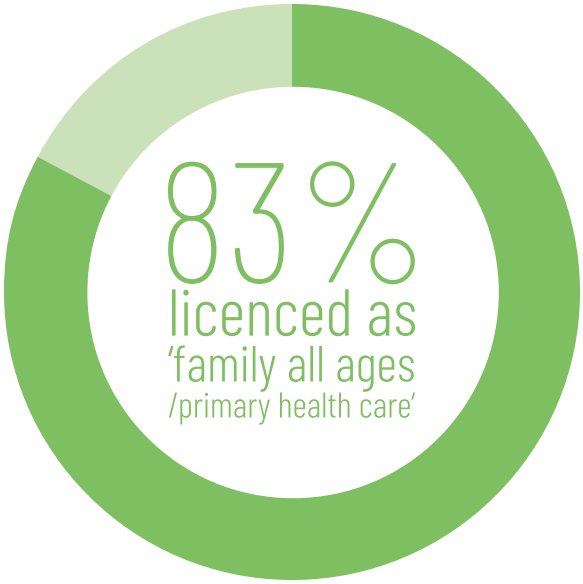


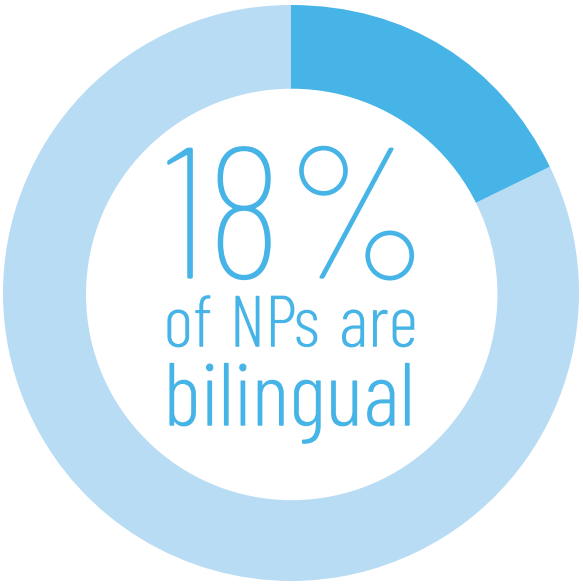
AGE & GENDER

Most respondents were female (94%), aged between 30 and 59.

PRACTICE

The large majority (83%) of NPs who responded were licensed in the category of "NP: Family All Ages/ Primary Health Care," with the exception of Alberta, where only 55% were licensed as "NP: Family All Ages." In Alberta, 32% were "NP: Adult."





BILINGUALISM

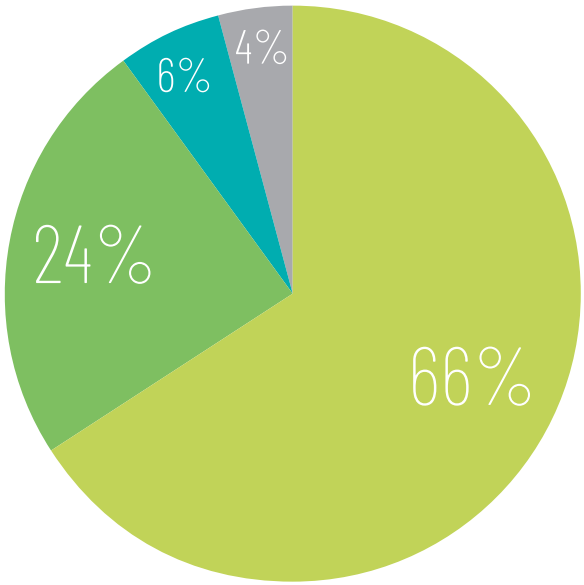
18% of NPs are able to provide NP services in both English and French. The provinces where most bilingual NPs are employed are:

- QC (36%)
- ON (32%)
- NB (9%)

EMPLOYMENT

92% of NPs who responded to the survey are currently working as NPs. Of these, 97% are working in clinical practice. The breakdown of their employment setting is as follows.

92%

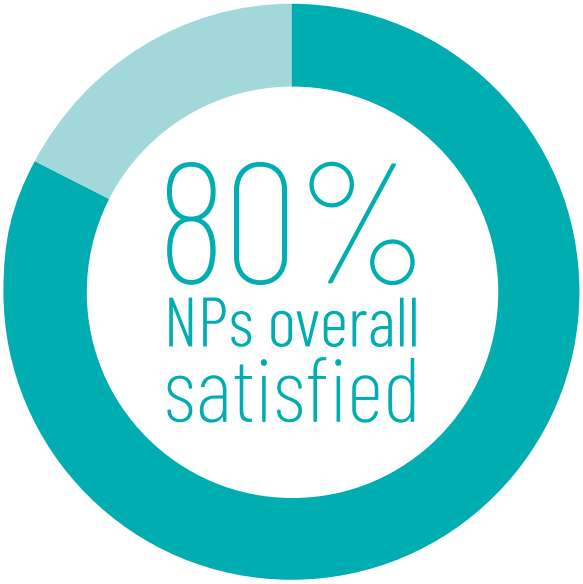


- COMMUNITY HEALTH SETTING[19]
- HOSPITAL[20]
- RESIDENTIAL CARE[21]
- OTHER SETTINGS[22]

OVERALL SATISFACTION

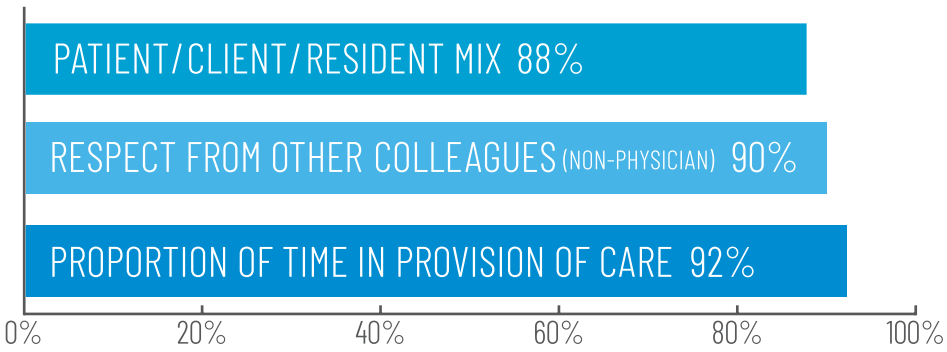
SATISFACTION

80% of NPs across Canada report that overall they are satisfied with their main NP position. This is fairly consistent across all settings.



TOP SOURCES OF SATISFACTION

The top three sources of satisfaction with their main NP position are:



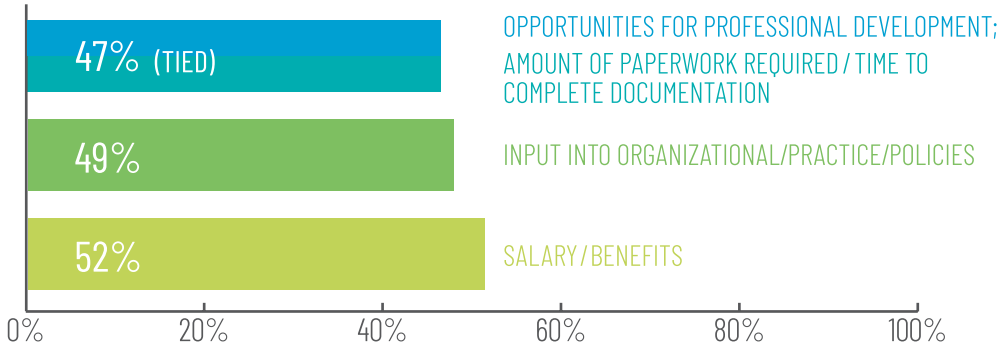
BY SETTING

The top three sources of satisfaction are fairly consistent across all settings, with some notable exceptions:

- "Respect from other (non-physician) colleagues" is not included among the top three for residential or hospital settings; "patient/client/resident mix" and "pension" are only included among the top three for the hospital setting.
- "Patient/client/resident case load" and "physician availability" are included among the top three for the residential and other settings; "level of autonomy" is included in both residential and community health settings' top three.

TOP SOURCES OF DISSATISFACTION

The top three sources of dissatisfaction with their main NP position are:



BY SETTING

With some notable exceptions, the top three sources of dissatisfaction are fairly consistent across all settings:

- "Salary/benefits" is not listed among the top three for other setting, while "managerial support" and "respect from physician colleagues" are only in the other setting as a top source of dissatisfaction.
- "Opportunities for professional development" is not among the top three for community health, but "input into organizational/practice/policies" and "amount of paperwork required/ time to complete documentation" are only in the top three for the community health setting.
- "Amount of administrative support" is among the top three sources for dissatisfaction only in the hospital setting, while "sense of value for what you do" is only found among the top three in the residential setting.

IMPROVING RETENTION & RECRUITMENT

FIVE FACTORS

NPs reported the following five factors as the most important to improving NP retention and recruitment:

1. BETTER SALARY/COMPENSATION
2. REMOVE LEGISLATIVE BARRIERS TO WORKING TO FULL SCOPE OF PRACTICE
3. INCREASE FUNDING FOR NP POSITIONS
4. EXPAND EMPLOYMENT SETTINGS FOR NPS
5. IMPROVE OPPORTUNITIES FOR CONTINUING EDUCATION/PROFESSIONAL DEVELOPMENT

These five factors, in addition to interprofessional relationships/collaboration, emerged from the overall study as the key themes affecting NP retention and recruitment.

Greg Bennett/Ontario Nurses' Association

THEME 1: REMUNERATION

Many authors, including a recent OECD paper,[23] have identified remuneration as one of the most important factors influencing job retention and satisfaction for NPs. NP compensation and pay structures have the potential to both negatively and positively influence job satisfaction and retention efforts.[24,25] There is a strong correlation between job satisfaction and one's pay scale.[26] The ability to practice in a holistic, collaborative model of care with an adequate salary all support job satisfaction and retention.[27] It should be noted that dissatisfaction with total compensation includes, benefits, portability of benefits, pensions and seniority, etc.[28,29]

Some of the specific issues identified in the research:

- Widely varying salaries exist both within provinces/territories and across the country.[30,31]
- Competition within the health sector itself has created salary differences and benefits gaps, particularly between acute and primary care,[32,33] as well as between acute care and Local Health Integration Networks (LHINs)(Ontario) or Community Primary Health Care (PHC) organizations.[34]
- Physician remuneration in comparison to salaries for NPs is identified as an irritant in acute care.[35]
- A new and expanded scope of practice has not resulted in an increase in pay.[36]
- Salary differences between unionized and non-unionized NPs.[37]
- All Canadian provinces fall below the recommendations of Ontario's Hay Group Report for Nurse Practitioners' salaries, which analyzed salaries and responsibilities across the health sector, with specific compensation recommendations for NPs.[38]

SURVEY RESULTS

- Salary/benefits is identified as the top source of dissatisfaction with main NP position, and improving salary/benefits was reported as the key element to help improve the retention and recruitment of NPs.
- 44% of NPs are not satisfied with their overall compensation. AB and QC NPs reported significantly higher rates of dissatisfaction at 57% and 60% respectively. Those working in the community health setting report higher rates of dissatisfaction (48%).
- NPs reported working an average of 3-4 hours of unpaid overtime per week. This is consistent across all settings.
- One in five report participating in on-call activities (a mix of paid and unpaid).
- 80% receive benefits in one of their NP positions.
- More than half (52%) of NPs across Canada are not satisfied with their number of paid vacation days, with much higher dissatisfaction rates reported by NPs in PE (73%) and QC (65%). This rate is consistent across community health, hospital and residential care settings; it is much lower in other settings, where 24% are not satisfied.
- More than 90% of NPs in every province do not contribute to overhead costs, except for in QC, where only 60% do not.
- 51% of NPs reported being unionized in their main position and 24% in their secondary position.
- 83% of NPs do not feel their union represents the specific issues of concern to NPs. There is a perception that unions do not fully understand NP practice, responsibilities and worklife due to their small numbers relative to RNs.

NP PERSPECTIVES

"I was making more per hour as an RN in the hospital. I am not appropriately compensated for the level of responsibility I have and the overtime I put in."

"Currently it [on-call] is "free" as I get nothing official, but ... (they) can call anytime day or night, weekend or weekday, and I have to answer."

"Publicly funded NP positions are poorly paid for the scope of work and complex caseload of patients."

"In light of my educational background, years of experience and productivity at work, I feel I deserve better compensation."

3-4 HOURS

NPs reported working an average of 3-4 hours of unpaid overtime per week.

OVERALL COMPENSATION

44% of NPs are not satisfied with their overall compensation.

VACATION DAYS

More than half (52%) of NPs across Canada are not satisfied with their number of paid vacation days.

ANALYSIS OF SALARY DATA FROM THE CFNU PAN-CANADIAN NP SURVEY (2017-2018)

Based on the results of the CFNU Pan-Canadian NP **Survey** (2017-2018), the following table shows the median total income for full-time and part-time NPs in their primary position for each province and territory, with an overall average salary (including overtime and on-call premiums) for each category (full-time and part-time).

TABLE 2 – Median Total Income for Main NP Position by Province

FOR UNIONIZED AND NON-UNIONIZED NPs, INCLUDING OVERTIME AND ON-CALL PREMIUMS (PART-TIME AND FULL-TIME)

PROVINCE/TERRITORY	FULL-TIME ($)	PART-TIME ($)
British Columbia	105,353	77,000
Alberta	112,000	73,000
Saskatchewan	114,200	60,000
Manitoba	110,000	82,500
Ontario	103,822	60,000
Quebec	85,000	45,000
New Brunswick	100,000	44,000
Nova Scotia	103,000	82,500
Prince Edward Island	96,500	N/A
Newfoundland and Labrador	101,622	45,000
Northwest Territories	106,000	N/A
Nunavut	126,000	N/A
OVERALL	**103,000**	**70,000**

* Overall salary is the average total income (including overtime/on-call premiums) for all 1,160 respondents, including those who did not identify their province or territory.

Note: According to the survey results, unionized and non-unionized NPs do not differ in median total income (including overtime and on-call premiums) for their main NP position: both are $103,000 for full-time and $68,000-70,000 for part-time.

Based on the results of the CFNU Pan-Canadian NP **Survey** (2017-2018), the following table shows the median total income (including overtime and on-call premiums) for unionized and non-unionized respondents for full-time and part-time NPs within each setting.

TABLE 3 – Median Total Income for Main NP Position by Setting (PART-TIME AND FULL-TIME)

	FULL-TIME ($)	PART-TIME ($)
Community health	103,000	70,100
Hospital	107,000	62,500
Residential care	106,500	55,000
Other	106,500	232,000*

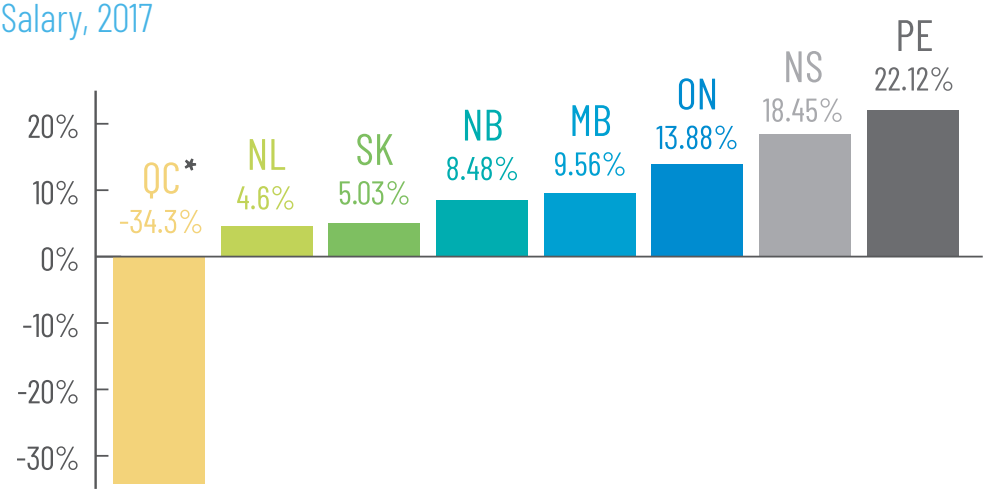
* Caution must be exercised with this number due to very low number of NPs in this unique employment situation.

ANALYSIS OF UNIONIZED NP AND RN SALARY DATA[39]

COMPENSATION: PERCENTAGE DIFFERENCE BETWEEN STARTING (MINIMUM) NP AND MAXIMUM RN SALARIES

Based on the CFNU's 2017 contract comparison data, there is a wide salary differentiation between unionized NPs and unionized RNs in different provinces. When analyzing starting salary data for NPs in comparison to the maximum salary for general duty RNs, the difference ranges from 5% in Newfoundland and Labrador and Saskatchewan to 22% in Prince Edward Island. All other provinces represent an increase, of varying degrees, with Quebec being an exception. This excludes additional pay premiums for general duty RNs such as leadership positions (clinical nurse specialist), time of work (evening, nights, weekends, etc.), position (in charge, team leader, etc.) and overtime. Given all these premiums, the total actual salary for a general duty RN at the top level of the pay scale is likely to be higher than the base salary used here. This means the actual salary percentage differences between a starting NP and a top-scale general duty RN would be less than those presented here.

FIGURE 1: Percentage Difference Between Maximum RN Base Salary & Minimum NP Base Salary, 2017



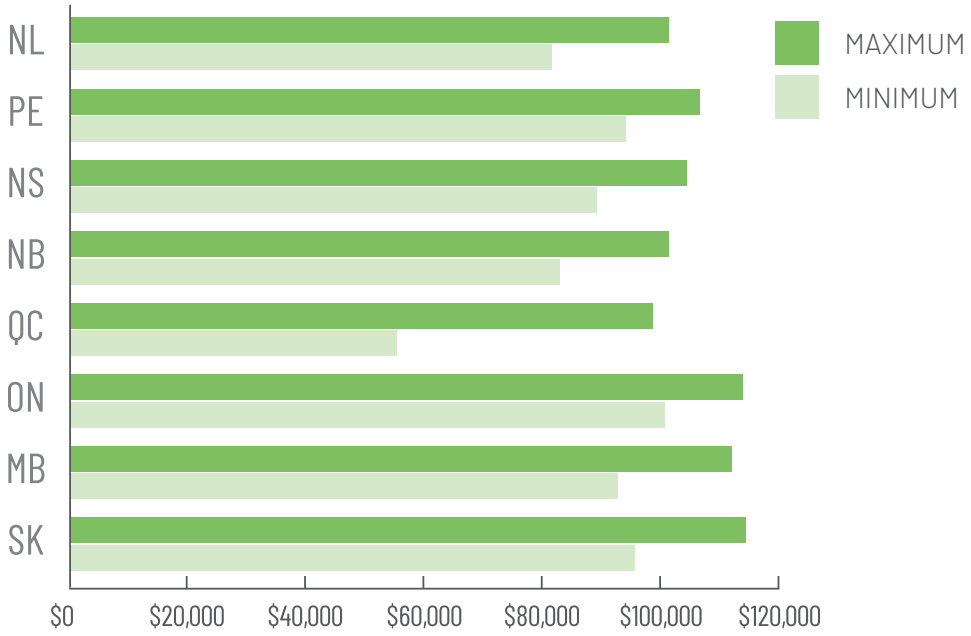
Source: CFNU, Overview of Key Nursing Contract Provisions, 2017.

* Note regarding Quebec NPs: In Quebec, it is clear that there is a dramatic disparity in NPs' salaries throughout the province. The nurses' union (FIQ) and provincial government are working to find an agreed-upon solution to move towards greater harmonization of NP salaries province-wide.

Notes: Represents data available as of October 31, 2017, from contract wage grids and does not include long service awards. Weighted averages were used for NP salaries in ON. BC & AB data were not available in source document (AB NPs are not permitted to unionize).

FIGURE 2: Provincial Unionized NP Salary Comparison, 2017

MINIMUM AND MAXIMUM SALARIES (FROM CONTRACT WAGE GRIDS)



Source: CFNU, Overview of Key Nursing Contract Provisions, 2017.
Notes: Represents data available as of October 31, 2017, from contract wage grids and does not include long service awards.

Weighted averages were used for NP salaries in ON. BC & AB data were not available in source document (AB NPs are not permitted to unionize).

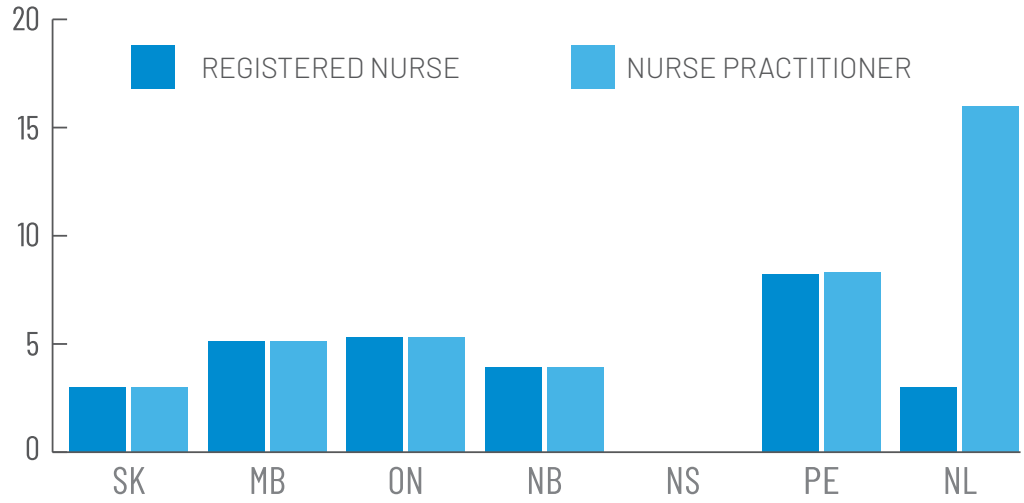
NP vs. FAMILY PHYSICIAN SALARY

Average maximum base salary for unionized NP based on the contract salary grid: **$106,633.72**

Average salary (less overhead costs) for family physician: **$178,000**

Sources: CFNU Overview of Key Nursing Contract Provisions, 2017; http://www.cbc.ca/news/canada/nova-scotia/doctors-nova-scotia-fees-timothy-matheson-salary-expenses-1.3603743; CIHI, Physicians in Canada 2016. Ottawa: Author.

FIGURE 3: Percentage Increase in Minimum Salary 2014-2017



Source: CFNU Overview of Key Nursing Contract Provisions, 2014-2017.

Notes: Represents data available as of October 31 annually, from contract wage grids and does not include long service awards. Weighted averages were used for NP salaries in ON.

BC & AB data were not available in source document (AB NPs are not permitted to unionize). NS data was unchanged due to ongoing contract negotiations. NL NPs have benefited from an occupational review negotiated by RNUNL with the provincial government.

KEY FINDINGS

- Survey results indicate salary/benefits is the biggest source of job dissatisfaction for NPs.
- Significant remuneration variation exists across the country.
- Salaries do not reflect additional education, scope of practice, responsibility, accountability of NPs compared to RNs.
- NPs are frustrated with compensation levels as compared to their physician counterparts.

THEME 2: ROLE CLARITY & SCOPE OF PRACTICE

Numerous studies point to a general lack of awareness and understanding about the role that NPs can play, their education, and their relationship with physicians and other team members.[40,41,42,43,44,45,46,47,48,49] This lack of role clarity, along with legislative and regulatory barriers,[50,51,52] impacts their ability to work to their full scope of practice, leading to job dissatisfaction. While progress has been made in harmonizing legal NP scopes of practice across Canada, differences persist.[53,54]

Some of the specific issues identified in the research:

- There is confusion about the NP being an autonomous provider or a physician extender.[55]
- Limited stakeholder understanding of the NP role limits the full utilization of NP skill sets to enhance interprofessional care. NP-led models have been identified as one solution to overcome barriers.[56,57]
- Members of the health care team value the NP role far less when leaders, including physicians, constrain the NP role.[58]
- When working in a rural or northern community, NP scope of practice may increase because they are the only health professional available.[59] A Canadian study of rural NPs found 6.2% thought of their nursing role as below their licensed scope of practice, and 11% as above their licensed scope of practice.[60]
- Hospital leaders' awareness and understanding of the NP role and its value vary considerably, leading to poor hiring choices and inadequate role integration.[61]
- Setting clear goals and expectations for the NP role in the team environment was identified as critical to support job satisfaction.[62,63,64]
- Having a wide scope of practice is rewarding and challenging,[65] yet it has been found that only about half of NPs felt they are able to practice to their full scope.[66]
- Use of a quality framework such as PEPPA (participatory, evidence-based, patient-focused process for advanced practice nursing), the participatory framework designed for the NP role introduction, is essential for role success.[67]

SURVEY RESULTS

26% of NPs reported not working to their full scope of practice in their main NP position. Notably in NT and QC, the numbers were significantly higher: 75% and 35% respectively. Far fewer reported not working to their full scope of practice in BC (15%) and NB (20%).

NOT WORKING TO SCOPE

26%

- The highest rates of not working to full scope of practice were experienced in the hospital setting (33%), with the lowest in the community health setting (24%).
- Higher rates of not working to full scope of practice were reported by unionized (30%) versus non-unionized NPs (22%).
- 74% of those who reported not working to their full scope of practice in their main NP position work in an urban setting, 22% work in rural and 4% in remote.
- Higher rates of not working to full scope of practice were reported by those NPs who are paid an hourly wage based on actual hours worked (28%) versus those paid an annual predefined salary irrespective of hours worked (22%).
- Above average rates of not working to full scope of practice were reported by those whose position is funded by a private, for-profit company (41%) and by a publicly funded individual facility such as a hospital or long-term care facility (30%).

When asked to rank why they are not working to full scope of practice, the top three reasons were:

THE WAY MY ROLE HAS BEEN DEFINED

EMPLOYER/INSTITUTIONAL BARRIERS

THE PERSONALITY & PHILOSOPHY OF PHYSICIANS WITH WHOM I PRACTICE

These three reasons were fairly consistent across all settings, albeit in different order. An exception was noted in residential care: NPs identified lack of access to a funding model that would permit patients/clients/residents to access NP services and legislative barriers.

Manitoba Nurses Union

NP PERSPECTIVES

"The setting where I practice is not equipped or designed for me to work to full scope."

"Our manager tells us what we can and can't do based on funding for supplies."

"Both provincial and federal arms of the government need to work towards changing legislation to allow NPs to work at their full scope. Currently, I can prescribe mifegymiso and narcotics, but I am not legally allowed to perform a driver's medical or determine competency, due to legislation. Many federal and provincial forms specify only a physician may fill them out, and that limits how quickly this can be done, as they will then need to see my collaborative physician."

KEY FINDINGS

- Various barriers (federal/provincial/territorial legislation/regulation, lack of role clarity, employer policies, etc.) prevent NPs from working to their full scope of practice.
- More than a quarter of NPs report not working to full scope of practice, leading to job dissatisfaction.
- Lack of role clarity contributes to the suboptimal utilization of NPs in the system.

THEME 3: INTERPROFESSIONAL RELATIONSHIPS, RESPECT & COLLABORATIVE MODELS OF CARE

Interprofessional collaborative models of care are recognized as being effective and form the basis for health care policy going forward. Community health centres (CHCs) and NP-led clinics are two examples of such models.

CHCs are non-profit, community-governed organizations that have provided primary health care, health promotion, and community development services in an interprofessional team model for more than 40 years.[68] Ontario's CHCs deliver care to socially disadvantaged and underserved populations and employ almost 400 primary care physicians, more than 300 NPs and many others.[69] Numerous Canadian research studies find that CHCs provide high quality and cost-effective care, achieving better overall outcomes than other traditional medical models like fee-for-service medicine.[70,71,72]

NP-led clinics have been shown to produce high patient satisfaction with clinic services, including effective counselling, resulting in positive health-related behavioural change.[73] Evaluation of the first of 26 NP-led clinics indicates increased access to care and high levels of patient and provider satisfaction.[74] Furthermore, an NP-led interprofessional outpatient geriatric clinic was found to have positive patient outcomes, and high patient, caregiver and primary care physician satisfaction.[75]

NPs practice in a wide variety of care delivery models, with more emerging each day, with many different health care workers in a wide range of models of care. Successful integration of NPs within interprofessional teams is key to their effectiveness, but also to the retention and recruitment of NPs and other providers. Care models need to be supportive, comprehensive, collaborative, and coordinate all health care providers.[76,77,78]

A recent OECD working paper highlights some of the barriers to the implementation of NPs, including the opposition from certain stakeholders (notably the medical workforce). Territorial rhetoric and resistance to change were identified as significant barriers impacting the uptake of NPs.[79] Physicians have been taught to be leaders with all-encompassing responsibility in health care, and are generally resistant to sharing authority in patient care, as they view the expansion of NPs as economically threatening.[80] The focus needs to be on teams, not on individual fee-for-service doctors.[81]

Some specific findings from the research:

- Health professional scopes of practice and associated models of care tend to be organized on the basis of tradition and politics rather than in relation to the evidence of how best to meet current health needs. Expanded scopes of practice, including those for NPs, often "have been introduced without full articulation of how [they] ... will be integrated into existing service delivery models".[82]
- There is a general lack of understanding, on the part of physicians, RNs, and others[83] about how the NP role interfaces with other members of the health care team in a collaborative care model in all practice settings,[84] which may result in the blurring of responsibilities.[85]
- Some researchers found that NP models were poorly understood and defined.[86] Practice structure — not funding arrangements — are important determinants for providing evidence-based primary health care.[87]
- The model of care needs to reflect the practice values that are important to NPs: holistic care is the underpinning of their practice. When NPs are unable to practice holistically because of their role in a team, they may become dissatisfied.[88] Lack of continuity of care between acute and primary care is viewed as a barrier by NPs with their holistic approach to health care and needs to be addressed with new models of care.[89,90] The model of care used in acute care needs to consider the NP contribution.[91]
- Organizational facilitators that lead to job satisfaction include adequate physician support[92] and effective communication, role delineation and team goals from management.[93]

NP PERSPECTIVES

"...Resistance from institutional radiology/ laboratory, community pharmacy and specialist doctors who don't know our role."

"The nurse practitioner-led clinics (NPLCs) are by far the best model for NPs, for patient care and for work satisfaction."

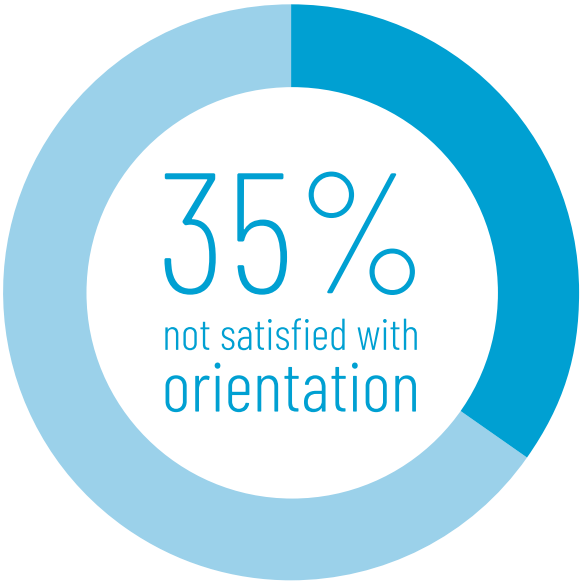
"Further awareness [is needed] by administrators and colleagues/physicians regarding the NP role and the positive advantage within a team approach..."

Alex Lisman/Ontario Nurses' Association

SURVEY RESULTS

The personality and philosophy of physicians with whom NPs practice was ranked as the third reason why NPs are not working to full scope of practice.

35% of NPs were not satisfied with their orientation to the physician/health care team. This varies from a low of 32% in the community health setting to 42% in the hospital setting.



NPs collaborate with many different health professionals in a wide range of models of care. One of the newer roles in Canada is the physician assistant (PA). A common misconception is that an NP and a PA are interchangeable — one can be replaced with the other. This is not the case. An NP is an autonomous, accountable, regulated health care professional that provides comprehensive, holistic health care, while a PA is a technical, unregulated role working under the direction and supervision of an individual physician. The significant difference in roles is a result of the substantial difference in their educational preparation. NPs have master's-level education combined with a minimum of two years of full-time RN experience based on baccalaureate education, for a total of eight years, whereas PAs have one year of course work and one year of clinical experience in their training program. Their key role differences are noted in Table 4.

The value of NPs to patient, organizational and system outcomes is well documented, including their cost-effectiveness. For example, a review of 17 studies, comparing nursing home residents who are patients of NPs to others, revealed lower rates of hospitalization and overall costs for the NPs' patients.[94] Utilizing NPs to manage nursing home patients could result in U.S. $166 billion (2010-2019) in health care savings through reducing avoidable and inappropriate care.[95] A systematic review of randomized controlled trials of NPs showed that NPs in alternative-provider ambulatory primary care roles have equivalent or better patient outcomes than comparators and are potentially cost-saving.[96] Few evaluation studies have been conducted on the costs and/or effectiveness of PAs in primary care practices or hospital settings, other than emergency departments.[97] Furthermore, the evidence comparing the clinical effectiveness of PAs to mainstream management of emergency care is only fair in methodological quality.[98] NPs bring significant added value to various models of health care, health systems and the health of Canadians.

TABLE 4 – Key Role Differences Between NPs and PAs[99]

	NURSE PRACTITIONERS	PHYSICIAN ASSISTANTS
Description	Possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals, and perform specific procedures within their legislated scope of practice. The NP role is derived from blending clinical, diagnostic, and therapeutic knowledge, skills, and abilities that emphasize holism, health promotion and partnership with individuals and families, as well as communities.	Possess the knowledge, skills, and attributes to undertake delegated medical services.
Autonomy	As a regulated health care profession, NPs are autonomous professionals, legally responsible for their own practice and clinical judgment, and are title-protected.	PAs are not autonomous health care providers. The scope of practice and their degree of autonomy in clinical decision making, including prescribing authority, is negotiated on an individual basis with a supervising physician. No PA may prescribe without physician delegation and supervision.
Education	NPs receive two years of NP education, typically at the master's level, in addition to their initial four years of baccalaureate nursing education and a minimum two years of full-time clinical experience, for a total of eight years.	PA training programs are about 24 months in duration, including one year of course work and one year of clinical experience.
Educational Model	Holistic focus that addresses not only disease but also all dimensions of the individual (physical, emotional, mental, etc.), including the effects of illness on the lives of the patients and their families. A strong emphasis on prevention, wellness, and provision of resources to engage patients in self-management of their health. An NP emphasizes knowledge acquisition and decision making skills, population health and prevention, recognizes the social determinants of health, and stresses the more analytical activities associated with primary care.	Grounded in the medical model, which in general emphasizes the physical and biological aspects of specific diseases and conditions, and the clinical procedures or strategies to address that defect or dysfunction. Preparing PAs to work as assistants to physicians, rather than as independent providers, results in their training being less focused on analytical processes and more technically oriented.
Underlying Values	Improved quality of patient care, including: increased comprehensiveness of care, improved experiences, and increased accessibility.	Improved efficiency and productivity of physician services.

Greg Bennett/Ontario Nurses' Association

KEY FINDINGS

- The ability to practice independently and holistically within collaborative models of care supports NP job satisfaction and retention.
- A lack of physician support contributes to NP job dissatisfaction.
- A lack of understanding of the NP role by physicians, health care leaders and other health care providers contribute to job dissatisfaction and suboptimal utilization of the NPs to meet the health care needs of Canadians.
- PAs are not a substitute for NPs.
- Investing in NPs represents a positive return on investment.

THEME 4: FUNDING & COMPENSATION MODELS

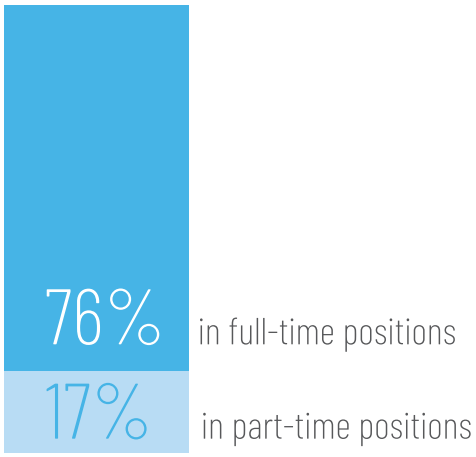
For NPs to fully participate in health care, funding needs to be allocated to models of remuneration that support team-based primary health care.[100] Monies for health care delivery are provided to regional health authorities (RHAs) or local health integration networks (LHINs) who decide on NP positions within global budgets. There is some specifically targeted funding for NPs by provincial/territorial governments and RHAs/LHINs.[101] The goal is to create a financial environment that supports collaboration and sharing of care, and links funding to activities of the team, rather than to specific providers.[102] "Funding model reform, regardless of setting, should support a team care approach to ensure that the money follows the patient and not the provider."[103] Several authors have identified a lack of comprehensive team-based funding models that support NP practice.[104,105] Funding mechanisms, specifically types of primary care delivery and methods of payment for health care providers, is one of four factors identified as a barrier to implementing NPs.[106] Salaried employees is the predominant compensation model and currently the preferred model to support interprofessional collaboration.[107]

Specific findings:

- In general, the salary model has been well received by NPs.[108]
- The fee-for-service model does not align well with comprehensive team-based care[109] and has the potential to place NPs and physicians in direct competition for funding.[110] It may perpetuate the perception of competition with doctors.[111] In addition, NPs cannot bill the system directly,[112] although NPs can be integrated into this model if paid by the province in a salaried model.[113]
- Incentive-based plans, based on productivity and quality in acute care, have been found to be an effective motivator and have increased gains in quality of care and satisfaction.[114] However, others found that financial incentives are the most significant barriers to interdisciplinary and collaborative care.[115]
- "The salary model depends on securing new money or reallocating money from existing health budgets to employ more NPs and other APNs [Advanced Practice Nurses]. This has limited the number of new NP positions in Canada...Moreover, the envelope for physician funding is separate from other health services. This division has created some inflexibility in the ability of health planners to redistribute money. It has also created a disincentive to hire NPs because physician income does not come from the global health or hospital budget." [116]

SURVEY RESULTS

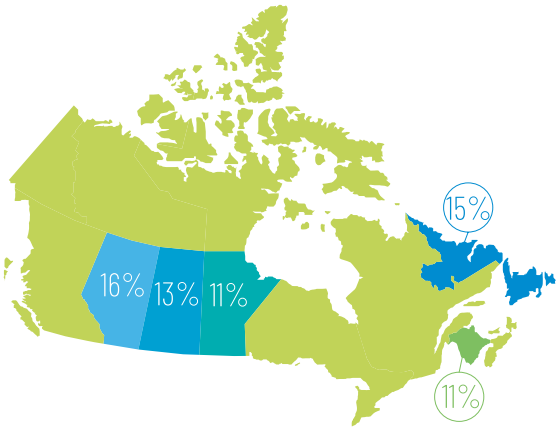
- Increasing funding for NP positions is one of the five most important factors identified by NPs to improve NP retention and recruitment.
- The majority of NPs in most provinces are employed in their preferred employment status: 76% in full-time positions and 17% in part-time positions.
- Notably, full-time rates were considerably lower in AB and MB (below 60%) and higher in PE, BC, NS, NB, QC, NT and NL (above 80%).



9%

RN & NP POSITIONS

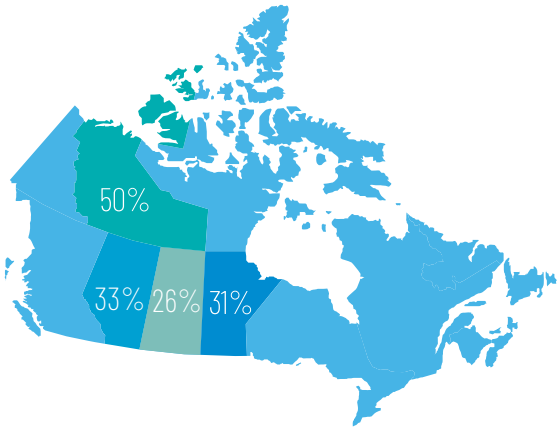
- Across the country, 9% are employed in both NP and RN positions, with higher than average rates seen in:



23%

ONE+ NP POSITION

- 23% of NPs report having more than one NP position, with those in several jurisdictions reporting higher levels of multiple employment:

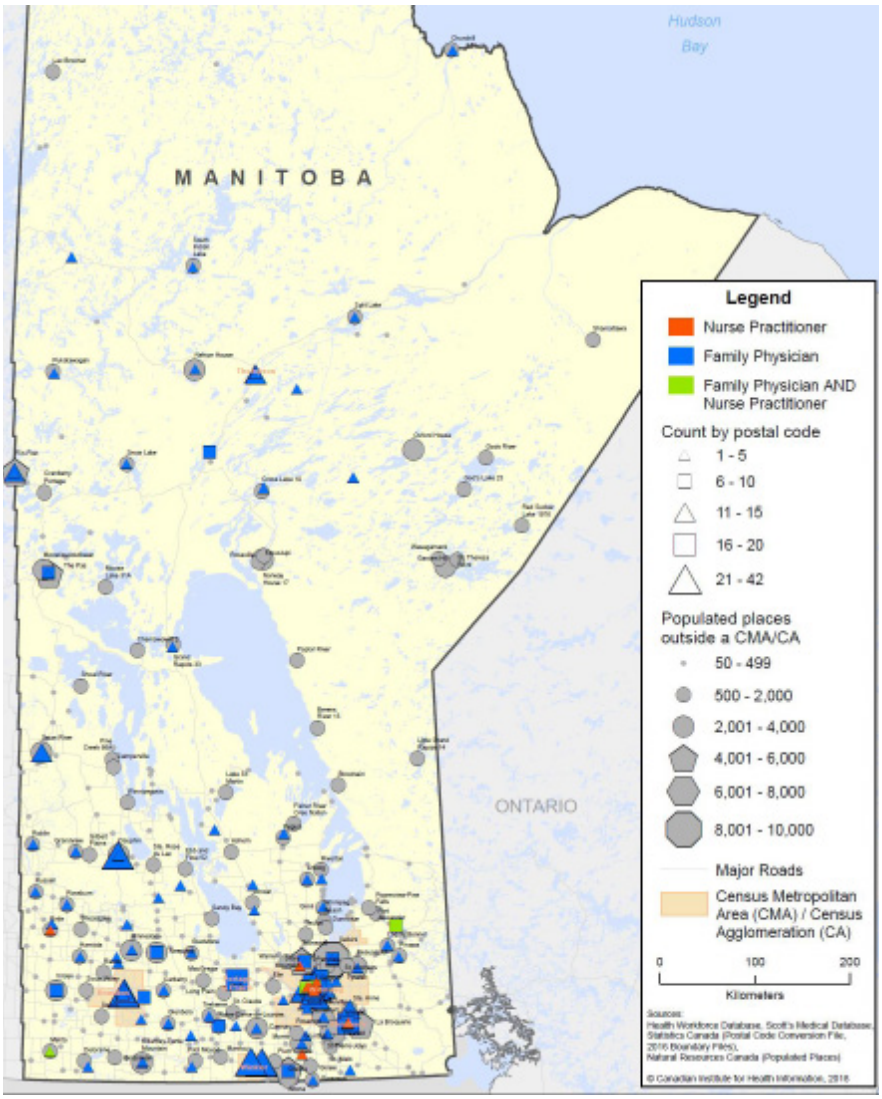


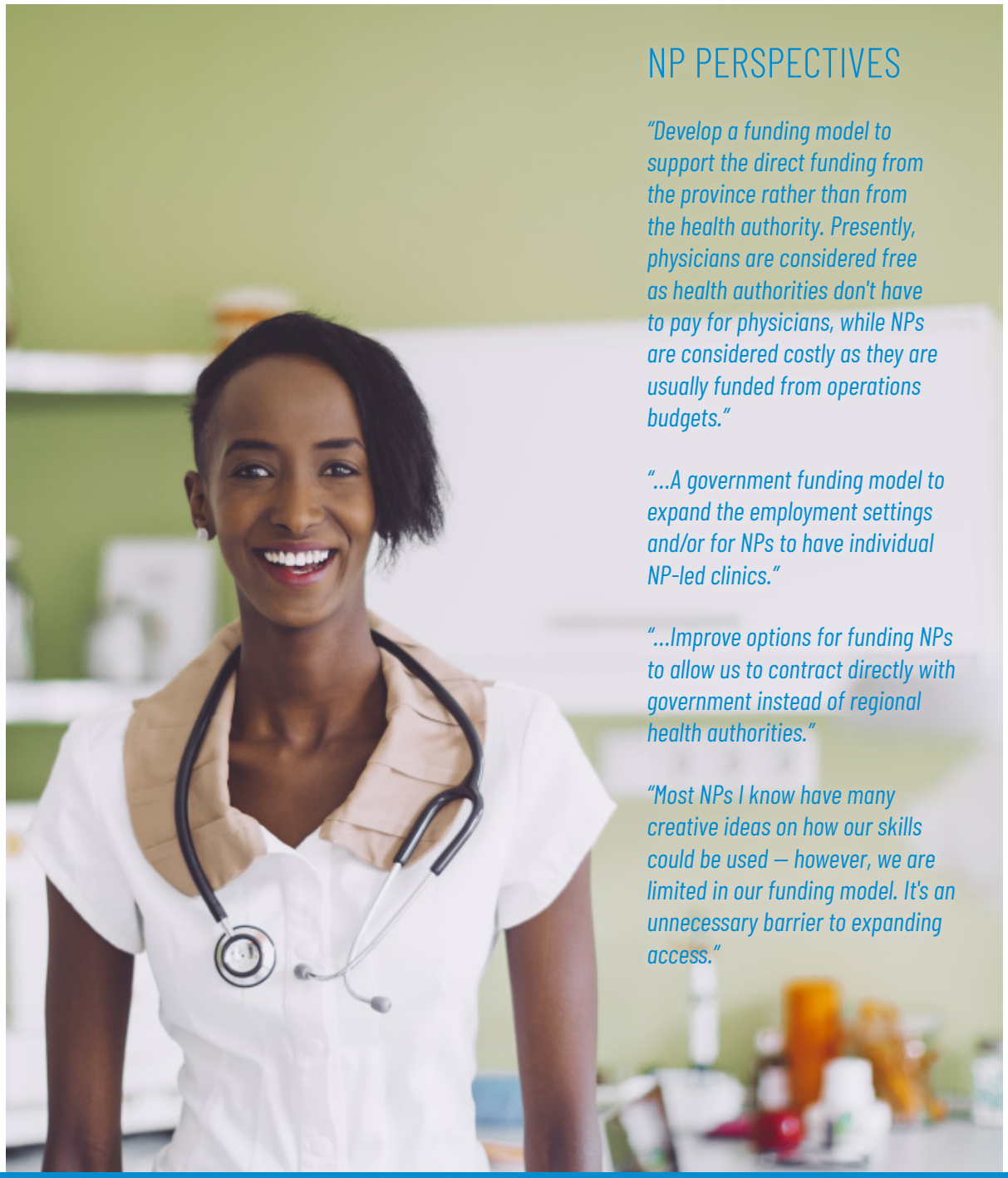
GEO-MAPPING: ACCESS TO PRIMARY CARE PROVIDERS

The CFNU partnered with the Canadian Institute for Health Information (CIHI) to undertake a geo-mapping exercise to map primary care providers (NPs and family physicians) by health region, census sub-division and per 100,000 population, for each jurisdiction across Canada in 2016. These maps are derived from the national workforce databases housed at CIHI and provincial/territorial population statistics. This is the first time such an exercise has been undertaken.

The old adage that every picture tells a story holds true. The sample map of primary health care providers for Manitoba depicted below shows where there is no primary care provider and thus an opportunity to create NP positions to improve access to primary care. A visual comparison of the various provincial/territorial maps illustrate how some governments and health regions/ LHINs have strategically positioned NPs, while there remains significant potential in others. Visit www.nursesunions.ca to view all the maps for Canada.

FIGURE 4: Primary Health Care Providers, Manitoba, 2016





NP PERSPECTIVES

"Develop a funding model to support the direct funding from the province rather than from the health authority. Presently, physicians are considered free as health authorities don't have to pay for physicians, while NPs are considered costly as they are usually funded from operations budgets."

"...A government funding model to expand the employment settings and/or for NPs to have individual NP-led clinics."

"...Improve options for funding NPs to allow us to contract directly with government instead of regional health authorities."

"Most NPs I know have many creative ideas on how our skills could be used – however, we are limited in our funding model. It's an unnecessary barrier to expanding access."

KEY FINDINGS

- A lack of comprehensive team-based funding models that support the NP role limits Canadians' access to health care.
- Settings such as long-term care have limited funding models to support NP implementation.
- Many areas of Canada have no primary care provider, or family physician only, and would benefit from the introduction of NP positions.

THEME 5: CONTINUING EDUCATION/PROFESSIONAL DEVELOPMENT

The links between continuing education/professional development and job satisfaction are well-established in the literature. In addition to influencing job satisfaction,[117] it is well-recognized in today's health care workplace that ongoing learning and removing the barriers to continuing education for NPs "...is essential given the importance of basing care on current best practice and developing and maintaining specialist knowledge."[118] "Without the support, protected time, and resources to participate in education, research and leadership activities, APNs risk job dissatisfaction and lose the opportunity to develop and/or disseminate new nursing knowledge."[119]

Some specific findings from the research:

- Professional development and mentorships need to be supported.[120,121] In support of professional development, mentoring can enhance retention, job satisfaction and role enhancement, and programs (including e-mentorships) have been shown to be effective in furthering research competencies and capacity.[122,123]
- Belonging to a community of practice for NPs was important for some practitioners.[124]
- Consistent funding, protected release time and access to appropriate continuing education continue to be issues.[125]
- NP-specific language in collective agreements, related to professional development, varies greatly by province/territory.[126]
- NPs have specific continuing education requirements for annual registration renewal.[127]
- There is variation across provincial/territorial governments and employers in their level of support for professional development/continuing education, i.e. relocation assistance for hard-to-recruit positions/locations; loan forgiveness programs; NP bursary programs in exchange for return for service; signing bonuses for difficult-to-fill positions; recruitment initiatives.[128]

NP PERSPECTIVES

"I believe we need more training days. We have jobs where we need to constantly remain up-to-date."

"I would love more opportunity to attend paid educational sessions"

"...Continuing competencies that genuinely enhance the NP's practice/knowledge; routine sessions to educate NPs on procedure-related skills."

Prince Edward Island Nurses' Union

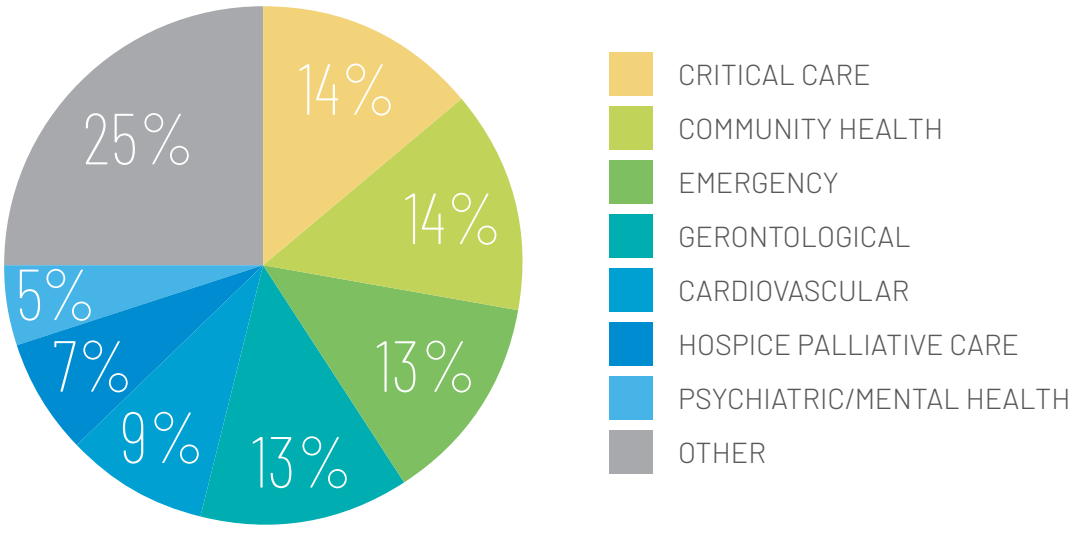
SURVEY RESULTS

- Improving opportunities for continuing education/professional development was identified as one of the top five most important factors to improve NP retention and recruitment.
- Opportunities for professional development were identified as one of the top three sources of NPs' dissatisfaction with their main position (47%).
- 62% of NPs are not satisfied with their number of paid education days, with much higher dissatisfaction reported in PE (82%), SK (82%), MB (76%), NT (75%), and AB (73%). Rates of dissatisfaction are higher for those NPs working in the hospital sectors (73%) and residential care (64%).
- 27% of NPs reported that their educational expenses are not reimbursed, with higher rates experienced in NL (58%) and AB (50%).
- 17% of NPs across Canada have additional Canadian Nurses Association specialty certification which exceeds their core NP education. Several jurisdictions exceed this level, including AB (28%), QC (20%), NB (23%), NS (22%) and NT* (40%).

*Caution should be exercised given small number of responses.

SPECIALTY CERTIFICATION

The predominant certification specialties that bring further NP expertise include:



KEY FINDING

- Opportunities for professional development/continuing education is a significant source of NP job dissatisfaction and rated by NPs as very important to their retention and recruitment.

RECOMMENDATIONS & CONCLUSION

Governments, employers and others have invested significantly in the NP role over the years with the goal of improving access to quality care. This role will become even more integral as the population ages and rates of chronic diseases escalate. Research on the impact of the NP role to patients, organizations and the health system is abundant and compelling. NPs are a cost-effective solution to the provision of comprehensive, high quality care in a variety of settings. The evidence acquired through this study points to further opportunities to improve the retention and recruitment of NPs, further realizing their untapped potential. Based on the thematic analysis of the results of this study, the CFNU has several recommendations for governments, employers and unions.

Greg Bennett/Ontario Nurses' Association

RECOMMENDATIONS: Remuneration

Findings from the various components of this study point to the pivotal importance of remuneration as a factor in retention and recruitment. Currently, widely varying total compensation (including salaries, pensions and benefits) for NPs exist between different health care settings and across the country. The analysis of unionized salaries shows that the gap between RN maximum and NP minimum salaries is insufficient to attract and retain NPs.

THE CFNU RECOMMENDS THAT WITHIN TWO YEARS PROVINCIAL/TERRITORIAL **GOVERNMENTS**:

- Harmonize NPs' salaries across all health care settings within each province/territory to substantially bridge the wage gap that currently exists. In determining what constitutes appropriate compensation, account for NPs' formal education and experience, their scope of practice, professional responsibilities, as well as their accountability as autonomous health care providers.

WE ALSO RECOMMEND THAT **EMPLOYERS:**

- Enhance NP benefit packages to include premiums for on-call work (standby and call-back), mentoring and preceptorships;
- Enhance the sustainability of employment relationships through the provision/expansion of NP pensions, health benefits (e.g., dental, vision, paramedical, etc.), vacations and other leave provisions, time for research, leadership, and professional development, as well as compensation for WSIB, malpractice, and liability costs;
- Enhance access to funding for professional development, and innovative and responsive opportunities for continuing education (especially in rural/remote/isolated and Indigenous communities). Provide access to video/electronic/innovative educational opportunities to ensure ongoing learning regardless of where an NP lives and works.

RECOMMENDATIONS: Funding Models

It is evident that governments, employers, nurses' unions and NP associations have to examine better funding models that recognize and support the autonomous role of NPs if populations are to be better served by the full spectrum of NP care across all settings. Funding mechanisms have been identified as barriers to utilizing NPs across Canada. Currently, there is a maldistribution of NPs across settings, geographic locations, and specialties (to meet the needs of specific populations, e.g., seniors) in part because funding models lack the flexibility to support their use.

A health human resources innovation strategy would see the expansion of NP positions equitably across all settings to utilize NPs' unique competencies to address the growing health care needs of all those living in Canada. This would help to increase access and reduce wait times, benefiting patients, providers and our health care system alike.

AS SUCH, WITHIN THE NEXT YEAR (2018-2019), THE CFNU RECOMMENDS THAT FEDERAL/PROVINCIAL/TERRITORIAL **GOVERNMENTS**:

- Adopt/implement sustainable funding models that reflect population health needs, support interprofessional collaboration, enable optimal scope of practice for all providers, and involve NPs in the development, implementation and evaluation of their role;
- Adopt a mechanism inclusive of governments, employers, unions, associations and NPs to overcome barriers to NP practice, including, but not limited to, establishing a means of engaging with NPs on the current challenges to NP practice and providing suggestions for positive change, as well as input into planning for future innovations;
- Expand or create NP-led clinics.

RECOMMENDATIONS: Health Human Resources Planning

Implementing a comprehensive health human resources plan to optimize the use of NPs to meet the needs of Canada's diverse communities, populations and geographic disparities will require many important elements. The following initiatives would help to increase access to health care in underserved communities and support the optimal use of NPs in Canada.

THE CFNU RECOMMENDS THAT FEDERAL/PROVINCIAL/TERRITORIAL **GOVERNMENTS**:

- Fund permanent employment positions for NPs in a variety of settings to improve access to high quality holistic health care to meet the health needs of underserved populations;
- Provide targeted funding for isolation/housing allowances for NPs in rural/remote/isolated and Indigenous communities;
- Work with Indigenous communities to expand and recruit NPs from, and for, Indigenous communities;
- Work with schools of nursing to develop, and provide incentives, to support programs that prepare NPs to work in difficult-to-recruit geographic locations (such as rural/remote/isolated);
- Amend federal/provincial/territorial legislation/regulations and employer policies, in consultation with NPs, to allow NPs to work to their optimal scope of practice to better serve patients;
- Implement quality frameworks (such as PEPPA) to better integrate NPs into the health care system.

RECOMMENDATION FOR **UNIONS**:

- When working in a unionized environment, ensure there are opportunities for NPs to provide input into collective bargaining, support for ongoing retention and recruitment programs, etc.

CONCLUSION

Greg Bennett/Ontario Nurses' Association

With close to $9 million in federal funding invested in the Canadian Nurse Practitioner's Initiative from 2004-2006, there have been many calls over the ensuing years for the integration of NPs as a solution to Canada's ongoing access and wait times issues. Over the past decade, these issues have persisted. They continue to dominate the national agenda and are top of mind when people are asked about health care. With the expansion of our seniors' population, escalating rates of chronic diseases, an increased demand for mental health services, an underserved Indigenous population and overcrowded acute care facilities, there is a pressing need to act now to fully integrate NPs within our health care system. NPs represent a significant return on investment. It is hoped that this report will act as a catalyst for change so that provincial/territorial governments will harness the untapped potential of NPs for Canada's health system.

ENDNOTES

1 Martin-Misener, R. et al. (2015a). Cost-effectiveness of nurse practitioners in primary and specialized ambulatory care: systematic review. *BMJ Open*, 5. doi:10.1136/bmjopen-2014-007167.

2 Maier, C., Aiken, L., & Busse, R. (2017). Nurses in advanced roles in primary care: Policy levers for implementation. *OECD Health Working Papers*, 98. doi.org/10.1787/a8756593-en.

3 Hurlock-Chorostecki, C. & McCallum, J. (2016). Nurse practitioner role, values in hospital; new strategies for hospital leaders. *Nursing Leadership*, 29 (3), p.82-92.

4 Canadian Nurses Association (CNA). (2016a). *The Nurse Practitioner Position Statement*. Retrieved from https://cna-aiic.ca/-/media/cna/page-content/pdf-en/the-nurse-practitioner-position-statement_2016.pdf?la=en&hash=B13B5142C8D02990439EF06736EA284126779BCC

5 Donald, F., et al. (2015). Hospital to community transitional care by nurse practitioners: A systematic review of cost-effectiveness. *International Journal of Nursing Studies*, 52, 436-451.

6 Martin-Misener, R., et al. (2015a).

7 CNA. (2016a).

8 DiCenso, A., & Bryant-Lukosius, D. (2010, June). Clinical *Nurse Specialist and Nurse Practitioners in Canada: A Decision Support Synthesis*. Canadian Foundation for Healthcare Improvement. Retrieved from https://www.cfhi-fcass.ca/SearchResultsNews/10-06-01/b9cb9576-6140-4954-aa57-2b81c1350936.aspx.

9 Russell, G. M., Dahrouge, S., et al. (2009). Managing chronic disease in Ontario primary care: The impact of organizational factors. *Annals of Family Medicine*, 7 (4), 309-318.

10 Donald, F., Martin-Misener, R., et al. (2013). A systematic review of the effectiveness of advanced practice nurses in long-term care. *Journal of Advanced Nursing*, 69, 2148-2161.

11 Maier, C., Aiken, L. & Busse, R. (2017).

12 Martin-Misener, R. et al. (2015a).

13 College of Registered Nurses of Nova Scotia. (2016). *Nurse practitioner-sensitive outcomes: 2016 summary report*. Retrieved from https://crnns.ca/wp-content/uploads/2016/04/Nurse-Practitioner-Sensitive-Outcomes-Summary-Report-one-pager.pdf

14 Nanos, N. (2016). Canadians' opinions on home healthcare and nurses. *Nanos Polling Series 2016-854*. CNA Research Summary. Retrieved from https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/canadians-opinions-on-home-healthcare-and-nurses.pdf?la=en&hash=07988EBAFB94277D4C48030B38C8FABEC10EE80A.

15 Canadian Institute for Health Information (CIHI). (2018). *Regulated Nurses*, 2017. Data Table 26 – NP Supply.

16 Maier, C., Aiken, L. and Busse, R. (2017).

17 American Association of NPs. NP Fact Sheet. Retrieved from https://www.aanp.org/all-about-nps/np-fact-sheet. Calculations based on a total population of 326,000,000 (U.S. Census).

18 Based on Statistics Canada. CANSIM Table 051-0005. Retrieved from http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510005&&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid and Canadian Institute for Health Information 2017 NP supply figures.

19 Includes community clinic/health centre, primary/family care clinic, urgent care clinic, private physician's office, homecare agency, public health department/unit, mental health center, outpost/nursing station, mobile clinic, NP-led clinic, retail clinic

20 Includes all types of hospitals: general, maternal, pediatric, cancer, mental health, rehab, correctional facility, etc.

21 Includes long-term care facility, nursing home, hospice facility, assisted living facility

22 Includes academic (university/college) education program, occupational/employee health, school/college/university health service, military, association, government, self employed

23 Maier, C., Aiken, L. & Busse, R. (2017).

24 MacLeod, M., Stewart, N., et al. (August, 2017). Nurse Practitioner National Survey Fact Sheet: Nursing Practice in Rural and Remote Canada. *Nursing Practice in Rural and Remote Canada II*. RRN2-04-03. Retrieved from https://www.unbc.ca/sites/default/files/sections/rural-nursing/en/rrniinpfinalfactsheetupdated20180202.pdf.

25 Rhodes, C., Bechtle, M., and McNett, M. (2015). An Incentive Pay Plan for Advanced Practice Registered Nurses: Impact on Provider and Organizational Outcomes. *Nursing Economics*, 33 (3), 227 – 230.

26 Roberge, C. (2009). Who Stays in Rural Nursing Practice? An International Review of the Literature on Factors Influencing Rural Nurse Retention. *Online Journal of Rural Nursing and Health Care*, 9 (1), 82-93.

27 Steinke, M., Rogers, M., Lehwaldt, D., & Lamarche, K. (2017). An Examination of Advanced Practice Nurses' Job Satisfaction Internationally. *International Nursing Review*, 65 (2). 162-172.

28 Association of Family Health Teams of Ontario, Association of Ontario Health Centres & Nurse Practitioner's Association of Ontario. (2014, Jan). *Toward a Primary Care Recruitment and Retention Strategy for Ontario*. Retrieved from http://www.afhto.ca/wp-content/uploads/Toward-a-Primary-Care-Recruitment-and-Retention-Strategy-January-2014.pdf.

29 Roberge, C. (2009).

30 DiCenso, A., & Bryant-Lukosius, D. (2010, June).

31 Martin-Misener, R. et al. (2015b). Benchmarking for Nurse Practitioner Panel Size and Comparative Analysis of Nurse Practitioner Pay Scales: Update of a Scoping Review. *Ministry of Health and Long-Term Care Report*. Retrieved from https://fhs.mcmaster.ca/ccapnr/documents/np_panel_size_study_updated_scoping_review_ report.pdf.

32 Ibid.

33 Silversides, A. & Laupacis, A. (2012, July 5). Lower pay hampers nurse practitioner recruitment in primary care. *Healthydebates*. Retrieved from http://healthydebate.

ca/2012/07/topic/community-long-term-care/nurse-practitioners.

34 Association of Family Health Teams of Ontario, *et al*. (2014, Jan).

35 Doetzel, C., Rankin, J., & Then, K. (2016). Nurse Practitioners in the Emergency Department: Barriers and Facilitators for Role Implementation. *Advance Emergency Nursing Journal*, 38 (1). 43-55.

36 Silversides, A. & Laupacis, A. (2012, July 5).

37 Martin-Misener, R., *et al*. (2015b).

38 Ibid

39 Canadian Federation of Nurses Unions. (2017). Overview of Key Nursing Contract Provisions. Retrieved from https://nursesunions.ca/wp-content/uploads/2017/11/2017-11-08-Contract-comparison_for-web.pdf.

40 DiCenso, A., & Bryant-Lukosius, D. (2010, June).

41 Prodan-Bhalla, N. & Scott, L. (2016). Primary Care Transformation in British Columbia: A New Model to Integrate Nurse Practitioners. *BCNPA Report*. Retrieved from https://bcnpa.org/wp-content/uploads/BCNPA_PHC_Model_ FINAL -November-2-2016.pdf.

42 Fraser, E. (2017). *Province doesn't let Nurse Practitioners fill health care gaps, group says*. *CBC News*. Retrieved from http://www.cbc.ca/news/canada/new-brunswick/nurse-practitioners-doctors-1.4404747.

43 Hamilton, S. and Rickards, T. (2017, Nov) UNB researchers release first-ever study of nurse practitioners in the province. *University of New Brunswick*. Retrieved from https://blogs.unb.ca/newsroom/2017/11/16/unb-researchers-release-first-ever-study-of-nurse-practitioners-in-the-province/.

44 Wong, S., and Farrally, V. (2013). The Utilization of Nurse Practitioners and Physician Assistants: A Research Synthesis. *Michael Smith Foundation for Health Research and Nursing Research Advisory Council Report*. Retrieved from https://www.msfhr.org/sites/default/files/Utilization_of_Nurse_Practitioners_and_Physician_Assistants.pdf.

45 CNA. (2016b). *The Canadian Nurse Practitioner Initiative: A 10-year retrospective*. Retrieved from https://cna-aiic.ca/~/media/cna/page-content/pdf-en/canadian- nurse-practitioner-initiative-a-10-year-retrospective.pdf

46 CNA. (2016a).

47 Heale, R., & Pilon, R. (2012) An exploration of patient satisfaction in a nurse practitioner-led clinic. *Nursing Leadership*, 25 (3). 43-55.

48 O-Rourke, T., & Smith Higuchi, K. (2016). Activities and attributes of nurse practitioner leaders: Lessons from a primary care system change. *Nursing Leadership*, 29(3). 46-60.

49 Hunter, K.F., Murphy R.S., Babb, M., & Vallee, C. (2016). Benefits and Challenges Faced by a Nurse Practitioner Working in an Interprofessional Setting in Rural Alberta. *Nursing Leadership*, 29 (3). 61–71.

50 Sangster-Gormley, E., Martin-Misener, R. & Burge, F. (2013). A Case Study of Nurse Practitioner Role Implementation in Primary Care: What Happens When New Roles are Introduced? *BMC Nursing*, 12 (1).

51 Maier, C., L. Aiken & R. Busse. (2017).

52 Kleinpell, R., et al.(May 31, 2014). Addressing Issues Impacting Advanced Nursing Practice Worldwide. *The Online Journal of Issues in Nursing*, 19 (2).

53 Manitoba Nurses Union. (2016). *Nurse Practitioner Jurisdictional Scan* (unpublished).

54 Spence, L., Agnew, T., & Fahey-Walsh, J. (2015). A pan-Canadian environmental scan of the scope of practice of nurse practitioners. *Nurse Practitioner Association of Ontario*. Retrieved from http://npao.org/pdf/A_Pan-Canadian_Environmental_Scan_of_NPs_2015.pdf.

55 Wong, S., & Farrally, V. (2013).

56 Heale, R., & Pilon, R. (2012).

57 O-Rourke, T. & Smith Higuchi, K. (2016).

58 Hurlock-Chorostecki, C., & McCallum, J. (2016).

59 Roberge, C. (2009).

60 MacLeod, M., Stewart, N., *et al*. (2017, August).

61 Hurlock-Chorostecki, C., & McCallum, J. (2016).

62 Wranik, D., et al. (2015). How Best to Pay Interdisciplinary Primary Care Teams. Report for *Canadian Institutes for Health Research and Nova Scotia Health Research Foundation*. Retrieved from http://primaryhealthcareteams.ca/wp-content/uploads/2013/10/HRPA-Final-Report.pdf.

63 Labrosse, S. (2016). *Nurse Practitioners: Improving Access to Primary Care on Prince Edward Island*. University of Prince Edward Island. Signature Project. Retrieved from https://www.islandscholar.ca/islandora/object/ir:20220.

64 Sangster-Gormley, E., Martin-Misener, R. & Burge, F. (2013).

65 Steinke, M., Rogers, M., Lehwaldt, D., & Lamarche, K. (2017).

66 deGuzman, A., Ciliska, D., & DiCenso, A. (2010, July/Aug). Nurse Practitioner Role Implementation in Ontario Public Health Units. *Canadian Journal of Public Health*, 101 (4). 82-88.

67 Hurlock-Chorostecki, C., & McCallum, J. (2016).

68 Association of Ontario Health Centres. *Community Health Centres*. Retrieved from: http://aohc.org/community-health-centres.

69 Hutchison, B. & Glazier R. (2013). Ontario's primary care reforms have transformed the local care landscape, but a plan is needed for ongoing improvement. *Health Affairs*, 32 (4). 695-703.

70 Russell, G., et al. (2010). Getting it all done. Organizational factors linked with comprehensive primary care. *Family Practice*. 27 (5). 535-541. doi:10.1093/fampra/cmq037

71 Russell, G., et al. (2010). Managing Chronic Disease in Ontario Primary Care: The Impact of Organizational Factors. *Annals of Family Medicine* 7(4). 309-318. http://doi.org/10.1370/afm.982.

72 Glazier, R., Zagorski, B., & Rayner, J. (2012) Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10. *Institute for Clinical Evaluative Sciences*

73 Heale, R. & Pilon, R. (2012).

74 DiCenso, A., Martin-Misener, R., *et al*. (2010, Dec.). Utilization of nurse practitioners to increase patient access to primary health care in Canada-thinking outside the box. *Nursing Leadership*, 23. 239-259.

[75] Hansen, K., McDonald, C., et al. (2017). Formative evaluation of a nurse practitioner-led interprofessional geriatric outpatient clinic. *Journal of Interprofessional Care*, 31(4). 546-549.

[76] Starke, R., et al. (2015, March). *Rural Health Services Review Final Report: Understand the Concerns and Challenges of Albertans who Live in Rural and Remote Communities*. Government of Alberta Report. Retrieved from https://open.alberta.ca/publications/7030219.

[77] Mable, A., Marriott, J. & Marriott-Mable, E. (2012, January). Canadian Primary Healthcare Policy. The Evolving Status of Reform. *Canadian Foundation for Healthcare Improvement*. Retrieved from https://www.cfhi-fcass.ca/SearchResultsNews/12-01-16/33216492-5553-4b0e-a780-c6aed2a5b6b8.aspx.

[78] Jiwani, I., & Fleury, M. (2011). Divergent modes of integration: the Canadian way. *International Journal of Integrated Care*, 11. 1-11.

[79] Prodan-Bhalla, N., & Scott, L. (2016).

[80] Villegas, W., & Allen, P. (2012). Barriers to advanced practice registered nurse scope of practice: Issue analysis. *The Journal of Continuing Education in Nursing*, 43(9). 403-9.

[81] Cohen, M. (2014). How Can We Create a Cost-Effective System of Primary and Community Care Built Around Interdisciplinary Teams? *Canadian Centre for Policy Alternatives*. Retrieved from https://www.policyalternatives.ca/publications/reports/ccpa-bc-submission-select-standing-committee-health.

[82] Nelson, S., Turnbull J., Bainbridge, L., Caulfield, T., Hudon, G., D. Kendel, et al. (2014). Optimizing Scopes of Practice: New Models for a New Health Care System. *Canadian Academy of Health Sciences*. p. 8. Retrieved from http://cahs-acss.ca/wp-content/uploads/2015/07/Optimizing-Scopes-of-Practice_REPORT-English.pdf. p.8.

[83] deGuzman, A., Ciliska, D., & DiCenso, A. (2010, July/Aug).

[84] Sangster-Gormley, E., Martin-Misener, R. & Burge, F. (2013).

[85] Doetzel, C., Rankin, J., & Then, K. (2016).

[86] Starke, R., *et al*. (2015, March).

[87] Dahrouge, S., Hogg, W., Russell, G., Tuna, M., Geneau, R., Muldoon, L. et al. (2011). Impact of remuneration and organizational factors on completing preventative manoeuvres in primary care practice. *CMAJ*, 184(2).

[88] Steinke, M., Rogers, M., Lehwaldt, D., & Lamarche, K. (2017).

[89] Fraser, E. (2017).

[90] Hamilton, S. & Rickards, T. (2017, Nov).

[91] Doetzel, C., Rankin, J., & Then, K. (2016).

[92] Sangster-Gormley, E., Martin-Misener, R. & Burge, F. (2013).

[93] Steinke, M., Rogers, M., Lehwaldt, D., & Lamarche, K. (2017).

[94] Bakerjian, D. (2008). Care of nursing home residents by advanced practice nurses: A review of the literature. *Research in Gerontological Nursing*, 1(3). 177-185.

[95] UnitedHealth Group (2009). Federal Health Care Cost Containment: How in Practice Can It Be done? Options With a Real World Track Record of Success. *Working Paper 1*. Retrieved from http://www.unitedhealthgroup.com/~/media/UHG/PDF/2009/UNH-Working-Paper-1.ashx?la=en.

[96] Martin-Misener, R. *et al*. (2015a).

[97] Gafni, A., Birch, S., & Buckley, G. (2011). Economic analysis of physician assistants in Ontario: Literature review and feasibility study. *Centre for Health Economics and Policy Analysis*. Working Paper Series 11-03.

[98] Hooker, R. S., Klocko, D. J., & Larkin, G. L. (2011). Physician assistants in emergency medicine: The impact of their role. *Academic Emergency Medicine*, 18(1). 72-77.

[99] Wong, S., & Farrally, V. (2013).

[100] Ducatel, S. (2017). Funding Model Needed for Nurse Practitioners. Sundre Round Up. *Great West Digital*. Retrieved from https://www.sundreroundup.ca/article/funding-model-needed-for-nurse-practitioners-20171107.

[101] Principal Nurse Advisor Survey (unpublished)

[102] Wranik, D., Korchagina, M., Edwards, J., Bower, I., Levy, A., & Katz, A. (2015).

[103] Doetzel, C., Rankin, J., & Then, K. (2016). p.8.

[104] Fraser, E. (2017).

[105] Association of Family Health Teams of Ontario, *et al*. (2014, Jan)

[106] Kleinpell, R., *et al*.(May 31, 2014)

[107] Principal Nurse Advisor Survey (unpublished)

[108] Wranik, D., Korchagina, M., Edwards, J., Bower, I., Levy, A., & Katz, A. (2015).

[109] Cohen, M. (2014).

[110] Doetzel, C., Rankin, J., & Then, K. (2016).

[111] Wong, S., & Farrally, V. (2013).

[112] Fraser, E. (2017).

[113] Labrosse, S. (2016).

[114] Rhodes, C., Bechtle, M. & McNett, M. (2015).

[115] Cohen, M. (2014).

[116] Maier, C., Aiken, L., & Busse, R. (2017). p.34.

[117] DiCenso, A., & Bryant-Lukosius, D. (2010, June).

[118] Ibid. p.31.

[119] Ibid. p.25.

[120] Ibid.

[121] Roberge, C. (2009).

[122] Harbman, P., et al.(2017, April). Partners in research: building academic-practice partnerships to educate and mentor advanced practice nurses. *Journal of Evaluation in Clinical Practical*, 23(2). 382-390.

[123] Bryant-Lukosius, D. (2015). Mentorship: A navigation strategy for promoting oncology nurse engagement in research. *Canadian Oncology Nursing Journal*, 23(3). 1-4.

[124] Wong, S., & Farrally, V. (2013).

[125] Canadian Nurses Association. (2016b).

[126] CFNU Member Organizations. (2018). Environmental Scan (unpublished)

[127] Little, L. (2018). Environmental Scan (unpublished)

[128] Little, L. (2018). Environmental Scan (unpublished)

CFNU ACKNOWLEDGEMENTS

Thank you to Lisa Little Consulting, which was commissioned by the CFNU to undertake this research, to our pan-Canadian Advisory Committee (Mark Aylward, NP, NL; Laurie Thomas, NP, PE; Duana D'Entremont, NP, NS; Matt Hiltz, Executive Director, NBNU, NB; Beverly Mathers, Senior Director, Labour Relations, ONA, ON; Lisa Ladouceur, NP, ON; Mikaela Brooks, Researcher, MNU, MB; Barb Beaurivage, NP, SK; Eric Lavoie and Rosa Reyes, NPs, AB; Raleen Murphy and Lenora Brace, NPs, NPAC, Canada) and to CFNU Member Organizations, without whom this work would not be possible. The Principal Nursing Advisors and the Canadian Institute for Health Information also contributed valuable data to this report. Finally, to the 1,160 NPs from across Canada, who took the time to fill out the CFNU Pan-Canadian Survey (2017-2018), thank you for sharing your thoughts. As well, thanks to Carol Reichert, CFNU's Policy and Research Specialist.

FROM THE RESEARCHER LISA LITTLE, RN, BNSc, MHS

Thank you to the CFNU for the opportunity to once again study the retention and recruitment of NPs. My initial fore into this segment of the health workforce began as Manager of the HHR Component of the Canadian Nurse Practitioner Initiative in 2004. While significant progress has been made in some aspects of the role, several of the policy barriers identified more than a decade ago continue to impede the true potential of NPs. Numerous opportunities exist to fully leverage this role to meet the health needs of Canadians. The pan-Canadian NP survey is a unique component of this study and offers insight into the current work environment and other factors affecting NP job satisfaction and their effective deployment. Time constraints of this study did not support a full in-depth analysis of all survey variables. This robust and rich data set will continue to be analyzed. Stakeholders, including policy makers, decision makers, associations, researchers and others interested in specific data can submit their requests to me by email: lisa@lisalittleconsulting.ca.

THE CFNU PAN-CANADIAN NURSE PRACTITIONER RETENTION & RECRUITMENT PROJECT | 2017-2018

The Canadian Federation of Nurses Unions Pan-Canadian Nurse Practitioner (NP) Retention & Recruitment Project aims to improve NP working conditions to better retain and attract NPs and expand NP positions throughout the health care system. About three million Canadians receive care from an NP, but their numbers are not sufficient to meet the growing needs of an aging population. The CFNU Pan-Canadian NP Retention & Recruitment Project was undertaken between November 2017 and June 2018 to help develop recommendations for the expansion of NPs within our health care system to improve timely access to health care for all those living in Canada. The project included an online bilingual pan-Canadian survey with responses from every province and territory, except Yukon, email surveys soliciting specific information from the Principal Nursing Advisors and nurses' unions, an analysis of data from CFNU's annual contract comparison documents, CIHI/CFNU geo-mapping of access to primary care providers, and a comprehensive literature review (peer-reviewed and grey literature over a 5-year period) with a thematic analysis of data and recommendations based on the results of the project. An Advisory Committee, with representation from NPs from across Canada, worked with the CFNU in developing this report.

On June 29, 2018, it was presented to Canada's Health Ministers at their annual meeting held in Winnipeg, Manitoba.

Published by:

Canadian Federation of Nurses Unions
www.nursesunions.ca
2841 Riverside Drive
Ottawa, ON K1V 8X7

ISBN: 978-1-7753845-1-9

Citation for this Report:
Little, L., & Reichert, C. (2018). *Fulfilling Nurse Practitioners' Untapped Potential in Canada's Health Care System: Results from the CFNU Pan-Canadian Nurse Practitioner Retention & Recruitment Study.* Ottawa: CFNU.

Printed in Canada by Imprimerie Plantagenet Printing

THE CFNU PAN-CANADIAN NURSE PRACTITIONER RETENTION & RECRUITMENT STUDY

2017-2018

PROJECT TEAM MEMBERS

RESEARCHER	Lisa Little Consulting
CFNU PROJECT LEAD	Carol Reichert
ADVISORY COMMITTEE	Mark Aylward (NL) Barb Beaurivage (SK) Mikaela Brooks (MB) Duana D'Entremont (NS) Matt Hiltz (NB) Lisa Ladouceur (ON) Rosa Reyes & Eric Lavoie (AB) Beverly Mathers (ON) Lenora Brace & Raleen Murphy (NPAC) Laurie Thomas (PE)
COMMUNICATIONS TEAM	Lauren Snowball Oxana Genina Glenn Crawford (Jack of All Trades Design)

CANADIAN FEDERATION OF NURSES UNIONS

CANADIAN FEDERATION OF NURSES UNIONS

nursesunions.ca

CFNU MEMBER ORGANIZATIONS

ONSA | AEIC

Manitoba nurses Union

New Brunswick Nurses Union NBNU SNIB Syndicat des infirmières et infirmiers du Nouveau-Brunswick

Nurses Union

ONA Ontario Nurses' Association

pei nurses

SASKATCHEWAN SUN UNION OF NURSES

United Nurses of Alberta