

## Ontario's Primary Health Care NPs 2008 Update

Primary Health Care Nurse Practitioners (PHC NPs) are registered nurses (RNs) with advanced knowledge and decision-making skills and the legislated authority to perform an extended role. They offer comprehensive primary health care to individuals across the lifespan and practise in a variety of settings. The care they offer includes communicating a diagnosis, prescribing certain drugs, and ordering certain diagnostic and laboratory tests. Since 1998, PHC NPs have registered with the College of Nurses of Ontario as members of the Extended Class (RN[EC]).

The number of PHC NPs has been increasing steadily in Ontario. This publication reports findings from a survey of PHC NPs conducted in 2008. The survey is part of an annual (2006–2010) tracking study of NPs employed in the province. The results are based on 378 respondents, a sample representing 53% of all PHC NPs in Ontario in 2008.

Besides the core tracking questions about employment and practice characteristics, the 2008 survey asked about PHC NPs' relationships with their collaborative physicians and other health care professionals, barriers to their diagnostic and prescriptive authority, and their retirement plans.

### A Profile of PHC NPs

#### Who are they?

- 97% of the respondents were female.
- Their average age was 46 years, with the majority between 46 and 55 years of age (41%) and between 36 and 45 (31%).
- About 70% had an NP certificate from one of the ten universities in the Council of Ontario University Programs in Nursing (COUPN) or equivalent, and 22% had a master's degree in nursing.
- On average, respondents had worked as an RN for 17 years, as an RN[EC] for 6 years, and in their current position for 4 years.

#### Where are they?

- Survey respondents practised across all 14 Local Health Integration Networks (LHINs) in Ontario, with the largest number in the North East (54) and the smallest number in the Central West (fewer than 5).

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The interpretations and conclusions expressed here are those of the authors and no endorsement by the Ministry or the College is intended or should be inferred.

- Almost 40% of PHC NPs' practices were located outside large urban areas, whereas only 20% of Ontario's general population live there. 35% of respondents practised in communities with a population less than 25,000.
- About one third of respondents worked in multiple locations (on average, three locations per week), with most of these reporting an average travel time of 20 minutes or less between work locations.

### Employment status and remuneration

- 80% were employed full time, 15% worked part time, and about 3% were self-employed or had casual employment. Approximately 20% of the respondents' positions were unionized.
- More than 80% earned an income of over \$80,000. Most of the 7% earning less than \$60,000 worked part time.
- 72% of the PHC NPs earned a salary, while 26% were paid an hourly wage. More than 70% reported a salary increase in the last two years.
- More than half (55%) reported that the Ontario Ministry of Health and Long-Term Care (MOHLTC) funded their main NP position through their employer. A further 29% reported that MOHLTC funded their position directly.
- About 70% of survey respondents planned to stay in their current position for the next five years. They cited several positive aspects of their work, including excellent team work, work satisfaction, commitment to their clientele, and ability to work to the full scope of their practice.
- Three-quarters of the 27% who planned to leave their current position in the next five years said they would be seeking another PHC NP position. They hoped to move on to a more challenging job, a more supportive work environment, or a higher salary.
- Among the most valued employment incentives, PHC NPs listed higher salaries, financial support for continuing education and professional development, and better non-financial benefits, such as extended health plan.

### Work profile

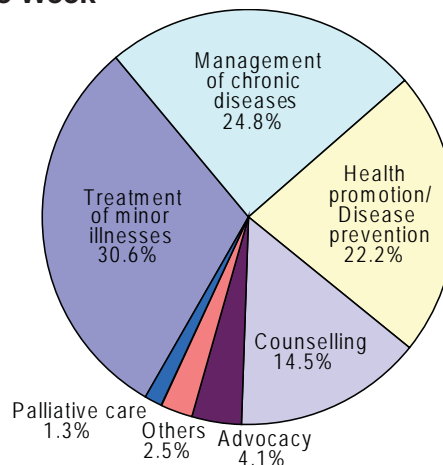
- The surveyed PHC NPs estimated they had on average 13 face-to-face appointments and four telephone consultations daily. Fewer than 5% provided online consultations. About 13% had on-call responsibilities and 43% provided home visits.

PHC NPs' Main Practice Settings by Percentage (n=378)	
Community health centre	30
Physician's office / Family practice unit	24
Family health team	13
Hospital – ambulatory care	6
Other community clinic	4
Public health unit	3
Long-term care home	3
Hospital – emergency department	3
NP clinic	3
Hospital – inpatient care	3
Aboriginal health access centre	2
Nursing station / Outpost nursing clinic	2
Other	6

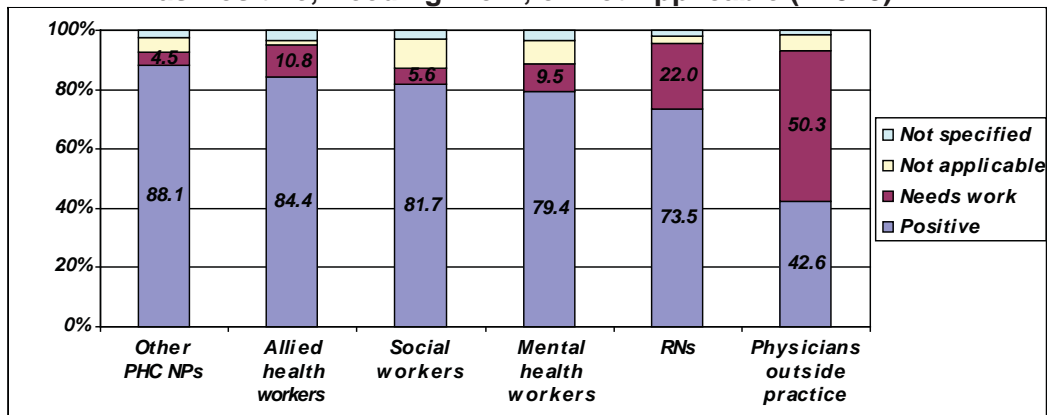
Percentages do not add up to 100 due to rounding.

- The most often mentioned client group was the “typical” family practice clientele (74%), followed by low income earners (62%), the unemployed (50%), and substance/drug abusers (46%).
- The average clientele consisted of adults (43%), seniors (25%), infants and children (16%), and adolescents (14%). Three-quarters of the respondents had clients from all four age groups.
- Over a typical month, PHC NPs spent on average 77% of their work time on direct patient care. The rest of their time was spent on teaching (6%), non-nursing tasks (6%), nursing administration (5%), research (2%), and other tasks (3%).

### Time Spent on Direct Care Activities During an Average Week



## Percentage of PHC NPs Who Rated Their Relationships with Various Health Care Providers as Positive, Needing Work, or Not Applicable (n=378)



### Relationships with Other Health Care Professionals

Almost a quarter (23%) of the PHC NPs' clients came directly to the NP without a referral. Others were referred by family physicians (29%), RNs (12%) and other health care providers.

When clients' health care needs required care beyond PHC NPs' scope of practice, NPs collaborated with family physicians or referred clients to other health care providers. On average, the surveyed PHC NPs provided care for 80% of their clients with little or no physician consultation. The other 20% consulted with an average of about four physicians each. Most (87%) spent less than two hours per week consulting with their main collaborating physician. They typically felt that they had sufficient consultation time.

More than 75% reported high or total satisfaction with the relationship with their main collaborating physician. Most agreed that the physician with whom they worked most often understood the NP role (87%), that the physician supported them to work to their full scope of practice (93%), and that collaborative relationships had improved with time (92%). PHC NPs estimated that they made on average 9 referrals during a typical week (numbers ranged from 0 to 50).

Fewer than 5% of respondents reported refusal of their referrals of clients to family physicians, social and mental health workers, and allied health workers. However, more than half (56%) said their referrals to specialists were not accepted by the specialists; they were sometimes accepted only if co-signed by the collaborating physician. About half said that their relationships with specialists "need work." As well, 20% thought that relationships with RNs required improvement. Many felt that the PHC NP role and scope of practice were generally poorly understood by other health care providers.

Asked to choose among strategies to improve interprofessional relationships, 31% of the PHC NPs selected "enable RN[EC]s to work autonomously/to full scope of practice" and 29% chose "increase mutual respect, trust and communication between members of different professions." Respondents added suggestions, including: reduce legislative barriers, promote the NP role within the health community and increase public awareness, increase multi-disciplinary education and interaction, encourage interdisciplinary team building, and pay specialists the same fees for referrals from NPs as for those from physicians.

### Prescribing and Diagnosing

PHC NPs are legislated to prescribe only those drugs, diagnostic tests or laboratory tests that are on one of three provincially regulated lists. Respondents estimated that on average they could not order about a third of drugs (e.g. warfarin, antidepressants, ventolin) and about a quarter of diagnostic and lab tests (e.g. some X-rays, bone mineral density tests, ultrasounds, PSAs) that they judged their patients needed. In these cases, they had to seek the signature of their collaborating physician.

Many respondents described how the current legislation caused challenges and frustrations in their day-to-day practice. The drug list was described as "very limiting" and "inconsistent." One third of those who commented said that the current drug list prevented them from practising to their full scope. Others said that waiting for a physician's signature was time-consuming and inefficient, or that it took too long for new drugs to be added to the list, thus preventing NPs from meeting current best practice standards. Some expressed frustration caused by limits on initiating, renewing, or adjusting dosages of medications commonly used to treat chronic conditions.

Similar comments were made about the restrictions on diagnostic and laboratory tests, and how they limited PHC NPs' scope of practice and autonomy and created inefficient care.

Although collaboration with physicians and medical directives were helpful in dealing with challenges around prescriptive and diagnostic authority, many thought those were only partial solutions. More profound legislative changes were deemed necessary.

- ▶ *[My job is] "wonderful, fulfilling, challenging."*
- ▶ *[I hope our role] "continues to progress and develop."*
- ▶ *"Tremendous energy is being spent on fighting the barriers."*
- ▶ *"Family Health Teams are a great concept for primary care delivery, but a big barrier is the incentives bonus the MDs receive for the work the PHC NPs do. This payment model is not constructive for team building."*
- ▶ *"What I do is appreciated and extremely needed or my patients would be without health care, but the present restriction of prescribing and ordering of diagnostics tests is beyond frustrating."*
- ▶ *"Amongst five full-time NPs we manage the care of 8,000 patients who are orphaned. If recognition of the real scope of practice we experience [in the North] could be realized, it would be much better for client care."*

## Retirement Plans

Only six PHC NPs among those who responded to the survey planned to retire within a year at the time of the survey. On average, PHC NPs wanted to retire at age 60 but expected to retire at 62. Younger PHC NPs were more likely to want and expect to retire at a younger age than older PHC NPs.

About half of the surveyed PHC NPs would delay retirement for five or six years if such incentives as increased salary or flexibility in work arrangements or part-time work were available. About 40% said their spouse's retirement plans would affect their own: some would retire at the same time as their spouse, others would stay on for financial reasons.

## Concluding Notes

- Many of Ontario's PHC NPs work in towns and small cities. They work in a variety of settings, some of which are new (e.g. NP-led clinics).
- Among the challenges for PHC NPs are barriers to practice to a full scope and a lack of familiarity with NP practice among other health care providers.
- There is a need to examine the variety of models of NP practice, of their implications for practice organization, and ultimately their impact on health outcomes.

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For further information, please contact:  
**Centre for Rural and Northern Health Research**  
Laurentian University  
Ramsey Lake Road  
Sudbury, Ontario, Canada P3E 2C6

phone: 705-675-1151 ext. 4357  
fax: 705-675-4855  
e-mail: [cranhr@laurentian.ca](mailto:cranhr@laurentian.ca)  
URL: [www.cranhr.ca](http://www.cranhr.ca)