Optimizing Collaborative Practice of Nurses in Primary Care Settings

Nelly D. Oelke
Amanda Wilhelm
Karen Jackson
Esther Suter
Rebecca Carter

Final Report
February 2012
Acknowledgements

We wish to acknowledge the funding provided by Alberta Health and Wellness for this project.
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Executive Summary

The aim of this project, “Optimizing the Collaborative Practice of Nurses in Primary Care Settings,” was to facilitate nurses’ capacity to practice to the full extent of their knowledge and skills, including population health and health promotion, in a primary care setting. A multi-pronged approach was used, building upon findings from recently completed research on nursing in primary care settings. Four key activities were undertaken as part of this project.

1. An environmental scan was conducted to better understand nursing service delivery models and provider roles in primary care settings across Canada.

2. Interviews were conducted with nurses (NPs, RNs, RPNs, LPNs), managers, educators, and regulatory bodies in Alberta to better understand the educational needs of primary care nurses to be able to practice to the full extent of their knowledge and skill in these settings.

3. A Summit was held to bring together key Alberta stakeholders (educators, primary care managers, primary care nurses, regulatory bodies, physicians, researchers, policy-makers, and Alberta Health Services stakeholders) to discuss role optimization of nurses in primary care settings, review previous research results, validate data collected, and obtain input for recommendations to optimize the practice of nurses in primary care settings in Alberta.

4. Actionable recommendations were developed to facilitate optimization of nursing roles in primary care settings.

Evidence of current innovative and effective practices in primary care settings was reported by participants. For example, effective interprofessional (IP) collaborative practice was described in some clinics and teams. Participants suggested newer graduates had a greater emphasis on health promotion, disease prevention, and community health than those nurses graduating in the past. There also seemed to be an increase in the coverage of primary care concepts in entry-to-practice education, and newer graduates were generally more prepared to work collaboratively in IP teams. Overall, there was support (e.g., time to attend, some financial support) for nurses wanting to pursue continuing education opportunities.

However, based on stakeholder interviews conducted in Alberta, some issues were raised about nursing practice in primary care settings. For example, there were inconsistencies across Primary Care Networks (PCNs) in terms of orientation, education, and nursing role enactment. Awareness of PCNs in general and their activities varied. Another issue was role ambiguity, and the ability of nurses to be able to work to their full scope. There were differences in terms of expectations for nurses – their education prepared them for a generalist role, however, there was an expectation from primary care managers that nurses would come prepared to take on a more specific role in primary care. This gap between education and practice highlighted the importance of orientation and mentorship in the transition of nurses into primary care settings. In addition, clinical placements continue to be an issue, in terms of

Health Systems and Workforce Research Unit, Alberta Health Services
both availability and coordination. We also found that the Nurse Practitioner (NP) role was underutilized in Alberta, particularly compared to some other settings examined across Canada. Finally, ‘turf protection’ continued to exist among nurses as well as nurses and other team members.

Ten proposed actions were developed by Summit participants. They encompassed various foundational components for primary care including: emphasis on patient-centred practice; establishment of funding and governance models to support nursing roles and IP collaborative practice in primary care; defining nursing roles, responsibilities, and core competencies within the context of the IP team in primary care settings; the importance of orientation and mentorship for new nurses working in primary care; and the inclusion of primary care settings in clinical placements for students.

Based on the literature, environmental scan, interview results, and proposed actions from the Summit the following overall recommendations were developed.

1. Build on foundational components in primary care to facilitate the optimization of nursing roles
   • Increase patient and community engagement
   • Establish funding and governance models to support nursing roles and IP collaborative practice
   • Include evaluation of nursing role optimization in a broader evaluation framework
2. Define nursing roles, responsibilities, and core competencies in primary care settings
3. Support IP education and facilitate clinical placements in primary care settings
4. Implement IP collaborative practice
5. Establish a standardized continuing education program for nurses in primary care settings including orientation and mentorship of new nurses entering primary care

This project was successful in accomplishing each of the objectives it set out to achieve. The environmental scan provided us with a better understanding of nursing models in primary care settings across Canada, and the interviews with Alberta stakeholders gave us a better understanding of the educational needs of primary care nurses in Alberta. The recommendations developed are a step in the right direction in creating environments to support nurses’ ability to practice to the full extent of their knowledge and skills in a primary care setting. Implementing these recommendations has the potential to facilitate positive outcomes at the patient, provider, and system levels.
Background

The overall goal of this project, “Optimizing the Collaborative Practice of Nurses in Primary Care Settings,” was to facilitate nurses’ capacity to practice to the full extent of their knowledge and skills in a primary care setting. This project included various approaches to explore issues in primary care nurses’ capacity to practice in the primary care setting. The following pages of this report will outline the results of the project. A glossary of terms used in this report is included in Appendix A.

The project described in this report builds upon research recently completed by the Health Systems & Workforce Research Unit, Alberta Health Services, exploring the optimization of the role of RNs and LPNs in primary care settings (Besner, Drummond, Oelke, McKim, & Carter, 2010). Findings from this research (Besner et al., 2010) revealed the following: 1) nursing roles had evolved over the period of the study but the primary focus of nurses’ practice was tasks and activities related to chronic disease management; 2) psycho-social assessment, education, support, and linkage with other providers was evident at the individual patient level; 3) the practice of primary care nurses (RNs/LPNs) was not based on population needs nor did they focus on health promotion; 4) there was a lack of differentiation between RN and LPN roles leading to role confusion and duplication; and 5) the extent to which nurses were able to use their knowledge and skills was dependent to a large degree on the development of trusting relationships with other care providers (e.g., physicians, other team members). Another key theme arising from the research was the fact that nurses did not feel they were educated to work in the primary care setting (Besner et al., 2010). In summary, RNs and LPNs practicing in the primary care setting were not using the full extent of their knowledge and skills, the optimization of nursing roles was contingent on their relationships with other providers, there was a lack of a population-based approach, and nurses felt their entry-to-practice education did not prepare them well to work in this type of setting.

Findings from the study described above were consistent with a report recently published by the University of Alberta where nurses reported that the transition to the primary care setting was a significant change and “a major learning curve,” despite having many years of nursing experience (Sayah, Bell, Szafran, Williams, Robertson, & Wood, 2011, p. 11). Nurses reported a lack of preparation for their position in primary care and stated that when they first started, their role was vague and particularly unclear to other team members which resulted in under utilization of nurses. Another challenge in some settings was a lack of training and physician buy-in. However, over time, nurses were able to inform and educate other team members, which resulted in increased collaboration and better working relationships (Sayah et al., 2011). Other previous research also demonstrated RNs were not working to their full scope of practice in primary care (Akeroyd, Oandasen, Alsaffar, Whitehead, & Lingard, 2009; Alsaffar, 2005 & Allard, Frego, Katz, & Halas, 2010).

The underutilization of nurses (RNs and LPNs) in primary care settings was in part due to nurses’ inability to clearly articulate the contribution they could and should make in promoting health. Successful IP collaboration in healthcare required all health team members to have a strong sense of professional identity and a clear understanding of the contribution they each made to achieving health outcomes (Besner et al., 2010).
Funding models, such as the fee-for-service (FFS) model, were identified as a potential barrier to collaborative practice (DiCenso et al., 2010). In the past decade there was a shift away from FFS towards alternate funding models. Such models included capitation (set amount of money provided per patient), salary (based on hours rather than services provided), or blended payment (Devlin, Sarma, & Hogg, 2006). An alternate option examined was placing salaried NPs into FFS practices, supporting IP teams (Heale & Butcher, 2010).

Nurse Practitioner-Led Clinics are an example of an alternate delivery model for primary care services in healthcare to facilitate the optimization of all nursing roles including the NP (Heale & Butcher, 2010). Effective leadership and teamwork as well as strong NP representation on community boards of directors contributed to the success of NP led models (Heale & Butcher, 2010). A common vision facilitated providers to work to their full scope of practice in primary healthcare delivery; however, a lack of a common vision resulted in tension between healthcare providers (DiCenso et al., 2010). The importance of all team members understanding the vision and goals of a practice should not be underestimated (Heale & Butcher, 2010).

In summary, although progress was made in incorporating nurses into primary care settings in Canada, there was significant room for improvement in the optimal utilization of nurses in this setting. The lack of role clarity between nurses as well as between nurses and other providers was apparent. Current preparation for nurses to work in primary care settings did not prepare them to work in this setting. NP clinics have shown promise in other provinces, but such a model has not yet been considered nor implemented in Alberta. Given these gaps in current nursing practice in primary care and the fact that nurses practicing to the full extent of their knowledge and skills have the potential to positively impact outcomes at the patient, provider, and system levels, this project will address gaps in knowledge and bring together key stakeholders to discuss and make recommendations for optimizing nursing roles in the primary care setting.

The overall goal of this project was to facilitate primary care nurses’ capacity to practice to the full extent of their knowledge and skills including population health and health promotion in a primary care setting. Specific objectives included:

1. To identify “leading practices” in implementing models of care that optimize the utilization of nurses in primary care medical settings in other areas of Canada;
2. To identify the gaps in pre-service and continuing education for nurses to optimize their practice in the primary care medical setting;
3. To gather a group of key stakeholders (e.g., primary care managers, primary care nurses, educators, regulatory bodies, researchers) to discuss role optimization of nurses in primary care medical settings; and
4. To develop recommendations to ensure readiness of practice for nurses in primary care settings.
Methods

Multiple data sources were used to elicit information on nursing service delivery models, provider roles, collaborative practice, and educational needs of nurses in primary care settings. Data were collected through an environmental scan and interviews with Alberta stakeholders, and culminated in a Summit with broad stakeholder representation.

Environmental Scan

Primary care settings across Canada (provinces and territories other than Alberta) were identified via an internet search. Our overall list included 84 clinics, from which we focused on settings where a variety of nurses were working. Project team members reviewed the list and chose clinics that represented a broad range of nursing providers and geography. Snowball sampling was also used in identifying other clinics by asking participants for recommendations of exemplary service delivery models in primary care. Initial contact with the clinic was made by the research analyst via an email or a phone call. Information about our project was then sent to the program manager or executive director. Three attempts were made to establish contact with these clinics before moving on to the next. Semi-structured, in-depth phone interviews were conducted. Prior to the interview, participants were sent an informed consent form (Appendix B) and interview questions (Appendix C). With participant consent, interviews were recorded to assist in supplementing field notes recorded by the interviewer. In some cases participants provided us additional documents including job descriptions and clinic brochures. This information was incorporated into the environmental scan. Nursing service delivery models were summarized in a table (Appendix D). Interview data were analyzed thematically (Appendix E).

Alberta Interviews

Recruitment of PCN managers and nurses was completed through the AHS PCN liaison who forwarded our project information to PCN Executive Directors and then on to managers and nurses. Educators and regulatory bodies were directly contacted to participate. Interviews were conducted in the same manner as for the environmental scan (see Appendix B and C for interview guides and consent forms). PCN models were summarized in a table (Appendix F) based on interviews completed with stakeholders (e.g., managers, nurses) from the participating Alberta PCNs. This information was then verified by most interview participants and PCN managers. This was not a comprehensive overview of PCN models in Alberta, nor was it representative of ‘exemplar’ models as this was not the intent of the project.

Interview data were analyzed thematically. For the Alberta interviews, the themes were first analyzed by stakeholder group and then overarching themes were identified (Appendix G).

Results

Environmental Scan Participants

Interviews were conducted with Clinic Managers, Clinic Coordinators, Directors of Nursing and Professional Practice, Executive Directors, NPs, RNs, physicians, and Chief Nursing Officers to validate earlier research findings and examine models of nursing service delivery in primary care and primary
healthcare settings across Canada. All provinces and the territory of Nunavut were represented. Eighteen individuals were interviewed from 14 clinics/teams from urban, rural, and remote primary care settings. These service delivery models include nurse practitioner/nurse led clinics, family health teams, family medical groups, community health centres, interdisciplinary/multidisciplinary teams, and other primary care nursing models. Detailed environmental scan information, which was validated by all participants, is provided in Appendix D.

Alberta Stakeholder Participants
Interviews were conducted with PCN nurses (n = 11 NPs, RNs, RPNs, LPNs), PCN managers (n = 6), regulatory bodies (n = 3), and educators (n = 8), from urban, rural, and remote areas, to validate earlier research findings and to better understand the educational needs (entry-to-practice and continuing education) of nurses to facilitate practice to the full extent of their knowledge and skills in these primary care settings. These stakeholders also informed us about nursing roles, role ambiguity, and IP collaboration.

Themes
Six themes emerged from the environmental scan and Alberta stakeholder interviews:

1. A vision for nursing in primary care settings

The environmental scan and Alberta stakeholder interviews highlighted the importance of a vision for nursing in primary care settings. To more effectively implement nursing roles, a philosophy and vision was required with buy-in from all team members. The involvement of nurses in program development could facilitate the development of a vision for nursing and increase buy-in.

2. Organizational design, roles and responsibilities

Transformational change in primary care settings was seen to be slow. In many primary care settings, models of nursing care were new and continued to evolve. Organizational design, including clinic structure and funding models, varied across settings and impacted the optimization of nursing roles. Little evaluation had been completed to date on nursing models to guide changes.

3. Scope of practice / nursing role ambiguity

Role ambiguity was an issue – overall there was a lack of understanding or differentiation of roles between nurses and between nurses and other team members. Role enactment varied across settings and in some cases nurses were taking on the roles of other providers. Furthermore, the implementation of the NP role was limited in Alberta.

4. Entry-to-practice nursing education

Entry-to-practice education prepared nurses to work in a generalist role, however, there was a need for greater focus on primary care knowledge and skills (e.g., CDM). The opportunities for clinical placements in primary care settings were limited for students.
5. Workplace learning and continuing education

The importance of previous nursing experience prior to taking a position in primary care was highlighted in the interviews, although it was also acknowledged that the transition to a primary care setting was a significant adjustment regardless of one’s prior experience. Orientation and mentorship were identified as an important part of this transition as nursing entry-to-practice education prepared nurses for a generalist role as opposed to a specific setting. Overall, there was support (e.g., time to attend, some financial support) for nurses wanting to pursue continuing education opportunities.

6. Interprofessional collaborative practice

Nurses appeared to work well in an interprofessional collaborative setting. However, collaborative practice was sometimes hindered by issues of role overlap and territoriality. Trust from team members as well as co-location facilitated IP collaborative practice.

More detailed information on the themes from the environmental scan and interviews is provided in Appendix E and F.

Achievements

Summit

A Summit was held to bring together key Alberta stakeholders to address role optimization of nurses in primary care settings. Approximately 50 participants attended the Summit, representing various stakeholder groups including representatives from the Primary Care Initiative, Alberta Health Services, PCN managers, primary care nurses (LPNs, RPNs, RNs, and NPs), educational institutions for all categories of nurses, regulatory bodies (e.g., CARNA, CLPNA, CRPNA), physicians, representatives from government (policy), and researchers. Individual seating charts were created to ensure diverse representation at each table. This way the voices of different stakeholders were shared and actions developed reflected the perspectives of all stakeholder groups. The majority of Summit participants were pleased with the broad representation of stakeholders.

“All stakeholders were represented – Kudos”

“Vast medley of professionals in various positions”

Summit objectives included the following:

1) Bring together stakeholders from across the province to discuss the effective utilization of nurses in primary care settings
2) Validate findings from previous research and Alberta stakeholder interviews
3) Develop proposed for the effective utilization of nurses in primary care settings

The Summit began with a brief overview of the key findings from the environmental scan and Alberta interviews. The identified six themes (see pages 6 - 7) provided the framework for the Summit.
Discussion was facilitated around each topic area using World Café and appreciative inquiry approaches. Proposed actions were then developed by synthesizing ideas, prioritizing actionable strategies, and identifying activities for each strategy. These actions were then prioritized by all participants. Following the Summit, recommendations were synthesized, validated by Summit Planning Committee members, and then sent out and validated by all Summit attendees. Feedback from Summit attendees and the planning committee was incorporated into the final proposed actions.

Participants were encouraged to fill out an evaluation at the conclusion of the Summit. Participant feedback was very positive and overall the Summit was seen as a great success. Of those who responded, 95% stated that their expectations of the Summit were met. Participant feedback included:

“You really are preaching to the choir for me, it was refreshing to hear others that have the same voice”

“I just know I’m not alone in the struggle we have”

“A really good opportunity to meet and dialogue around the issues. Build awareness of what needs to change and what is working”

**Proposed Actions from the Summit**

From the Summit, proposed actions were developed to optimize the role of nurses in primary care settings. The top three proposed actions based on prioritization by Summit participants were: 1) establish a funding model centred on patient needs, access to care, and support for interprofessional collaborative practice; 2) define primary care nursing roles, responsibilities, and core competencies within the context of the interprofessional team; and 3) develop a framework for evaluation and promote ongoing performance measurement for primary care service delivery. Overall, there were 10 key actions developed from the Summit:

1. Increase patient/community engagement in primary care service delivery
2. Develop a governance model to support interprofessional shared decision-making at all levels in primary care settings
3. Establish a funding model centred on patient needs, access to care, and support for interprofessional collaborative practice
4. Develop a framework for evaluation and promote ongoing performance measurement for primary care service delivery
5. Define primary care nursing roles, responsibilities, and core competencies within the context of the interprofessional team
6. Implement interprofessional collaborative practice
7. Embed primary care philosophy in all nursing curriculum for entry-to-practice and continuing education
8. Establish a standardized education program for nurses working in primary care settings
9. Enhance opportunities for interprofessional education in entry-to-practice nursing programs
10. Facilitate clinical placements in primary care settings
Please refer to Appendix H for the complete set of recommendations including rationale and accountability for recommendations.

Discussion

The overall goal of this project was to facilitate nurses’ capacity to practice to the full extent of their knowledge and skills in a primary care setting. This was accomplished through the development of proposed actions at the Summit and informed by interviews conducted with Alberta stakeholders and environmental scan participants. Summit participants were very enthusiastic and their passion and expertise assisted in the development of strong actions. There was also a great deal of interest in the outcomes of this project by stakeholders across the country, especially those who participated in the environmental scan.

Funding models, such as the fee-for-service (FFS) model, are identified as being a potential barrier to collaborative practice (DiCenso et al., 2010) and role optimization. In the past decade there has been a shift away from FFS towards alternate funding models. Such models include capitation (set amount of money provided per patient), salary (based on hours rather than services provided), or blended payment (Devlin, Sarma, & Hogg, 2006). Currently there is no consensus on a preferred funding model, but a model that facilitates patient focus and IP collaborative practice is needed.

Primary care organisations require systems and local arrangements to support interprofessional teams and ensure quality of care (Tait, 2004). A focus on patient and family-centred care, leadership, teamwork, and communication are necessary to achieve an effective, collaborative governance system (Tait, 2004). Review of current governance structures in primary care will be essential for interprofessional collaboration, shared philosophies, and standardized principles for primary care.

Clearly defining nursing roles, responsibilities, and competencies is one step towards optimizing the role of nurses’ in primary care. Role ambiguity has been shown to be a significant issue across professions (Besner et al., 2010; Health Systems & Workforce Research Unit, 2009; White et al., 2009). A clear understanding of all team members’ roles is important (O’Neill & Cowman, 2008). Evaluation of primary care service delivery should include evaluation of the optimization of nursing roles in this setting.

Given the complexity of the needs of many patients served in primary care settings, an interprofessional team will assist in meeting those needs. Interprofessional collaboration has been associated with many positive outcomes (Suter & Deutschlander, 2010), including enhanced relationships (Gifford, Zammuto, Goodman, 2002), positive work environment (Canadian Nursing Advisory Committee [CNAC] 2002; Hanson, Fahlman, & Lemone, 2007), provider satisfaction (Larivaara & Taanila, 2004; O’Neill & Cowman, 2008; Searle, 2008), better coordination (and quality) of patient care (O’Neill & Cowman, 2008; Searle, 2008; Schofield, Fuller, Wagner, Friis, & Tyrell, 2009), and cost benefits (Murray et al., 2009; Sutton, Franklin, Reeder, & Laws, 2008; Unutzer et al., 2008). Integrating interprofessional learning experiences into education has positive outcomes for students including improved knowledge of roles, communication skills, and collaboration skills (Suter, Taylor, Arthur, & Clinton, 2008).
of health education programs and participation in interprofessional education across disciplines and schools will assist in implementing interprofessional collaborative practice (Suter et al., 2008) in primary care settings. Furthermore, a standardized approach is needed for nursing education including embedding primary care philosophy into nursing curriculum and increasing the availability of clinical placements in primary care settings.

Based on the literature, environmental scan, interview results, and proposed actions from the Summit the following overall recommendations were developed.

1. Build on foundational components in primary care to facilitate the optimization of nursing roles
   - Increase patient and community engagement
   - Establish funding and governance models to support nursing roles and IP collaborative practice
   - Include evaluation of nursing role optimization in a broader evaluation framework
2. Define nursing roles, responsibilities, and core competencies in primary care settings
3. Support IP education and facilitate clinical placements in primary care settings
4. Implement IP collaborative practice
5. Establish a standardized continuing education program for nurses in primary care settings including orientation and mentorship of new nurses entering primary care

Accountability for action and implementation of changes recommended will require the support and work of various stakeholder groups (See Appendix G).

A limitation of the project is the lack of representation of particular categories of nursing providers. Recruiting RPNs and LPNs for Alberta interviews and Summit participation was difficult. It appears that few of these providers are employed in PCNs in Alberta. Representation in the environmental scan includes a broad range of stakeholders from across Canada. However, we were unsuccessful in conducting interviews with individuals in the Yukon or North West Territories.

Outcomes

This project provided the following outcomes:

1. An environmental scan with a better understanding of nursing models in primary care settings across Canada, including the identification of ‘leading practices’
2. Alberta stakeholder interviews for a better understanding of the gaps in pre-service and continuing education for nurses in primary care settings
3. A Summit was held to bring together a group of key stakeholders to discuss role optimization of nurses in primary care settings
4. The Summit resulted in the development of five overall recommendations and 10 proposed action items to further optimize the role of nurses in primary care settings
To date, little research has been completed on nursing roles in primary care settings. The recommendations from this project will provide direction for moving forward to facilitate the effective utilization of nurses in primary care settings in Alberta.

Next Steps

- Submission of recommendations to Alberta Health and Wellness
- Dissemination of results of the project to all stakeholder groups (refer to Appendix I for Knowledge Translation Plan)
- Share results with environmental scan participants and Alberta interview participants
- Evaluate nursing role optimization initiatives and the effective integration of all members of the interprofessional team in primary care settings

Overall, this project was successful in accomplishing each of the objectives it set out to achieve. The environmental scan provided us with a better understanding of nursing service delivery in primary care settings across Canada, and the interviews with Alberta stakeholders gave us a better understanding of the educational needs of primary care nurses in Alberta. This project has created great excitement – project team members have had conversations with stakeholders across the country who were incredibly enthusiastic about this project and the potential it has to create change. The recommendations that were developed are a step in the right direction to create environments that will facilitate nurses’ ability to practice to the full extent of their knowledge and skills in primary care settings. Putting these recommendations into action has the potential to facilitate positive outcomes at the patient, provider, and system levels. One Summit participant commented:

“I truly hope these recommendations will get to the appropriate people so we can see some change”
References


Appendix A - Glossary

**Collaboration:** An interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the patient care provided. (Way et al, 2000)

**Collaborative practice:** A partnership between health care providers from across disciplines and the patient/family that involves a coordinated approach to shared decision-making about the patient’s care. (adapted from Canadian Interprofessional Health Collaborative, 2010 definition of *interprofessional collaboration*)

**Collaborative practice team:** A group of people from different professional backgrounds who deliver services and coordinate care programs in order to achieve different and often disparate service user needs. Goals are set collaboratively through consensual decision making and result in an individualized care plan which may be delivered by one or two team members. This level of collaborative practice maximizes the value of shared expertise and minimizes the barriers of professional autonomy. Often, one team member is appointed as a key worker or case manager for the service user; in this role they coordinate communication between practitioners and the patient or client or carer. The team meets regularly to evaluate outcomes and quality of care delivery. (adapted from World Health Organization, 2008)

**Entry-to-practice competencies:** The competencies expected of the new graduate from an approved health profession education program for initial entry-to-practice as a health professional. (adapted from College & Association of Registered Nurses of Alberta, 2006)

**Integration:** Services, providers, and organizations from across the continuum of care working together so that services are complementary, coordinated, in a seamless unified system, with continuity for the client. (Canadian Council on Health Services Accreditation, 2006)

**Interprofessional education (IPE):** Bringing together health care providers from different professions to “learn with, from and about each other” to enhance collaboration and the quality of patient care (Centre for the Advancement of Interprofessional Education, 2002). Formal IPE, including debriefs, reflection and evaluation of IP competencies (e.g. role clarity, shared decision-making), are critical to IPE. This is different from incidental (or informal) IP opportunities that lack the intention of IP competency development and hence fail to produce significant IP learning outcomes. (Freeth et al, 2005). Interprofessional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. (WHO Framework for Action on IE & CP).

**Primary care:** First point of contact between individuals and the health care system, typically through a visit to a family doctor. (adapted from College & Association of Registered Nurses of Alberta, 2005; Lewis, 2004; Smith, 2005)
Primary health care: Essential health care, based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination (World Health Organization, 1978). Primary health care extends beyond the traditional health care system to include services that encompass the determinants of health such as housing, income education and environment. (College & Association of Registered Nurses of Alberta, 2005)

Role clarity: Learners and practitioners understand their own roles and the roles of those in other professions, and use this knowledge appropriately to establish and achieve patient/client/family and community goals. (Canadian Interprofessional Health Collaborative, 2010)

Scope of practice: Knowledge and skills acquired through professional education, reflected in legislative authority, described in the practice standards of respective disciplines and demonstrated by all members of a professional group at entry-to-practice. (adapted from College & Association of Registered Nurses of Alberta, 2006)
Appendix B – Consent Forms

Nurses, Managers, Regulatory, Educators

INTERVIEW PARTICIPANT CONSENT FORM
Nurses, Managers, Regulatory, Educators

TITLE: Optimizing Collaborative Practice of Nurses in Primary Care Medical Settings
SPONSOR: Alberta Health Services and Alberta Health and Wellness

PROJECT TEAM:
Nelly D. Oelke, Senior Research and Evaluation Consultant, Alberta Health Services
Jeanne Besner, Provincial Lead, Alberta Health Services
Esther Suter, Senior Research and Evaluation Consultant, Alberta Health Services
Karen Jackson, Senior Research and Evaluation Consultant, Alberta Health Services
Rebecca Carter, Research and Evaluation Consultant, Alberta Health Services

BACKGROUND.
Nurses (e.g., Nurse Practitioners, Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses) in primary care medical settings are often underutilized in their practice. Nurses practicing to the full extent of their knowledge and skills have the potential to positively affect patients, providers, and the health system.

PURPOSE OF THIS PROJECT.
The purpose of this project is to help nurses working in primary care settings in Alberta to fully use their knowledge and skills. We hope to better understand the structure of nursing care in primary care settings including interprofessional collaboration, the extent to which nurses work to the full extent of their knowledge and skills, and outcomes of the model of care through a scan of primary care settings in Canada. Following the scan we will interview nurses and managers in Alberta primary care settings to gain further input on nursing practice in their settings. A Summit will then be organized with key stakeholders to review the data collected and to develop recommendations to enhance the effectiveness of nursing roles in primary care.

WHAT WILL I BE ASKED TO DO?
You are being contacted to participate in the scan. We would appreciate your participation in a phone interview about the nursing service delivery model in your setting. The interview will take about 30 to 45 minutes. Interviews will be booked in advance and will be conducted by a research analyst. We will ask your permission to audio record the interview so that we have an accurate record of the conversation. You may request that the recorder be turned off at anytime during the interview. Notes will also be taken by the research analyst.

RISKS TO PARTICIPATION.
There are no known risks to participating in this study.

BENEFITS TO PARTICIPATING.
There is no direct benefit to participating in this study although the information will assist with the implementation of effective nursing roles in primary care medical settings. At the end of the project you will receive a copy of the scan and final report for the project.
IS PARTICIPATION VOLUNTARY?
Your participation in the project is voluntary. You may decline to answer any of the questions and end your part in the interview or project at anytime. Should you wish to withdraw, please inform the interviewer or contact one of the individuals listed below. You also have the right to ask questions and ask for more information whenever you like.

WILL I RECEIVE ANY COMPENSATION FOR PARTICIPATING?
You will not be paid to participate in the interview.

PRIVACY AND CONFIDENTIALITY.
We are seeking your permission to include information about your model of care and your organization in the scan. Your name will not be identified, but readers and others in your own organization may know that you have participated in an interview. Therefore it may not be possible for you to take part in the project anonymously.

Code numbers will be used on transcripts and notes. Lists of participants along with the code numbers and consent forms will be stored separately from the data. All other information from the project will be presented in summary format; your name will not be identified. Only project team members and the research analyst will review transcripts and notes. All data collected will be stored in a locked cupboard at the Health Systems and Workforce Research Unit, Alberta Health Services, for three years.

Ideas and quotes from interviews and notes will be used in the scan and final reports, publications, and presentations, but at no time will your name be identified. Anonymity and privacy will be assured as much as possible. You may have a copy of the scan and final report.

If you have any further questions please contact:

Amanda Wilhelm  
Research Analyst, Health Systems and Workforce Research Unit,  
Alberta Health Services  
(403) 943-0185

Nelly D. Oelke  
Senior Research and Evaluation Consultant, Health Systems and Workforce Research Unit,  
Alberta Health Services  
(403) 943-1177

________________________________________  __________________________________________
Participant’s Name                          Signature and Date

________________________________________  __________________________________________
Research Analyst Name                       Signature and Date

Please return via fax 403-943-2875 (Attn: Amanda Wilhelm) or scan and email to:  
Amanda.Wilhelm@albertahealthservices.ca
INTERVIEW PARTICIPANT CONSENT FORM
Environmental Scan

TITLE: Optimizing Collaborative Practice of Nurses in Primary Care Medical Settings
SPONSOR: Alberta Health Services and Alberta Health and Wellness

PROJECT TEAM:
Nelly D. Oelke, Senior Research and Evaluation Consultant, Alberta Health Services
Jeanne Besner, Provincial Lead, Alberta Health Services
Esther Suter, Senior Research and Evaluation Consultant, Alberta Health Services
Karen Jackson, Senior Research and Evaluation Consultant, Alberta Health Services
Rebecca Carter, Research and Evaluation Consultant, Alberta Health Services

BACKGROUND.
Nurses (e.g., Nurse Practitioners, Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses) in primary care medical settings are often underutilized in their practice. Nurses practicing to the full extent of their knowledge and skills have the potential to positively affect patients, providers, and the health system.

PURPOSE OF THIS PROJECT.
The purpose of this project is to help nurses working in primary care settings in Alberta to fully use their knowledge and skills. We hope to better understand the structure of nursing care in primary care settings including interprofessional collaboration, the extent to which nurses work to the full extent of their knowledge and skills, and outcomes of the model of care through a scan of primary care settings in Canada. Following the scan we will interview nurses and managers in Alberta primary care settings to gain further input on nursing practice in their settings. A Summit will then be organized with key stakeholders to review the data collected and to develop recommendations to enhance the effectiveness of nursing roles in primary care.

WHAT WILL I BE ASKED TO DO?
You are being contacted to participate in the scan. We would appreciate your participation in a phone interview about the nursing service delivery model in your setting. The interview will take about 30 to 45 minutes. Interviews will be booked in advance and will be conducted by a research analyst. We will ask your permission to audio record the interview so that we have an accurate record of the conversation. You may request that the recorder be turned off at anytime during the interview. Notes will also be taken by the research analyst.

RISKS TO PARTICIPATION.
There are no known risks to participating in this study.

BENEFITS TO PARTICIPATING.
There is no direct benefit to participating in this study although the information will assist with the implementation of effective nursing roles in primary care medical settings. At the end of the project you will receive a copy of the scan and final report for the project.
IS PARTICIPATION VOLUNTARY?
Your participation in the project is voluntary. You may decline to answer any of the questions and end your part in the interview or project at anytime. Should you wish to withdraw, please inform the interviewer or contact one of the individuals listed below. You also have the right to ask questions and ask for more information whenever you like.

WILL I RECEIVE ANY COMPENSATION FOR PARTICIPATING?
You will not be paid to participate in the interview.

PRIVACY AND CONFIDENTIALITY.
We are seeking your permission to include information about your model of care and your organization in the scan. Your name will not be identified, but readers and others in your own organization may know that you have participated in an interview. Therefore it may not be possible for you to take part in the project anonymously.

Code numbers will be used on transcripts and notes. Lists of participants along with the code numbers and consent forms will be stored separately from the data. All other information from the project will be presented in summary format; your name will not be identified. Only project team members and the research analyst will review transcripts and notes. All data collected will be stored in a locked cupboard at the Health Systems and Workforce Research Unit, Alberta Health Services, for three years.

Ideas and quotes from interviews and notes will be used in the scan and final reports, publications, and presentations, but at no time will your name be identified. Anonymity and privacy will be assured as much as possible. You may have a copy of the scan and final report.

If you have any further questions please contact:

Amanda Wilhelm  
Research Analyst, Health Systems and Workforce Research Unit,  
Alberta Health Services  
(403) 943-0185

Nelly D. Oelke  
Senior Research and Evaluation Consultant, Health Systems and Workforce Research Unit,  
Alberta Health Services  
(403) 943-1177

__________________________________________  ____________________________________________
Participant’s Name  Signature and Date

__________________________________________  ____________________________________________
Research Analyst Name  Signature and Date

Please return via fax 403-943-2875 (Attn: Amanda Wilhelm) or scan and email to:  
Amanda.Wilhelm@albertahealthservices.ca
### Appendix C – Interview Guides

#### Environmental Scan

<table>
<thead>
<tr>
<th>Interview Guide – Environmental Scan</th>
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</table>
| **1.** What is your role (e.g., program manager, nurse) in this primary care practice? | • If nurse: category of nurse (NP, RN, RPN, LPN), diploma/degree/masters, & year of graduation.  
  • Previous nursing experience  
  • Length of employment in this primary care setting?  
  • Length of time employed in primary care? |
| **2.** Describe the structure of care delivery for nurses in your organization. | • Categories & number of nurses employed (NP / RN / RPN / LPN).  
  • Role of nurses on the team  
  • Differentiation of nursing roles |
| **3.** Describe the nature of the practice of nurses | • Degree to which nurses are working to the full extent of their knowledge and skills  
  • Who do they report to?  
  • Extent to which they practice autonomously  
  • RN: focus on prevention, health promotion, population health (definitions). |
| **4.** What type of patient population do you serve? | • Target population for services  
  • Specific age group  
  • Focus of services |
| **5.** Who are the other members of the practice team? How do your nurses relate to other professionals as part of the collaborative practice team? | • Other healthcare professionals employed  
  • Referrals to other team members or collaborative team-based care  
  • What is the role of the various categories of nurses on the team |
<p>| <strong>6.</strong> What particular successes have you had in implementing effective nursing roles (e.g., nursing practicing to the full extent of their knowledge and skills) in your organization? | • Please provide examples |
| <strong>7.</strong> Do you think there are missed opportunities for implementing effective nursing roles (e.g., nurses practicing to the full extent of their knowledge and skills) in your organization? | • Please provide examples |</p>
<table>
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<tr>
<th>Question</th>
<th>Response Details</th>
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</table>
| 8. What is the level of readiness for practice of nurses in primary care medical settings? | • Strengths and gaps in basic education for practice in this setting  
• Strengths and gaps in continuing education  
• Adaptation of newly hired nurses to roles in this setting  
• Is there a gap between what nurses are taught and what they do in a practice setting? |
| 9. What type of evaluation and outcomes measurement have you completed with your nursing care delivery model? What type of evaluation/outcomes do you intend to complete in the next 6-12 months? | • Type of evaluation  
• Outcomes measured  
• Meeting desired outcomes or not?  
• Future evaluation? |
| 10. Does your clinic offer clinical placements for nursing students?     | • Availability of clinical placements in primary care for nursing students |
| 11. Do you have any additional information about your setting you would like to share? |                     |
| 12. Do you have any written materials that you could share with us?     | • Brochure describing program  
• Reports  
• Evaluation reports  
• Job descriptions |
| 13. Do we have your permission to identify this model of care and the name of your organization in our environmental scan? |                     |
| 14. Are there other exemplary clinics in Canada that you would recommend we contact? | • Name of clinic / manager or director / contact info |
1. First I would like to collect some basic demographic information.
   - Institution, role
   - Category of nurse (NP, RN, RPN, LPN)
   - Length of employment in this educational setting?
   - Length of time employed in nursing education?

2. In a recent study we examined nursing practice as part of an interprofessional team in primary care. We found considerable role ambiguity, in that nursing roles were not particularly clear within nursing groups, or between nurses and other health care professionals. As a result, nurses who work in primary care settings were not necessarily using the full extent of their knowledge and skills as effectively as they could be.
   - How is this similar or different to information you have read or heard about?
   - How is this similar or different to the experience you or your students may have had in primary care?

3. How is your current content/approach to basic education targeting the primary care setting?
   - Level of readiness for practice
   - Content & approach to basic education
   - Adaptation of newly hired nurses

4. Can you provide examples of content (theory and practice) specific to primary care practice?

5. How are students prepared to work in more independent / autonomous roles that are common in primary care?
   - Provide examples

6. What proportion of clinical/practicum time is spent in primary care settings?
   - Availability of clinical placements in primary care for nursing students
   - Types of settings, etc.

7. Tell me about the strengths and gaps in your education program for preparing students for primary care?
   - What recommendations do you have for addressing any gaps?
   - Is there a gap between what nurses are taught and what they do in a practice setting?
8. Overall, do you feel that basic nursing education prepares your graduates for working in the primary care setting?  
   - Provide examples  
   - Recent grads compared to older cohort

9. How are students prepared to work in interprofessional teams in the primary care setting?  
   - Provide examples of how they are prepared  
   - What types of other professional groups are involved in this process?

10. Do you have any additional information you would like to share?
# Managers

## Interview Guide – Managers

| 1. First I would like to collect some basic demographic information. | • Institution, Role  
• If applicable: category of nurse (NP, RN, RPN, LPN)  
• Length of employment in this primary care setting?  
• Length of time employed in primary care?  
• What was your previous experience? |
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<td>2. Can you tell me about your current role in this primary care practice?</td>
<td>• Obtain a brief overview of current role</td>
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| 3. In a recent study we examined nursing practice as part of an interprofessional team in primary care. We found considerable role ambiguity, in that nursing roles were not particularly clear within nursing groups, or between nurses and other health care professionals. As a result, nurses who work in primary care settings were not necessarily utilizing the knowledge and skills from their basic education as effectively as they could be. | • How is this similar or different to information you have read or heard about?  
• How is this similar or different to the experience your nurses may have had in primary care? |
| 4. Can you tell me about the role of different categories of nurses in your setting? | • NP, RN, RPN, LPN  
• Type of population served  
• Focus on prevention, health promotion, and population health (see below for definition)  
• Interprofessional collaborative practice |
| 5. Describe the nature of the practice of nurses. To what extent do they practice autonomously? Does their education prepare them for this type of independent practice? | • To what degree are they practicing to the full extent of their knowledge and skills?  
• Reporting relationships  
• Care decisions |
| 6. Can you tell me about the interprofessional team in your setting? How do nurses relate to other professionals (including physicians) as part of the collaborative practice team? Do you feel your nurses are adequately prepared to work in interprofessional teams? | • Other healthcare professionals employed  
Referrals to other team members or collaborative team-based care role of the nurse as team member |
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<th>Question</th>
<th>Points</th>
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| 7. Overall, do you feel that basic nursing education prepares nurses for working in the primary care setting? What gaps do you see in basic education for working in this setting? | • How and why  
• Availability of clinical placements in primary care for nursing students  
• Recent grads compared to older cohort  
• Is there a gap between what nurses are taught and what they do in a practice setting? |
| 8. Do you feel that nursing education (basic and continuing education) provides nurses with the ability to work to the full extent of their knowledge and skills in the primary care setting? | • Appropriateness of education  
• Gaps in knowledge/skills |
| 9. Are there particular areas where you feel there are learning needs?   |                                                                       |
| 10. How can such learning needs best be addressed? What types of continuing education sessions would you like to see? | • Probe for: course delivery method; content; target audiences. |
| 11. What content and format would you recommend for continuing education? |                                                                       |
| 12. Do you have any additional information you would like to share?      |                                                                       |
**Interview Guide – Nurses**

1. First I would like to collect some basic demographic information.
   - Category of nurse (NP, RN, RPN, LPN) (clarify diploma/degree/masters)
   - Year of graduation
   - Length of employment in this primary care setting?
   - Length of time employed in primary care
   - What was your previous nursing experience?

2. In a recent study we examined nursing practice as part of an interprofessional team in primary care. We found considerable role ambiguity, in that nursing roles were not particularly clear within nursing groups, or between nurses and other health care professionals. As a result, nurses who work in primary care settings were not necessarily utilizing the knowledge and skills from their basic education as effectively as they could be.
   - How is this similar or different to information you have read or heard about?
   - How is this similar or different to the experience you or other nurses may have had in primary care?

3. Can you tell me about your current role in this primary care practice?
   - Obtain a brief overview of current role
   - Type of population served
   - Focus on prevention, health promotion, and population health (see below for definition)
   - Who do you report to
   - Who are other members of the practice team? (Especially category and number of nurses, and their roles)
   - Referrals to other team members
   - Interprofessional collaborative practice

4. How did your basic education prepare you for this role? What gaps do you see in your basic education for working in this setting?
   - How and why
   - Prepared to work in interprofessional teams? Independent/autonomous role?
   - Availability of clinical placements in primary care for nursing students.
   - Is there a gap between what nurses are taught and what they do in a practice setting?

5. What type of preparation did you receive to work in your current role?
   - Orientation
   - Continuing education
   - Other
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<tr>
<td>6.</td>
<td>How has your nursing education (basic and continuing education) provided you with the ability to work to the full extent of your knowledge and skills in this primary care setting?</td>
</tr>
</tbody>
</table>
|   | • Appropriateness of education  
<p>| • Gaps in knowledge/skills |
| 7. | Are there particular areas where you feel you have learning needs? |
| 8. | How can such learning needs best be addressed? What types of continuing education sessions would you like to see? |
|   | • Course delivery method; content; target audiences. |
| 9. | What content and format would you recommend for continuing education? |
| 10. | Do you have any additional information you would like to share? |</p>
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<tbody>
<tr>
<td><strong>Interview Guide – Regulatory</strong></td>
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</table>
| 1. | First I would like to collect some basic demographic information. | • Institution, role  
• If nurse: category of nurse (NP, RN, RPN, LPN)  
• Length of employment in this setting?  
• Previous experience? |
| 2. | Are you currently aware of any of your members (nurses) working in primary care? | • If answer is no: Do you believe there is a role for your members to be in primary care? Please describe. |
| 3. | In a recent study we examined nursing practice as part of an interprofessional team in primary care. We found considerable role ambiguity, in that nursing roles were not particularly clear within nursing groups, or between nurses and other health care professionals. As a result, nurses who work in primary care settings were not necessarily utilizing the knowledge and skills from their basic education as effectively as they could be. | • How is this similar or different to information you have read or heard about?  
• How is this similar or different to the experience your members (nurses) may have had in primary care?  
• To what degree are nurses practicing to the full extent of their knowledge and skills in primary care? |
| 4. | Overall, do you feel that basic nursing education prepares nurses for working in the primary care setting? What gaps do you see in basic education for working in this setting? | • Level of readiness for practice  
• Independent / autonomous roles  
• Content & approach to basic education  
• Adaptation of newly hired nurses  
• Availability of clinical placements in primary care for nursing students  
• Recent grads compared to older cohort  
• Is there a gap between what nurses are taught and what they do in a practice setting? |
| 5. | How does your college / association support nurses to work in primary care settings? | • Provide examples |
| 6. | Do you feel your nurses are adequately prepared to work in interprofessional teams? | • Other healthcare professionals  
• collaborative team-based care role of the nurse as team member |
| 6. | Are there particular areas where you feel there are learning needs? | • How can such learning needs be addressed? |
| 7. | As a regulatory body, what do you feel is your role in continuing education? What content and format would you recommend for continuing education? | • Probe for: course delivery method; content; target audiences. |
8. Do you feel that nursing roles in primary care align with the roles and competencies outlined by your association?

- Actual versus ideal role
- Role differentiation b/w NPs/RNs/LPNs/RPNs?
- Focus on prevention, health promotion, population health

9. Do you have any additional information you would like to share?

Definitions:

**Disease prevention** focuses on prevention strategies that reduce the risk of disease, identify risk factors, or detect disease in its early, most treatable stages. Examples of disease prevention activities include immunizations, calcium and Vitamin D supplements to reduce the risk of osteoporosis, blood pressure and cholesterol assessments during annual health exams, and screening for illnesses such as breast, cervical, colorectal and prostate cancer.

**Health promotion** is the process of empowering people to make healthy lifestyle choices and motivating them to become better self-managers. To achieve this, health promotion strategies focus on patient education, counselling and support tools. Examples of health promotion strategies in primary care include education and counselling programs that promote physical activity, improve nutrition or reduce the use of tobacco, alcohol or drugs.

**Population health**: An approach to health that aims to improve the health of the *entire population* and to reduce *health inequities* among population groups. In order to reach these objectives, it looks at and acts upon the *broad range of factors and conditions* that have a strong influence on our health (PHAC, 2002). Examples include social, economic, and physical environments, early childhood development, personal health practices, individual capacity and coping skills, human biology and health services.
### Clinic

<table>
<thead>
<tr>
<th><strong>Clinic</strong></th>
<th><strong>Structure of Nursing Model</strong></th>
<th><strong>Other IP Team Members</strong></th>
<th><strong>Focus of Services</strong></th>
<th><strong>Website / Contact Information</strong></th>
<th><strong>Website</strong></th>
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| Comox Valley Nursing Centre (Courtenay, BC) | • Nurse-led clinic  
• 4 permanent (P/T) RNs; 2 Causal RNs; no LPNs or NPs  
• Nurses are case managers. They assume a lead role for care, do assessments, specialized assessments, triage  
• “Nurse led clinics only work well if they have an interdisciplinary team to work with” as complex patients require an interprofessional (IP) team to address all of their needs  
• Nurses are generalists with additional skills and knowledge in leadership and program development. They often have a special focus (e.g., eating disorders, chronic pain, street nursing) | • Pharmacist, mental health, social worker  
• RPN, clinical counsellor & dietician are part of eating disorder clinic  
• Receptionist, volunteers  
• Contracted staff: registered counsellor, men’s health counsellor, rehab (P/T), kinesiologist  
• Collaborate with local respirologist  
• Connect with physicians by sending consult notes or notification letters for follow-up with physician  
• Regular exchange of information when dealing with complex patients  
• Virtual psychiatrist | • Chronic complex health issues, poverty, clients with unmet needs  
• Majority of patients are younger (40-60 yrs of age) | 615 10th Street Courtenay, BC, V9N1R2  
P: 250-331-8502  
F: 250-331-8503  
Website: [http://www.viha.ca/comox_valley_nursing_centre/about/history.htm](http://www.viha.ca/comox_valley_nursing_centre/about/history.htm)  
| Evergreen Community Health Centre (Vancouver, BC) | • 1 NP & 1 RN (chronic disease nurse) shared between two clinics  
NP has own roster of patients, usually complex & longer term clients  
RN works with very complex patients referred from primary care program  
All clinicians provide CDM services to their clients  
All clinicians provide general primary care, but some specialize in youth detox, HIV care, etc.  
RN needs to go through GP or NP to make referral to specialist | • Primary care site has 3 physicians  
Access to public and community health nurses  
Pharmacist (other sites)  
Mental health and addiction counsellors  
Dental clinics  
Speech therapists  
Nutritionists  
Youth drop-in health clinics  
Very collaborative  
For the most part each clinician doing care plan for own client  
Some clients shared between several clinicians or with other program teams | • Marginalized & vulnerable populations  
Complex patients with many chronic conditions | 3425 Crowley Drive  
Vancouver, BC, V5R6G3  
P: 604-872-2511  
F: 604-872-2368  
Website: [http://www.vch.ca/EN/find_locations/find_locations/?&site_id=59](http://www.vch.ca/EN/find_locations/find_locations/?&site_id=59) |
Raven Song Community Health Centre (Vancouver, BC)  
- 1 NP (F/T), 1 RN (F/T)  
- Just beginning to integrate LPNs  
- Patients can have GP or NP as primary provider dependent on appropriateness (each has different lens) or availability  
- NP has family practice and takes on own patients (very autonomous)  
- RN shared care with other primary care providers, lots of outreach, initial intake  
- RNs can have advanced scope of practice (certified practice) – STIs, contraceptive management, education, and intervention in remote northern communities  
- 1 LPN in wound care will be brought into primary care (once comfortable) to support & expand nursing role in primary care  
- LPN works with RN  
- Fluid structure in that staff can approach any team member for advice  
- Internal referrals can be completed by RN, although referrals to specialists must be completed by physician/NP as it is a billable service  
- All salaried positions including family physician, with shadow billing being completed by family physicians  

| 4 family physicians (P/T)  
- Clinical coordinator  
- Dietician  
- Respiratory therapist  
- Social worker  
- Community support worker  
- Counsellor  
- Relationship with addictions & mental health team  
- Clinical and clerical support  
- Onsite linkages & referrals to health-related programs  
- Interdisciplinary team, very collaborative  
- Care across the lifespan (e.g., cradle to grave)  
- Consists of a couple of clinics: primary care, wound care, Bridge clinic (refugees), Transgender Health Clinic  
- Nursing team spans services in multiple clinics  
- Marginalized patients first and foremost - not well served by the fee-for-service system as they have multiple complex care needs & chronic conditions  
- Major focus in addictions and mental health across lifespan  

2450 Ontario Street  
Vancouver BC, V5T4T7  
P: 604-709-6400  
F: 604-872-5223  
Website: [http://www.vch.ca/en/find_locations/find_locations/?&site_id=132](http://www.vch.ca/en/find_locations/find_locations/?&site_id=132)  
Website2: [http://www.vch.ca/find_services/find_services/?program_id=11013](http://www.vch.ca/find_services/find_services/?program_id=11013)
| SK | **Saskatoon Community Clinic (Saskatoon, SK)** | • 13 RNs (5 F/T, the rest are casual) between two clinics, no LPNs  
• 2 NPs (one at each site), very autonomous  
• Clinical office assistant (being introduced)  
• RN: Care planning/care coordination, and sometimes prep for physician  
• Since so many physicians, nurses do a lot of triage  
• Lots of disease prevention & health promotion  
• Hypertension education & smoking cessation counselling done by nurses (starting)  

|  | • 14 physicians between the two clinics  
• Counselling department, social workers, community mental health nurses, Aboriginal counsellors  
• Lab & X-Ray department  
• Nutritionist, occupational therapy services, pharmacy, physical therapy, foot care  
• Client care committee (more administrative / programs) meets to discuss health needs of clients and community  
• Interprofessional team health care co-operative  

|  | • Families, younger people, vulnerable elderly  
• Two main clinics: Family & Geriatrics at one, inner city at the other  
• Mental health patients, poverty, homelessness, HIV, diabetes, other infectious diseases, etc.  

|  | 455 2nd Ave N, Saskatoon, Sask, S7K2C2, P: 306-652-0300  
|  | F: 306-664-4120  
|  | member.relations@saskatooncommunityclinic.sk.ca  
|  | Website: [http://www.saskatooncommunityclinic.ca/about_us.htm](http://www.saskatooncommunityclinic.ca/about_us.htm) |
| ACCESS River East Primary care (Winnipeg, MB) | • 1 LPN(0.1EFT), 3 RNs (3.0EFT), 3 NPs(2.0EFT)  
• Clear cut roles  
• LPN assists physician in minor procedures clinic  
• RNs: Assessments, teen clinic, lab review/preview, immunizations, serum management, suture removal, teaching, well baby care, well women care (including PAP), prenatal care, complete CPE and DM class  
• NPs have own patients and function autonomously. They are masters prepared and function to the full extent of their scope which includes prescribing medications, etc.  
• Primary care provider can be NP or family physician  
• The ability to focus on prevention, health promotion, population health, is dependent on the capacity related to full time / part time nurses  
• RNs can make referrals internally through the EMR, externally via Fax or intake forms  
• Nurses and allied health providers are all salaried  
• MDs are independent contractors | • Physicians 11 (5.0EFT)  
• Primary care assistance (PCA) (5.0EFT)  
Allied health members:  
• 6 midwives (6.0EFT)  
• Shared-care mental health counsellors (1.0EFT)  
• Psychiatrist (0.1EFT)  
• Dieticians (1.0EFT)  
• Speech language pathologist for paediatrics (1.0EFT)  
• Audiologist (1.0EFT)  
• Lab Tech (1.0EFT)  
• Interprofessional team  
• Interdisciplinary care plan  
Within the Access centre:  
• Public health, home care (home visiting nurses, case coordinators, resource coordinators), family services & housing, GMAT, employment insurance(EIA) and limited CFS.  
• All located in same building  
• More informal discussions  
• HART (2.0EFT for area – 1.0EFT is a RN) – seniors only service located at the Bronx community centre | • Largely 50+  
• The River East area is quite large and has a variety of income levels represented. The Northern region is very affluent single families and in the southern region low income, social services and assistance is prevalent (similar to the inner city). | 975 Henderson Highway, Winnipeg MB, R2K4L7  
P: 204-938-5000  
<table>
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<th>Location</th>
<th>Description</th>
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| South Eastman Health (Niverville area in Ontario) | - Nursing structure is very similar across the three different clinics  
- 1 Chronic disease nurse, 1 community health nurse (public health / primary care dual role), 1 NP, 1 primary care nurse  
- NP or family physician can be primary provider  
- NP has own roster of patients  
- Scopes of practice overlap, but try to prevent duplicating services  
- Prevention, promotion, & population health all covered  
- Referrals can come from RNs, physicians, allied health professionals, self referrals  
- NP is salaried |
| Lakehead Nurse Practitioner-Led Clinic (Thunder Bay, ON) | - 4 NPs (1 is a lead NP), 1 RN, 1 RPN  
- NP-led clinic  
- Collaborative approach, interprofessional team  
- RN role still evolving, act as mentor for RPNs  
- NP role easier to define & consults with off-site physician when needed  
- Nurses can refer to other team members.  
- For internal medicine or psychiatrist, referral goes through NP |

Note: provided job descriptions for community health nurse, primary health care nurse & NP

Note: fact sheet & job descriptions (NP, Lead NP, RN, RPN) provided

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1 RPNs in Ontario are Registered Practical Nurses
| Marathon Family Health Team (Marathon, ON) | • 1 NP, 2 RNs, 2 RPNs  
• Family Health Team: can choose to have either a family physician or an NP as primary health care provider  
• Unpredictable outcomes client sees RN  
• Predictable outcome client sees RPN  
• Clients can request a provider, but usually try to match them with the most appropriate provider  
• Questions: RPNs > RNs > NP  
• Physicians have taught RNs some things in advanced scope of practice such as well women’s exams, which frees up time for the physician  
• Front staff have triage guidelines: certain conditions can see NPs vs. family physician etc.  
• Team approach, no one has their “own” patients  
• Personal interest specialities are encouraged  
• Referrals: RNs can make suggestions, but physicians would have to sign off  
• Care plans interprofessional | • 4 physicians  
• Physician assistant  
• Social worker  
• Dietician  
• Epidemiologist  
• Admin team: executive director, finance supervisor, billing clerk, IT coordinator, healthcare assistant, administrative assistants (2), coordinator/administration  
• Appointed resource physician  
• Health team works very well together | • Care across the lifespan.  
| 22 Peninsula Road, P.O. Box 399, Marathon, Ontario P0T 2E0  
P: 807-229-3243  
F: 807-229-2672  
*can email through website  
Website: [http://mfht.org/?page_id=81](http://mfht.org/?page_id=81) | 

| Clinton Family Health Team (Clinton, ON) | • 2 NPs, 6 RNs, 5 RPNs  
• NPs practice independently and consult with physicians when needed  
• NPs do not have their own practice of patients separate from physician  
• NPs specialize in preventative care  
• NPs can make direct referrals to any other health professionals  
• RNs & RPNs paired with physician and can make direct referrals to dietician | • 5 physicians  
• Social worker  
• Mental health worker  
• Dietician  
• Psychologist  
• Child psychiatrist  
• Support staff & executive director (RN) | • Care across the lifespan.  
| Box 69, 105 Shipley St., Clinton ON, N0M 1L0  
P: 519-482-3000  
F: 519-482-7648  
Website: [http://www.clintonfht.ca/5552.html](http://www.clintonfht.ca/5552.html) | 

Note: provided job descriptions for RNs
Note: Job descriptions (RPN, RN, NP, & brochure were provided.
<table>
<thead>
<tr>
<th>Province</th>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
</table>
| QC | Quebec Primary Care Nursing Services (an example) (Laval, QC) | RNs, LPNs, NPs  
NPs started out in specialized roles (cardiology, nephrology, neonatology), but in the last 3-4 years 5 NPs have been implemented in community health  
Focus on patients with chronic diseases  
RNs scope increased with well woman assessments (pelvic exams, paps etc.)  
Clinical nurse specialists examine professional practice of nurses and how to improve practice (education, clinical tools)  
Large part of nurses’ time is spent on curative aspects of care, which means not enough time to spend on promotion & prevention  
GMFs: team of doctors and a nurse who work together to provide care to patients  
Largest health establishment in Quebec (17 establishments fused)  
3 dimensions: acute (hospital), health community (primary care) & long term care  
Includes mental health, medical and surgical care, child and mothers health, elderly & community care  
As of 5 years ago, patients are now separated based on age. Some nurses focus on children under 14, others elderly etc. Helps to develop expertise. |
| NS | Annapolis family medical group (Annapolis Royal, NS) | NP, 1 RN  
Practice Nurse (RN) will be joining clinic, who will be another independent clinician – needs to be utilized to full scope  
Can see either family physician or NP, it’s a patient by patient case  
NP salaried, shadow bills, has a independent practice, does a lot of screening  
Referrals informal and formal  
Family Medical Group: generalists, IP team  
5 physicians, diabetic nurse educators (within building have diabetes centre), nutritionist, social workers, addictions, psychiatrist, OT, PT, mental health support, respiratory therapist, special support, outpatient department staffed by LPNs & RNs  
Collectively consult & collaborate with mutual respect  
Co-location: work closely and collaboratively  
Population: lots of COPD, hypertension, diabetes, congestive heart failure  
821 St. George St PO Box 426, Annapolis Royal, NS, B0S1A0  
P: 902-532-2324  
Website 1: [http://novascotiaphysicians.ca/annapolis_family_medical_group_practice.html](http://novascotiaphysicians.ca/annapolis_family_medical_group_practice.html) |
| Hatchet Lake, NS | • 3 RNs hired by 3 of the physicians. 1:1 ratio, nurse only works with that one physician. Nurses work to full scope of nursing practice and roles vary based on patient population (younger families vs. more geriatric/CDM focus).  
• Patient booked in with team (nurse & physician) – some patients see nurse for their visit and the physician joins the visit at some point, some see physician only. Nurses try to see the more complex or time-consuming patients. Strong focus on chronic disease management, preventative care and screening. Very collaborative approach.  
• Fee-for-service model where physicians have to see every patient in order to bill except for immunizations, cervical screening or injections  
• Nurses can attend to issues that often cannot be addressed due to lack of time – prevention & health promotion, etc.  
• RNs can refer independently to certain services i.e. diabetes centre, hearts in motion, etc.  
• Health promotion: every visit; population health varies by clinic but Hatchet Lake is involved in many community programs | • 4 physicians, 3 have hired registered nurses. Physicians have their own practice with shared support staff but see each others’ patients when needed  
• Mental health counsellor  
• Dietician  
• Meetings are informal, in the hallway or between patients. They are ongoing throughout day. No compensation for formal sit down team meetings. | • Huge focus on CDM  
• Care across the lifespan  
• Each physician has more of an emphasis on a certain area  
• If physician has older patient base, nurse will be caring for patients with more chronic illnesses such as diabetes, COPD, hypertension, cholesterol, geriatric issues, etc.  
• Due to increased capacity to see patients with nurses on the team (40-70%), access to appointments is usually same day or next day | Hatchet Lake Medical Centre (Halifax) & Family Practice Nurses Association of Nova Scotia |
<table>
<thead>
<tr>
<th>NB</th>
<th>Community Health (Primary Healthcare) Program — Horizon Health St. John Zone (Saint John, NB)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Note: provided job descriptions for RN (2&amp;3), LPN &amp; brochure listing programs etc.</td>
</tr>
</tbody>
</table>

- Larger clinic is more interdisciplinary (NPs, RNs, LPNs, other professionals)
- Other clinics: mainly NP & doctor
- Urban clinic: greater focus on determinants of health
- Outreach work
- NPs: assist with unattached patients – in rural areas there is often no physician
- NPs & family physicians share roster of patients, and patient is seen by whoever is more appropriate
- NPs diagnose & prescribe
- RNs: education, follow-up, immunizations
- LPNs: support, seeing patients before RN / NP
- Nurses doing all 3: prevention, promotion, population health
- Formal & informal referrals
- RNs & LPNs go through NP to make specialist referrals

- Social workers, dieticians, physicians, pharmacist, community developers, occupational therapist, visiting psychiatrist, domestic violence counsellors, community developers
- Collaborative rounds, interdisciplinary electronic care plan

- 5 Community Health Centres
- Care across the lifespan
- Vulnerable community members, poverty, complex chronic diseases, older rural population etc.
- Determinants of health

<table>
<thead>
<tr>
<th><strong>NU</strong></th>
<th><strong>Nunavut Community Health Primary Care Model</strong></th>
<th><strong>Attached CHN job description &amp; Nunavut formulary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>244 nursing positions: 4 NPs, 27 LPNs, approximately 15 RPNs, the rest are RNs</strong></td>
<td><strong>Visiting IP team members: Social workers, physio therapy, OT, speech therapy, audiologist, dentist, dental therapist</strong></td>
</tr>
<tr>
<td></td>
<td><strong>RNs have a very expanded primary care role and refer to a physician if needed</strong></td>
<td><strong>Physicians are also visiting team members, except in five communities where they have a permanent practice</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Verbal orders to start patients on medications can be done over the phone with a physician</strong></td>
<td><strong>Wellness centres: addictions services, wellness programs, aboriginal head start programs etc.</strong></td>
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<td></td>
<td><strong>LPNs care for stable clients</strong></td>
<td><strong>Health centres:</strong> Community health representatives who are local Inuit trained in health prevention and promotion. They know the culture, language and understand the community practices. Able to share the message in a way that will be most receptive to the community needs.</td>
</tr>
<tr>
<td></td>
<td><strong>Is a new role, Nunavut started licensing LPNs in April 2011 (previously they were certified nursing assistants). Developed scope of practice and standards of practice and adopted competencies from another jurisdiction.</strong></td>
<td><strong>Community therapy assistants who work with patients when PT, OT, and speech and language aren’t</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Currently LPNs are working in the hospital, continuing care facility, and 2 regional health centres (specific roles)</strong></td>
<td><strong>Care across the lifespan</strong></td>
</tr>
<tr>
<td></td>
<td><strong>NPs: autonomous, but are not in community settings. Many NPs are working as community health nurses due to a lack of NP positions.</strong></td>
<td><strong>25 geographically isolated communities in Nunavut, 24 of which have community health centres</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Specialist referrals can be done through NP or physician</strong></td>
<td><strong>85% Inuit, 50% speak Inuktitut (limited English)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Most nurses are employed by the government with the exception of 3rd party contracted nurses (agency nurses)</strong></td>
<td><strong>Population does not do good preventative healthcare (lifestyle, economics, social determinants of health)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Strong emphasis on emergency services due to few physicians in community settings</strong></td>
<td><strong><a href="http://www.hss.gov.nu.ca/en/Home.aspx">http://www.hss.gov.nu.ca/en/Home.aspx</a></strong></td>
</tr>
<tr>
<td></td>
<td><strong>Prevention, health promotion, population health: a struggle due to understaffing and all the emergency services nurses have to provide</strong></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E - Environmental Scan Themes

A Vision for Nursing in Primary Care Settings

In some primary care settings, best practices were identified.
- Utilizing other clinic teams in mentoring nursing roles.
- Using the right provider for the right patient.
- Dedicated evaluation resource.

Team vision and communication was commonly mentioned as one of the reasons for effective utilization of nurses.
- Ensuring new team members have a similar philosophy and facilitation of buy-in was part of the interview process for hiring new staff.
- Communication and openness to try new things was key.
- Discussion of effective nursing utilization should occur from the start.

Organizational Design

Transformational change in primary care settings can be slow. Little evaluation has been completed to date on nursing models to guide changes. Outcome studies were difficult; particularly delineating nursing outcomes.
- Organizational culture and context are important to consider in health system change.
- Lack of time, funding, and expertise were barriers to evaluation.
- Client satisfaction and patient outcomes were commonly measured.
- Those clinics that conducted evaluation had a dedicated resource on site or collaborated with a local university.

Clinic structures evolved overtime.
- Some clinics were starting to introduce group appointments for Chronic Disease Management (CDM) led by a nurse or NP.
In some primary care settings, the funding model had an influence on nursing roles and interprofessional (IP) collaboration.

- The fee-for-service model was generally identified as a challenge to IP collaboration and optimizing roles:
  - For example, when the physician was away, nurses could not carry out some of their regular nursing programs (i.e., well woman days) as the physician would not be able to see his or her patients at the same time and bill for that time.
  - As physicians were not compensated for formal meetings with other team members, collaboration was hampered.
- Another participant suggested having physicians provide all care was no longer financially feasible, even in a fee-for-service model, hence collaboration was becoming necessary.

> "The collaborative nature of the practice has to do with organizational structure – it wouldn’t occur so well in a fee-for-service model"

> "Transfer of care and communication isn’t as good [in fee-for-service sites] as in this clinic"

> "If there was more [full-time positions], nurses would have more time for health promotion, prevention, etc."

The political environment also had an influence, such as the number of nursing positions available and the ability to fill them.

- Availability of positions and/or staff impacted the use of nursing knowledge and skills.
  - In remote settings, there were community health nurses with an NP education working in RN roles due to a lack of NP positions.
  - The number of nursing staff and variability of nursing providers was generally smaller in rural and remote areas; if there was no LPN, an RN may be hired even though it was intended to be an LPN role.
  - Inability to create/access other nursing positions (e.g., LPN) affected how other nursing providers enact their roles.

> "An LPN role would make it easier for other nurses to practice to full scope"

### Roles & Responsibilities / Scope of Practice / Nursing Role Ambiguity

For the most part, NPs worked independently with their own roster of patients. Clinics/teams used the most appropriate provider for the patient whether that was an NP or physician.

- Based on discussions with patients, NPs felt patients were highly satisfied with having an NP as their primary provider.
- NPs were involved in a lot of teaching and managing programs, such as chronic pain, mental health, eating disorders, diabetic medication management, and well woman clinics.
Nursing roles varied based on staff mix and clinic settings. Within the same clinic and across clinics, sometimes the same role was being done by different nursing providers.

- For example, well woman exams were mainly being done by NPs (when this role was filled), however, in some clinics physicians taught RNs how to do this. One clinic anticipated LPNs (once the role was filled) would be able to do well woman exams.
- In some cases nurses were paired one-to-one with a physician, which meant their role varied based on the patient population and the needs of the physician.
- RNs in remote settings have a very independent role; in some cases working beyond their scope of practice.

“The clinic background affects what you can do and your scope. It really depends on the physicians and what the clinics designate what the nurses’ roles will be. It depends on the physician group accepting the advancing role of nurses as well. Understanding the role (or not) of a nurse can be a barrier”

“You always have to learn as you go – each clinic is different”

“You don’t get a recipe for what your role is – you respond to the community needs”

Role ambiguity and overlap result in duplication of services, which is a major concern in some clinics.

- There was overlap between LPNs and RNs, RNs and NPs, and NPs and physicians.
- In some cases, providers were not fully enacting their role to avoid duplication of services.

“NPs do about 80% of what a family physician does”

When asked how they differentiate between the RN and LPN role: “We don’t very often other than with the telephone triage – our RNs are more comfortable doing it and definitely have the knowledge base for doing it more. LPNs will refer to the RN, but other than that they almost work exactly the same within our clinic”

“In some cases nurses were not doing physical assessments when the patient comes in because the doctor will do it anyways so it would be a waste of time”

Nurses were not always working to their full scope of practice, and in some cases nurses were taking on the tasks of other providers.

- In one clinic, prior to hiring a clinical office assistant, RNs were doing tasks such as autoclaving, changing the sheets, and running specimens to the lab. Now nurses focused more on direct nursing care, teaching, and health promotion.
- In some cases involvement in clinic programs, such as a diabetes program, brought the role of nurses “to the forefront” and nurses completed more of the assessments.
• How nursing roles were enacted was sometimes determined by the population served

“A better team mix in primary care would allow nurses to work to fuller scope”

“[Nurses] need to be able to provide care across the continuum, but be more skilled in certain areas based on the population. The skills of a nurse are more population driven than anything else”

Entry-to-Practice Nursing Education

Entry-to-practice education prepared nurses to work in a generalist role. However, there was a need for greater focus on primary care (e.g., CDM).

• New nurses had strong critical thinking skills; important for assessments and documenting care.

Availability of clinical placements in primary care was limited or non-existent. One manager commented that there seemed to be an expectation that students would get the clinical hours after they graduated.

• Students’ exposure to “highly functioning teams” in primary care settings was important.
• Some clinics turned down student clinical placements as they felt their clinic was in transition; they wanted to wait until they could provide a better service delivery model for primary care.
• The fee-for-service model can be a hindrance to clinical placements as it takes time away from nursing staff.
• In remote areas, a lack of housing and preceptors for nursing students was a major issue.

“Students can get the education but not the practicum”

“If nurses are spending a lot of time teaching students, they don’t have time to help the physicians who are paying their salary”

Workplace Learning & Continuing Education

Previous nursing experience was important for working in primary care. Lack of experience was identified as one of the major gaps in preparation of new nurses

• With previous experience, nurses were more comfortable with their basic skill level.
• However, even with experience, adjustment to primary care was significant.
• One participant stated that in Quebec, nurses require two years of experience prior to entering a primary care setting.
Newly graduated nurses were not comfortable entering a practice setting without previous experience.
- Most participants felt new graduates would not be prepared to enter a primary care setting.
  - There was a general reluctance to hire new graduates.
- The focus of education for RNs and LPNs is on preparing students for acute settings.
- Orientation and mentorship were important, especially for new nurses in primary care settings.
  - Overall, high levels of support and mentoring were provided.

Speaking about new grads, “No – absolutely not. If they had more experience during their program it would be fine”
“There is an assumption that if you can do acute care then you can do anything else. It’s not easier, just different”
We expect new nurses to come with a “very high level of functioning”
“New graduates come out and putting theory into practice now seems to have been an employer issue. So that’s why all of these mentoring roles came up – a lot of places mentor new grads into positions because they can’t take that one step between theory and practice because they haven’t had enough practice”

- One participant highlighted the fresh perspective new graduates bring to the setting.

“When you have the majority of your staff doing things a certain way that’s maybe not fully utilizing their skills and their knowledge – it’s been a bit of a hard mountain to move. Whereas a new grad coming in is already there and that’s the benefit of having some younger blood in the organization. So having some new, younger nurses around would be beneficial, you’re not fighting as a big of a resistance to change”

Nurses were supported in pursuing continuing education opportunities, although in some settings it was more of a challenge due to limited time or funding.
- Many opportunities exist for nurses to attend continuing education sessions.
- Funding and time away was a challenge, especially in rural areas.
• There was a need for more education on primary care, such as CDM, which is a big focus of most primary care clinics.
• Other gaps included immunization and mental health.

**Interprofessional Collaborative Practice**

Overall, there was a perception of good quality IP collaborative practice in clinics and teams participating in the scan.

• Co-location facilitated successful collaboration.
  ○ More opportunity for informal and formal patient discussions among team members was suggested.

> “Nurse led clinics only work well if they have an interdisciplinary team to work with – in a full way, not just can I talk to you. Otherwise it’s a liability – complex patients need a multidisciplinary team”

Trust from team members was another key aspect of successful IP collaboration.

• Respect and trust from physicians, the IP team, and management was crucial.

> “If physicians haven’t worked with NPs previously, sometimes it takes a bit longer for them to develop trust of the NP and learn what she can and can’t do – how they can benefit the clinical team and patient care”

> “Physicians encourage full utilization and nurses working to full scope because the physicians feel that if they are able to utilize someone else for the tasks, this gives them more time to concentrate on the physician only things”

IP collaboration was sometimes hindered by territorial issues.

• Some nurses were not always accepting of the role of other nursing providers (e.g. LPN of RN, or vice versa, RN of NP).

> “Some nurses don’t want to give up a piece of what they do to someone else”

> “Stressful start [of the NPs] with the RNs being accepting of that role” – not really knowing where they stood.

A greater awareness of nursing roles was required among nurses themselves, physicians, other providers, and patients

• Nurses often did not know what their scope of practice was, making it difficult for other team members and patients to know.
• Understanding of the NP role varied across clinics.
“Nurses need to come out of school with a really good understanding of who does what”

“The ability to work to your own scope depends on your knowledge of other people’s scope”

“Even people with 10 years of hospital experience really struggle when they move into a primary care setting because they don’t fully understand their scope of practice. And where physicians also don’t understand it, you could get into some pretty tricky situations”
### Appendix F – Alberta Scan Detailed Description

<table>
<thead>
<tr>
<th>PCN</th>
<th>Structure of Nursing Model</th>
<th>Other IP Team Members</th>
<th>Focus of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCN 1</td>
<td>• NP&lt;br&gt;• RNs&lt;br&gt;• NP role is newer &amp; less defined – currently similar to the RN role. NPs don’t have their own patient panel&lt;br&gt;• NP focus is on women’s health &amp; geriatric clinic. Provides comprehensive assessment and support to the clinic&lt;br&gt;• Majority of nursing focus is chronic disease management (CDM) with some specialization; Chronic Pain Management Clinic, Senior’s Health Clinic, Women’s Health Clinic, Project Management support&lt;br&gt;• Centralized model: patient seen by nurse for assessment &amp; triage. Multidisciplinary teams (MDT) collaborate for care based on patient’s goals for treatment and their motivation to make lifestyle changes&lt;br&gt;• Nurses work closely with physicians as a partner in providing patient-centered care, but overall function fairly autonomously within the objectives of the CDM program&lt;br&gt;• Patient care provided is based on the principles of facilitating, self-management, empowering patients, providing family-centred care and applying stages of change model to achieve incremental lifestyle improvements</td>
<td>• Dietician&lt;br&gt;• Exercise specialist&lt;br&gt;• Occupational Therapist&lt;br&gt;• Pharmacist&lt;br&gt;• Psychiatrist, geriatricians, family physicians, etc. in specialty clinics&lt;br&gt;• Psychologists and Registered Psychiatric Nurse (Mental health therapists)&lt;br&gt;• Respiratory therapist&lt;br&gt;• Nurses determine along with the patient which other team members the patient should see&lt;br&gt;• IP team collaborates very closely&lt;br&gt;• Care plan developed by team and based on patient goals</td>
<td>• Mostly adult population but moving towards care across the lifespan&lt;br&gt;• Common conditions: Anxiety, Chronic pain, Depression, Dyslipidemia, Geriatrics, Grief, Hypertension, Mental Health, Obesity, Obstructive Sleep Apnea, Stress, Type 2 diabetes, Women’s Health Screening&lt;br&gt;• A cardiac rehab program will be added within the next 12 months</td>
</tr>
</tbody>
</table>

| PCN 2 | • LPN<br>• RNs<br>• RPNs<br>**CDM program:**<br>• Risk reduction & weight management programs – clients referred by physician only. Nurse triages client, nurse & client create care plan, client meets with other providers as needed<br>**Maternal Newborn Clinic:**<br>• Prenatal and postnatal care by RN in collaboration with physician(s). Physician referral required<br>**New Mom’s Network:**<br>• Client education provided by RN. No referral required<br>**Oncology Nurse Navigator:**<br>• Provision of informational support, guidance, community support for cancer clients and their significant others. No referral required | • Dietician<br>• Pharmacist<br>• Exercise Specialist<br>• Medical Office Assistants<br>• Allied health, fitness centre, and a walking track are co-located and collaborate to offer comprehensive client care. Allied health provides access to Dietician, Occupational and Physical Therapy, Speech and Language Pathology, Wellness Coaching, Respiratory Therapy, Kinesiologist/Exercise Therapist, Psychologist, Psychiatrist and associated supportive programming | • Focus on prevention and care for population with chronic disease |
### Geriatric Assessment Program:
- RPN/RN from Addiction & Mental Health providing assessment support to PCN care of the elderly. Physician to assist in completing Geriatric Assessment referrals. Physician referral required
- Nurses work to full scope of practice in collaboration with other health professionals and the client to provide team focused care
- Nurses or physicians can make internal referrals to other providers
- RPN: triage, mental health liaison
- RNs: triage, case management, coordination & education
- LPN: working in the unique (granted LPN training – usually provided to RNs only) role of Oncology Nurse Navigator (course/certificate offered through AHS/Cancer Care, Edmonton)

### PCN 3
- LPN: support for specific tasks and procedures (Note: these clinics have hired their own LPN, it is not a PCN provided service)
- NPs do not have their own panel of patients, rather they provide support for patients with complex health needs, and provide health care to patients of all ages
- Do a lot of prevention
- The clinic as a whole provides health promotion services

### PCN 4
- NP
- RN
- Patients offered the choice to see NP or physician (can get in faster to see the NP) but physicians still see all patients to facilitate payment through the fee-for-service model
- NP: physicals, orders tests, patients with chronic disease. Spends a lot of time educating about NP role
- NP or physician can make referrals to allied health professionals; referrals sent to central intake

### PCN 5
- RNs
- New model being developed to maximize the utilization of physicians and to better coordinate services for complex patients including involvement with community programs
- Nurses are involved in establishing parameters and focus for program
- Physician identifies needs (i.e. financial assistance for diabetic medications, patient not following through with medical regime). From

### IP practice well orchestrated – respect each other’s scope, informal/formal team meetings
- Attempts are made to create collaborative care plans with the interprofessional team
- Partner with community / other professional resources to coordinate access and optimize client care (foot care, massage therapy, dental care, social programming, etc.)

### PCN
- Mix of patients with general and complex needs
- Care is provided as required to entire population that a clinic serves

### Care across the lifespan

### Medically complex patients with co-morbidities and underlying social needs
| PCN 6 | • RNs  
• Physician refers patients with chronic disease to nurses  
• Nurse: intake, full assessment, teaching, counselling, makes recommendations to doctors, follow up with patients, report back to physician | • Diabetic educator  
• Dietician  
• Pharmacist  
• Physicians  
• Physiotherapist  
• Social worker  
• Client is either seen individually (one provider) or by a team (often an RN, Dietician, pharmacist, social worker)  
• Diabetic educators sees patients on their own | • Focus on population (mostly seniors) with one or more of the following chronic conditions: diabetes, hypertension, high cholesterol, obesity, asthma, COPD, chronic pain, risk for falls |
|---|---|---|---|
| PCN 7 | • RNs (diabetic clinic & home care)  
• Referrals can be made to other team members  
• Rural diabetic clinic requires physician signature for referrals  
• Nursing role is independent and autonomous | • Allied health  
• Dietician  
• Health aides  
• Medical office assistants  
• Occupational therapist  
• Pharmacist  
• Physicians  
• Physiotherapist  
• Recreational therapist  
• Respiratory therapist  
• Informal hallway talks – good for discussing patient related concerns, but less helpful for program development & evaluation. Formal meetings would be preferable, but no physician funding for this | • Focus on adult population |
| PCN 8 | • LPN  
• RNs  
• Focus: prevention of complications & disease progression rather than prevention of diseases  
• Referral-based clinic with focus on chronic disease. Anyone can refer: physicians, other providers, self  
• Nurses then refer patients to other services (e.g. acute care, dieticians, home care) | • Acute care  
• Dieticians  
• Home care  
• Medical office assistants  
• Medical social worker  
• Physicians  
• Physicians, nurses, patients all work together to develop care | • Population chronic disease |
**PCN 9**

<table>
<thead>
<tr>
<th>Nurse interaction with patients changes slightly based on physician and setting</th>
<th>Nurse interaction with patients changes slightly based on physician and setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs function quite autonomously, all have 20+ years experience</td>
<td>RNs function quite autonomously, all have 20+ years experience</td>
</tr>
</tbody>
</table>

**Street clinic:**
- Almost all drop-ins
- Some referrals come from downtown agencies, emergency rooms and other physicians
- Harm reduction model – try to be where people need them
- Bulk of care is nursing care
- RN role similar to NP – helps with navigation of clients
- NP expanded role of RN (95% overlap)
- NP – new role – own team fairly knowledgeable about role, but spends time educating other providers
- Prevention and promotion key purpose of clinic
- Link patients with services
- Nurses can make referrals to other team members, except for physician specialist – need NP to sign off on this

**Chronic Disease:**

**Family Nurse:**
- Provides self-management support, education and navigation on referral from physicians
- Assessment of blood pressure, weight, and waist circumference
- Goal: move the patient to action through goal setting and self-awareness of disease process and management
- Family nurse is co-located within the physician clinic and is assigned to specific physicians

**Maternal-Child Family Nurses:**
- Provide education, anticipatory guidance, informed decision-making, advocacy, and navigation to resources and support
- Depending on the clinic setup, there are 3 formats for providing service:
  - Drop-in for the prenatal patient while waiting for their physician. Family Nurse provides information or answers questions relevant to the pregnancy / mother’s needs. Plan further follow up as needed
  - Individual scheduled appointment with the family nurse based on physician referral
  - Routine scheduled appointment with the family nurse at patient’s first prenatal visit – overview of clinic process, PCN services, and

**Mental health liaisons**
- Outreach workers
- Physicians
- Staff meetings for clinic updates
- Physicians & NP form a sub-committee to discuss progress of clinic
- Ongoing communication with agencies to keep up to date
- Collaboration with other agencies to address social, financial, and other concerns
- Good collaboration between physician and nurse

**Street clinic works with vulnerable populations, often with mental health and substance abuse issues**
- Services range from non urgent medical care to navigating healthcare system
- Patients with chronic conditions
- Prenatal / postnatal women
| PCN 10 | \begin{itemize} 
  
  \item LPNs 
  \item RNs 
  \item Centralized & decentralized family practice nurses (FPNs) 
  \item Physicians refer patients to CDM or MH team. RN’s usually do the initial assessment but any team member can 
  \item Referrals are done to other professionals in collaboration with the physician when it looks like the possibility of Rx or meds might be given by the referred professional 
  \item Education classes are open for client self-referral 
  \item Decentralized program: places nurses directly in family physician clinics 
  \item Referrals to other professionals done in consultation with physician (signature required) 
  \item Nurses focus on chronic disease but have various interests/expertise 
  \item Blood pressure clinics, diabetes fair, weight management classes, etc. 
  \item Decentralized program: role of nurses varies across clinics based on physician’s practices and their needs 
  \item Centralized program: physicians guide nurses if needed, but nurses very autonomous. Patients see nurses first 
\end{itemize} | \begin{itemize} 
  
  \item Dietician 
  \item Exercise therapists 
  \item Medical office assistants 
  \item Pharmacist 
  \item Physicians 
  \item Respiratory therapists 
  \item Within the team decisions are reached with the client on who else they might see 
  \item Comprehensive care plan often developed by nurses and reviewed/signed by physician 
  \item Team meetings to discuss complex patients 
  \item Centralized program: central location for entire interdisciplinary team (except for mental health) allows for working together and problem solving. Formal & informal conversations 
  \item Cross-training of different disciplines (e.g., pharmacists & dieticians are both certified diabetic educators) results in role ambiguity/overlap between pharmacy, nursing, dieticians, exercise therapists etc. 
\end{itemize} | \begin{itemize} 
  
  \item Care across the lifespan 
  \item Focus on chronic disease (top 2 are diabetes and weight management) & mental health (depression & anxiety) 
  \item Some physicians/clinics are interested in specific populations (geriatrics, cardiac, chronic disease, women’s health etc.) 
\end{itemize} |
| PCN 11 | \begin{itemize} 
  
  \item LPNs 
  \item RNs 
  \begin{bquote} 
  \textbf{Chronic disease clinic:} nurse managed, patients referred by physicians. 
  \item Nurses provide patient assessment, education & guidance for lifestyle changes, and navigation to other resources as necessary 
  \end{bquote} 
  \begin{bquote} 
  \textbf{Family Care Clinic:} physician who mentors physicians new to city/country/profession – helps them to develop patient panel. 
  \item Nurses work closely with physician. Assist physicians, does patient assessment and \end{bquote} 
\end{itemize} | \begin{itemize} 
  
  \item Behavioural health consultants 
  \item Dieticians 
  \item EMTs 
  \item Kinesiologists 
  \item Physicians 
  \item Medical Office Assistants 
\end{itemize} | \begin{itemize} 
  
  \item Chronic disease clinic: must have 1 of 4 chronic diseases Patients are provided with education and support to help them become self motivated by an interprofessional team 
  \item Family care 
\end{itemize} |
education. Training to perform pap tests
- Every patient also seen by physician

**Low Risk Maternity Clinic:** The nurse provides patient assessment and education. Assists physician’s with care.

**COST Program (Clinic Office Support Team):**
Patient assessment, education. The program was designed to increase access to medical care by promoting role optimization.
- RN role: more critical thinking, care plan creation/management, mentorship
- LPN: hands on/task oriented
- Role of RNs differentiated by appointment types & patients seen as well job description/role
- Focus on prevention

<table>
<thead>
<tr>
<th>PCN 12</th>
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</thead>
<tbody>
<tr>
<td>RNs</td>
<td>Dieticians</td>
<td>Care across the lifespan</td>
</tr>
<tr>
<td>RPNs</td>
<td>Health Promotions Coordinator</td>
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</tr>
<tr>
<td>In some clinics, there is a backlog for procedures - have started doing group visits</td>
<td>Lactation Consultant</td>
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<tr>
<td>Nurses follow-up to ensure continuity of care and the link between patient and services is made</td>
<td>Mental health Coordinators</td>
<td></td>
</tr>
<tr>
<td>Referral to a specialist requires approval from physician</td>
<td>MOAs</td>
<td></td>
</tr>
<tr>
<td>RN role: about half is CDM half is triage and assessments</td>
<td>Occupational Therapists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmacists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physicians</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessments sent back to physician to review with suggestions of services for referral</td>
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</tr>
</tbody>
</table>
Appendix G - Alberta Interview Themes

A Vision for Nursing in Primary Care Settings

Areas for opportunity and growth were identified in primary care settings:

- The importance of consistency across PCN providers (e.g., nurses, physicians, other interprofessional team members etc.) was expressed.
  - Consistency of education around nursing roles was needed for nurses, interprofessional (IP) team members, and patients.
  - Staff mix varied across PCNs influencing how nursing roles were enacted.

- Early involvement in clinic and program development provided the opportunity for discussion of effective utilization of nursing roles from the beginning.
  - Examining other primary care settings provided insight on the optimization of nursing roles.
  - Nursing input on various committees in the PCN was considered to be very valuable.
  - Involvement in the planning process facilitated nurses to step into the clinic or program being well prepared to take on their role (e.g., assessments).

- Increasing the autonomous nature of nursing roles (especially the NP role in Alberta) could be accomplished through:
  - Physician engagement
  - Increased patient and physician trust in nurses

“Education plays a role, but there is also a rapid rate evolution happening at the PCN level – some with very innovative programs” [Regulatory]

“The entire system needs to build a culture around [interdisciplinary approach], not just a few disciplines” [Educator]

- Although very few participants were entirely satisfied with their current role in their PCN, some responses were very positive and provided a goal to work towards.

“I’m using every skill I’ve learned” [Nurse]

“The PCNs are strong, they’re growing. It’s by far the best nursing opportunity I’ve personally found. And I know that it maximized my education to the fullest potential. I feel challenged as a [nurse] every day and find personal satisfaction in this setting. It’s a great opportunity for nurses” [Nurse]
Organizational Design

In some primary care settings, nursing roles were still being developed. Also, not unexpected, the types of nursing providers differed across PCNs.

- Numerous participants entered their current role with no job description, or were responsible for creating the program, setting up the clinic, developing nursing roles, etc.
- Overall, a lot of their time was spent educating other staff and patients about specific nursing roles.
- The size and scale of PCNs and their clinics must be recognized. Due to their often small size, they may only be able to hire one type of nursing provider. Hence, the single provider is then required to do other components of the role that would be best suited to another nursing provider.

“There was a lack of awareness of PCNs for some stakeholders.

- Some participants not employed by PCNs (e.g., regulatory and educator stakeholder groups) had minimal information and conducted a search on PCNs prior to their interview.

Roles & Responsibilities / Scope of Practice / Nursing Role Ambiguity

There was a lack of understanding of roles. Very few participants stated their role was distinct or clearly differentiated from other nursing roles. Role ambiguity and overlap were major issues in primary care and led to duplication.

- Similar or the same role functions were noted for different providers (e.g., RNs and LPNs; RNs and NPs) – often there was no difference in what one nursing provider was doing as compared to another nursing provider.

Nurses were not working to their full scope of practice. Nurses from all provider groups did not always feel they were using the full extent of their knowledge and skills (scope of practice) in the practice setting.

- Nursing role enactment varied greatly from setting to setting causing frustration for nurses, and resulting in further misunderstandings of nursing roles.
- Nurses were not always aware of what their full scope was, hence they may not have understood whether they were working to full scope of practice or not.
- Some participants discussed the roles of the RN and the LPN, feeling that LPNs could do most things in primary care that RNs were currently doing. They felt RNs were certainly not working to their full scope of practice.
- Implementation of the NP role was very limited in Alberta primary care settings.
  - Managers and other healthcare providers had little or no awareness of the NP role.
Often the NP was working as an RN with an expanded scope of practice (e.g., prescribing). One participant suggested RNs and NPs did about 95% of the same work.

- Although participants discussed some focus on population health, prevention, and promotion in their practice, the majority of their practice was focused on the biomedical management of chronic disease.

Other nurses have said “you can’t do that” to which she responded “yes I can, it’s in my scope of practice” [Nurse]

“There are times when nurses are doing things they shouldn’t, but when in a small clinic it’s either you or no one” [Manager]

When you are the only nurse you end up doing a lot of “basic tasks” [Manager]

Entry-to-Practice Nursing Education

As expected, differences in educational preparation of nurses across provider groups (e.g., LPNs, RNs, RPNs, NPs) was apparent. Entry-to-practice education prepared nurses (e.g., LPNs, RNs, RPNs, NPs) to work in a generalist role. Overall nurses were flexible and could adapt to a new setting with appropriate support and training.

- Primary care concepts were covered but the emphasis was on preparing nurses for a generalist role.
- There was a tension between practice and education with core competencies being the focus of nursing education as opposed to a specific target population or service area (i.e. primary care).
- It was impossible to teach nursing students about all health conditions, therefore, nurses were taught skills to be able to search for further information when required.
- Strong critical thinking and problem solving abilities was noted for all nursing providers.

“You can only educate to a certain point” [Educator]

“Specialized knowledge develops in practice settings and through continuing education” [Educator]

Educational preparation has evolved over time.

- Newer graduates had a greater emphasis on health promotion, disease prevention, and community health (e.g., degree and diploma prepared nurses).
- Newer nurses were graduating with a somewhat greater understanding of primary care compared to previous cohorts.

Availability of clinical placements in primary care was limited or non-existent.

- In some cases, educators were unaware of whom to contact to arrange a placement.
- There was uncertainty about contract arrangements (e.g., was a contract with both AHS and the PCN required).
• Some managers stated they had only been asked once to take a nursing student, but would be happy to take on more students.

“The instructors just have to call” [Manager]

Workplace Learning & Continuing Education

Previous nursing experience was important for working in primary care.

• Experience increased confidence and the ability to take on more independent and autonomous roles as appropriate.
• More experienced nurses had a chance to build their skills, resulting in increased comfort levels.
• Working in other settings (e.g., hospital), provided nurses with the opportunity to work with other professionals.
• Working in a variety of settings prevented nurses from becoming too focused in one area, described as “tunnel vision” by some participants.
• Expectations of new nurses differed particularly between educators and managers:
  o Educators emphasized nurses were prepared as generalists to work in any setting.
  o Managers did not want to hire new nurses as their preference was for nurses with previous nursing experience with in-depth knowledge and skills.

Newer nurses were not comfortable entering a practice setting without previous nursing experience.

• Entry level education had a greater focus on acute care with little focus on primary care (e.g., Chronic Disease Management [CDM]).
• All participants agreed that even with experience, it was a huge adjustment to move from acute to primary care.

“It would be a REALLY big leap to go from school right into primary care” [Nurse].

“It’s a large transition from education to practice” [Educator].

Orientation and mentorship were important for nurses in primary care settings.

• Orientation allowed the new graduate to solidify skills and orient to the new position.
• Many nurses felt orientation in PCN clinics was lacking.
• Starting in an established PCN with mentorship from experienced RNs/NPs was the ideal situation for nurses working in primary care.
• Support and guidance from mentors allowed nurses to work more independently/autonomously.
• Mentorship was important, especially for new nurses with no prior experience. However, mentorship was not always there or appropriate.
  o Mentors often represented an older cohort where experience and philosophy of nursing differed from new graduates.
  o Nurses also expressed a preference for more one-on-one mentorship.
Continuing education opportunities were essential, especially on primary care topics such as mental health.

- There were many opportunities and overall support for nurses to attend continuing education sessions.
- However, sometimes funding, location, and time away from the clinic could be an issue, especially for rural nurses.
- Nurses expressed a need for more in-depth education on CDM topics; a big focus in primary care. There was a need for more specific information relevant to primary care.
- Some nurses preferred first hand learning experiences (interactive rather than lecture), providing opportunities to practice what was learned. (e.g., learning how to do PAP tests – which they did not think was offered in Alberta).
- Question and answer sessions were also suggested as a preferred method of learning.
- There were few continuing education sessions specific for NPs; they often attended physician continuing education sessions.

**Interprofessional Collaborative Practice**

Newer graduates were more prepared to work collaboratively in IP teams.

- Compared to older nurse cohorts, recent nurses graduated with more background in IP collaborative practice.
- Nursing students attended some classes with students from other health professions (e.g., med students, health sciences, paramedical, addictions, counselling, massage therapy & social work) increasing their contact with other disciplines.
- Education was needed on all provider roles so the IP team could see the benefit of each provider.

Overall, nurses appeared to work well in an IP team setting and were able to communicate with other team members. However, IP collaboration was hindered by territoriality among providers as well as by a lack of trust.

- Co-location facilitated IP collaborative practice.
  - Communication among team members was easier, increasing their ability to work together and problem solve.
  - More opportunities for informal “hallway conversations” as well as formal discussions about patients were noted.
• Territorial issues did exist among nurses and between nurses and other team members. In some cases, nurses were hesitant to take on certain components of their role for fear of stepping on another person’s toes.
• A trusting relationship was key to supportive relationships among nurses and other team members.
Appendix H – Key Actions

Optimizing the Role of Nurses in Primary Care Settings
Proposed Actions from the Summit

A Summit focused on optimizing nursing roles in primary care settings was held on September 20th, 2011, in Nisku, Alberta. Approximately 50 participants attended the Summit, representing various stakeholder groups (e.g., all categories of nursing providers, educators, primary care network managers, AHS, AHW, physicians). From this Summit, 10 actions were identified. The top three actions were: 1) establish a funding model centred on patient needs, access to care, and support for interprofessional collaborative practice 2) define primary care nursing roles, responsibilities, and core competencies within the context of the interprofessional team; and 3) develop a framework for evaluation and promote ongoing performance measurement for primary care service delivery. All Summit actions are outlined in the following pages.

A Foundation for the Delivery of Primary Care Services

Action #1: Increase patient/community engagement in primary care service delivery

Ultimately, the focus of primary care is the patient. Given the current pace of primary care and the emphasis on redesign, patient/family-centred care has often not received the focus it deserves. Care for the patient, family, community, and population as the central focus of care needs continual emphasis.

<table>
<thead>
<tr>
<th>Strategies to achieve action</th>
<th>Accountability</th>
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<tbody>
<tr>
<td>Include patients in planning of primary care service delivery</td>
<td>AHS, AHW, AMA²</td>
</tr>
<tr>
<td>Ensure patient/family are equitable team members</td>
<td>Advocacy from all organizations, primary care managers, primary care providers</td>
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<tr>
<td>• Goals are set by and with the patient/family</td>
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<tr>
<td>• Patient/family are active participants in the development of an integrated care plan</td>
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<tr>
<td>Develop models of care with a focus on health and wellness rather than a focus on illness</td>
<td>AHS, AHW, primary care managers, regulatory</td>
</tr>
<tr>
<td>• Consider terminology (e.g., primary care and primary healthcare)</td>
<td></td>
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<tr>
<td>Promote equitable and timely access for all Albertan’s to the most appropriate healthcare provider</td>
<td>Advocacy from all organizations, primary care managers</td>
</tr>
<tr>
<td>• Make appointment times more patient friendly (time for comprehensive assessment and patients’ stories)</td>
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</tr>
<tr>
<td>• Match the IP team to population needs</td>
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<tr>
<td>Create and utilize IT infrastructure to better define the needs of the community and patient panel (e.g., population statistics)</td>
<td>AHS, AHW, primary care manager</td>
</tr>
<tr>
<td>• Determine and utilize resources currently available (and maintain these) to avoid duplication</td>
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</table>

² Stakeholders are listed alphabetically and not in any specific order of priority
Provide opportunities for community involvement in primary care (e.g., community partnerships, having a community representative on Primary Care Network board) | AHW, primary care managers, regulatory (advocacy)

Promote Albertans understanding of primary care | AHS, AHW, AMA

**Action #2: Develop a governance model to support interprofessional shared decision-making at all levels in primary care settings**

There is a need to review current governance structures and models in primary care. An interprofessional (IP) participatory approach would allow stakeholders to come together and work towards a common goal.

<table>
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<tr>
<th>Strategies to achieve action</th>
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<tbody>
<tr>
<td>Foster partnerships between AHS, AHW, AMA and all professional groups in the development of primary care service delivery in Alberta</td>
<td>AHS, AHW, AMA, other health professional regulatory bodies and colleges</td>
</tr>
<tr>
<td>Expand boards (e.g., primary care networks, provincial primary care governance boards) to include broader IP representation (nursing and other professionals) and the public</td>
<td>AHS, AHW, AMA, CARN, CLPNA, CRPNA, other health professional regulatory bodies and colleges, primary care managers, provincial primary care organization³</td>
</tr>
</tbody>
</table>
| Facilitate the development of a shared philosophy and standardized principles for delivery of primary care by the IP team  
  • Develop a common language based on CIHC IP Competency Framework⁴  
  • Develop common, shared goals among stakeholder organizations  
  • Build on current provincial committee work reviewing primary care | AHS, AHW, AMA, CARN, CLPNA, CRPNA, other health professional regulatory bodies and colleges, primary care managers, provincial primary care organization, etc. |

**Action #3: Establish a funding model centred on patient needs, access to care, and support for interprofessional collaborative practice**

There is a need to explore and promote alternative funding models. The current physician fee-for-service model widely used in Alberta does not support IP team practice. Funding should be based on the population/client, rather than the physician and/or team, and requires a coordinated provincial approach.

³ Currently the Primary Care Initiative (PCI)
### Strategies to achieve action

<table>
<thead>
<tr>
<th>Action</th>
<th>Accountability</th>
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</table>
| Develop and implement a funding model in primary care to support:  
  - Integrated patient-centred care  
  - IP collaboration  
  - Appropriate utilization of all healthcare providers | AHW |
| Test and evaluate the outcomes of the new funding model | AHW |

#### Action # 4: Develop a framework for evaluation and promote ongoing performance measurement for primary care service delivery

An evaluation and planning framework to promote best practices for primary care service delivery, including dedicated funding and centralized support is required. There is a need for a standardized provincial approach to evaluation and measurement.

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<tr>
<th>Strategies to achieve the action</th>
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<tbody>
<tr>
<td>Establish measurable goals and core indicators for delivering quality primary care (accessible, acceptable, appropriate, effective, efficient, safe⁵) based on evidence</td>
<td>AHS, AHW, AMA, provincial primary care organization</td>
</tr>
<tr>
<td>Establish evaluation methodologies based on evaluation best practices</td>
<td>AHS, AHW, primary care managers, provincial primary care organization</td>
</tr>
<tr>
<td>Promote evaluation of programs and service delivery models</td>
<td>AHS, AHW, primary care managers, provincial primary care organization</td>
</tr>
</tbody>
</table>
| Measure and demonstrate improvement in the following outcomes:  
  - Patient outcomes  
  - Enhanced utilization of all health care providers  
  - Integration of care  
  - Fiscal accountability | AHS, primary care managers, provincial primary care organization |
| Share best and promising practices with all primary care settings across the province | AHS, AHW, AMA, provincial primary care organization |

#### The Role of Nursing in Primary Care

**Action # 5: Define primary care nursing roles, responsibilities, and core competencies within the context of the interprofessional team**

Clearly defined nursing roles are required in the primary care setting. Nursing roles should be based on the Health Professions’ Act practice statements, entry-to-practice competencies, and restricted activities for each provider. A key goal is to enhance optimization of nursing roles as well as the roles of all healthcare providers in order to facilitate improved outcomes.

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### Strategies to achieve action

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<th>Description</th>
<th>Accountability</th>
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<tbody>
<tr>
<td>Define nursing roles and develop policies based on patient/population needs</td>
<td>AHS, CARN A, CLPNA, CRPNA, primary care managers, primary care providers</td>
</tr>
<tr>
<td>Adapt global job descriptions (Alberta Health Services) for LPNs, NPs, RNs, and RPNs to reflect the primary care setting</td>
<td>AHS, primary care managers, primary care provincial organization</td>
</tr>
<tr>
<td>• Develop a one page synopsis of each job description (especially useful for developing PCNs)</td>
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</tr>
<tr>
<td>Assist nursing providers to transfer competencies, knowledge, skills, and abilities to the primary care setting</td>
<td>AHS, CARN A, CLPNA, CRPNA, educators, primary care managers, primary care nurses</td>
</tr>
</tbody>
</table>

### Interprofessional Collaborative Practice

**Action # 6: Implement interprofessional collaborative practice**

Given the complexity of many of the patients in primary care (e.g., those with multiple chronic conditions), delivery of collaborative services by an IP team will assist to better meet patients’ needs and has potential to improve patient outcomes. IP collaboration is facilitated by building trust through relationships, role clarity, better coordination of care, and communication. IP collaboration occurs not only within the primary care team, but also outside the team with other organizations. Infrastructure in primary care organizational design is required to support IP collaborative practice.

A clear understanding of each healthcare provider’s unique knowledge/skills/competencies as well as commonalities will improve understanding of scope of practice, assist with role delineation, promote the optimal utilization of providers, and ultimately result in positive outcomes for patients.

### Strategies to achieve action

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<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Support a common understanding of collaborative practice by utilizing the CIHC Interprofessional Competency Framework⁶</td>
<td>AHW, provincial primary care organization</td>
</tr>
<tr>
<td>Increase role clarity between RNs, NPs, RPNs, and LPNs, and nurses and other healthcare providers to support IP practice</td>
<td>CARN A, CLPNA, CRPNA, and other health professional regulatory bodies and colleges, primary care managers, primary care providers</td>
</tr>
<tr>
<td>• Provide opportunities for team building and ongoing communication</td>
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<tr>
<td>• Increase awareness of scope of practice for all providers</td>
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<tr>
<td>• Orientate staff (including office support staff) to the roles of all team members through dialogue, job shadowing, and mentoring</td>
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</tr>
<tr>
<td>Promote partnerships between patients and IP teams to:</td>
<td>AHS, primary care managers, primary care providers and advocacy from CARN A, CLPNA, CRPNA, and other health professional regulatory bodies and colleges</td>
</tr>
<tr>
<td>• Develop integrated plans of care (e.g., team meetings or case reviews, shared development of goals, care planning, and evaluation of care)</td>
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<tr>
<td>Promote effective networking and communication among providers</td>
<td>Primary care managers, primary care providers</td>
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Nursing Education in Primary Care

**Action # 7: Embed primary care philosophy in all nursing curriculum for entry-to-practice and continuing education**

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<th>Strategies to achieve action</th>
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<tbody>
<tr>
<td>Determine the extent to which primary care concepts are included in nursing curriculum</td>
<td>Educators, primary care managers, provincial primary care organization</td>
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<tr>
<td>Incorporate primary care into educational processes (e.g., primary care simulation, use of primary care case studies)</td>
<td>Educators, primary care managers, provincial primary care organization</td>
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**Action # 8: Establish a standardized education program for nurses working in primary care settings**

Consistent education, particularly in core areas, would support professional development for all nurses working in primary care settings. Currently, continuing education differs across the province and is not as easily accessible for those working in rural and remote areas.
Orientation is currently provided by each primary care setting as they have capacity (e.g., expertise, time). Consistency in information taught and length of orientation differs across each setting. Standardized approaches to orientation for all nurses working in primary care would be beneficial to contribute to more standardized evidence-informed practice, build capacity for improved outcomes, and contribute to cost-effectiveness.

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<tr>
<th>Strategies to achieve action</th>
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<tbody>
<tr>
<td>Share best practices in continuing/ongoing professional development across primary care settings</td>
<td>Primary care managers, provincial primary care organization</td>
</tr>
<tr>
<td>• Conduct an environmental scan of best practices</td>
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<tr>
<td>Develop a formal continuing education program</td>
<td>AHS, CARNA, CLPNA, CRPNA, educators, primary care managers, provincial primary care organization,</td>
</tr>
<tr>
<td>• Modules or certification program specific to the nursing role to ensure a consistent foundation for primary care nursing practice</td>
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<tr>
<td>• Content will vary by nursing provider with common elements across nursing providers</td>
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<tr>
<td>Develop a standardized approach to orientation</td>
<td>AHS, primary care managers, provincial primary care organization, and advocacy from CARNA, CLPNA, and CRPNA</td>
</tr>
<tr>
<td>• Share best practices in primary care orientation</td>
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<tr>
<td>• Develop a centralized orientation along with resource materials for core orientation topics for all nurses working in primary care</td>
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<tr>
<td>• Create a learning house/centre of excellence/community of practice to support orientation and continuing professional development in primary care for nurses</td>
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<tr>
<td>• Ensure orientation addresses different learning styles and needs</td>
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<tr>
<td>• Include information about working with other partners (e.g., other healthcare organizations, community organizations) and resources available through AHS</td>
<td></td>
</tr>
<tr>
<td>Dedicate resources for continuing education for nurses working in primary care settings</td>
<td>AHW, primary care managers, provincial primary care organization, and advocacy from CARNA, CLPNA, and CRPNA</td>
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<tr>
<td>• Ensure commitment by leadership</td>
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<tr>
<td>• Include continuing education for providers as a component of the funding agreement</td>
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<tr>
<td>• Fund primary care nurse educator positions across Alberta</td>
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<tr>
<td>Increase awareness of training opportunities for nurses in primary care settings across Alberta</td>
<td>Educators, provincial primary care organization</td>
</tr>
<tr>
<td>Support and develop leadership training for nurses in primary care</td>
<td>AHS, educators, provincial primary care organization</td>
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</tbody>
</table>

**Action # 9: Enhance opportunities for interprofessional education in entry-to-practice nursing programs**

IP theory is currently embedded in nursing curriculum, but the opportunities for students to experience IP education varies within and across educational institutions. IP education and learning opportunities for students across professions and institutions needs to be enhanced.
<table>
<thead>
<tr>
<th>Strategies to achieve action</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support a collaborative organization/committee(^7) to enhance IP education and create</td>
<td>All organizations</td>
</tr>
<tr>
<td>learning opportunities for students across professions and institutions</td>
<td></td>
</tr>
<tr>
<td>Identify current IP education opportunities with a focus on primary care to strengthen or</td>
<td>Educators, CARN, CLPNA, CRPNA, other health professional regulatory bodies and</td>
</tr>
<tr>
<td>enhance as necessary</td>
<td>colleges, primary care managers, provincial primary care organization</td>
</tr>
<tr>
<td>Collaborate with educational institutions to review and develop new resources if required for</td>
<td>Educators, CARN, CLPNA, CRPNA, other health professional regulatory bodies and</td>
</tr>
<tr>
<td>IP education with a focus in primary care for students</td>
<td>colleges, primary care providers, provincial primary care organization, students</td>
</tr>
<tr>
<td>Advocate for the inclusion of CIHC competencies (competencies for collaborative practice)</td>
<td>Educators, other organizations (advocacy), regulators</td>
</tr>
<tr>
<td>into entry-to-practice competencies</td>
<td></td>
</tr>
<tr>
<td>Explore opportunities for IP clinical experiences</td>
<td>AHS, educators, CARN, CLPNA, CRPNA, other health professional regulatory bodies</td>
</tr>
<tr>
<td>• Explore opportunities for IP supervision of students</td>
<td>and colleges, primary care managers, primary care providers</td>
</tr>
<tr>
<td>• Change policies to align with IP culture</td>
<td></td>
</tr>
<tr>
<td>Ensure the availability of IP practice settings to allow students to practice IP collaborative</td>
<td>AHS, educators, CARN, CLPNA, CRPNA, other health professional regulatory bodies</td>
</tr>
<tr>
<td>patient care in clinical placements</td>
<td>and colleges, primary care managers, primary care providers</td>
</tr>
<tr>
<td>Promote and support IP conferences</td>
<td>All</td>
</tr>
<tr>
<td>• Provide funding for conferences</td>
<td></td>
</tr>
<tr>
<td>• Provide funding and time for individuals to attend</td>
<td></td>
</tr>
</tbody>
</table>

**Action # 10: Facilitate clinical placements in primary care settings**

While there is a shortage of clinical placements for all healthcare students, nursing clinical placements in primary care settings are under-explored and/or under-utilized. Identifying more opportunities for clinical placements within primary care settings would facilitate nursing student experience in these settings and possibly facilitate recruitment.

\(^7\) AHW in collaboration with other stakeholders has established a Collaborative practice and Education Steering Committee for the purpose of developing a common vision, a set of principles, a change agenda, and a work plan.
<table>
<thead>
<tr>
<th>Strategies to achieve action</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with stakeholders to secure placements in primary care settings</td>
<td>Educators, primary care managers, primary care providers, provincial primary care organization</td>
</tr>
<tr>
<td>Refresh/re-new database for clinical placements as required to include PCNs</td>
<td>AHS, educators,</td>
</tr>
<tr>
<td>Identify appropriate clinical placements</td>
<td>Educators, primary care managers</td>
</tr>
<tr>
<td>Develop clear goals for clinical placements</td>
<td>Educators, primary care managers</td>
</tr>
<tr>
<td>Develop supports and resources for preceptors and staff in primary care settings to offer clinical placements for all nursing students (RNs, NPs, RPNs, and LPNs)</td>
<td>Educators, primary care managers</td>
</tr>
<tr>
<td>Consider incentives for preceptors (financial and/or other)</td>
<td>AHW, educators, primary care managers, provincial primary care organization</td>
</tr>
</tbody>
</table>

*AHW, AHS, and PCNs are acronyms for Alberta Health Services, Alberta Health, and Primary Care Networks, respectively.*
## Appendix I – Knowledge Translation Plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Audience</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental scan and Alberta interview results summary documents shared</td>
<td>• Summit participants (50 stakeholders representing primary care in Alberta including AHW, AHS, AMA, PCI, regulatory bodies, PCN managers, all categories of nurses, and physicians.)</td>
<td>September 2011</td>
</tr>
<tr>
<td>Summit recommendations shared</td>
<td>• Summit participants</td>
<td>February 2012</td>
</tr>
</tbody>
</table>
| Final report distribution                                               | • Policy-makers, decision-makers, Alberta PCNs, regulatory bodies, PCI, Environmental scan participants, and other interested stakeholders  
  • Final report will also be posted on HSWRU and PCI websites          | February 2012   |
| Presentations                                                           | • Primary care event in Alberta (e.g., Forum, conference)                        | Ongoing         |
|                                                                         | • Presentations to other interested audiences (e.g., PCNs, AHS Professional Practice, Pan PCN groups, PCN physician leads)  
  • Web-based presentation with broad distribution of invitations       | March 2012       |
| Peer-reviewed article                                                   | • General audience focusing on primary care, nursing                             | Spring/summer 2012 |