Appendix B Canadian literature

Author, Year, Province	Background	Objective	Study design/limitations	Findings	Conclusions
Andrusyszyn, Mary Anne, van Soeren, Mary, Laschinger Spence, Heather, Goldenberg, Dolly, DiCenso, Alba, "Evaluation of Distance Education Delivery Methods for a Primary Care NP Program", Journal of Distance Education, 1999, 14(1). Ontario	Primary Care NP programs have been operating in the US since 1965, but until recently, none existed in Canada. Note: similar to Journal of Advanced Nursing, 2000, 32(4).	Evaluation of the educational delivery methods employed in the first two years of the Primary Care NP program.	Professors, graduates and tutors participated. Questionnaires were distributed in 1996 and 1997, and focus group interviews were conducted evaluating: perceived satisfaction, changes in comfort with technology, technological support, interaction and development of relationships, development of a learning community and the ability to express opinions. Quantitative responses and qualitative responses were collected.	Multiple delivery methods were well received. Face-to-face most satisfying. Greatest comfort increase was with computer-conferencing. Orientation to all technologies before program is essential. For professors in the second year all methods of delivery met requirements except for video teleconferencing. Tutors measured face to face method most positively.	Strengths include: response rate and collection of quantitative and qualitative data. Limitations include: responses from group could be from highly motivated learners are biased in a positive direction. Multiple distance education delivery methods that combined traditional and non-traditional methods were used effectively in the Primary Care NP program.
Batchelor, G., Spitzer, W., Comley, A., Anderson, G., "NPs in primary care IV, Impact and attitudes of an interdisciplinary team on attitudes of a rural population", CMAJ, 1975, 112. Ontario	The Smithville-McMaster family clinic, which employs NPs, was established in 1971 in response to community initiative.	Report the changes in attitudes towards the expanding role of family NPs from 1971 and 1973 and the differences in 1973 of who chose the clinic as their source of health care and those who used other sources of health service. Report the way in which the introduction of interdisciplinary clinic affected attitudes towards acceptance,	Data was collected through questionnaires in respondents' homes using the same procedures in 1971 and 1973. In 1971, 1501 participants were interviewed, and in 1973 1132 were re-interviewed. These participants use either the family medical clinic or other arrangements referred to as the township respondents. In 1973 interviews were collected for a second	Of the 1707 participants interviewed, (1132 from sample A and 575 sample B) 29% had self-selected to obtain health services through the family medical clinic. Patients at the family clinic increased their dependence on doctors. Family clinic patients were more likely to indicate a nurse as their second choice even though most prefer to visit a doctor when they have a worry-inducing situation. Two years with the clinic did not greatly alter the view of township residents about the appropriateness of the nurses' role in home visits. The family clinic made health care more accessible and convenient to the residents.	Most consumers of care accept NPs in primary care as co-practitioners to family physicians in interdisciplinary practice.

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		accessibility and convenience of health services in the community.	probability from 600 respondents of which 575 were completed. The samples from A and B involved stratification by town and rural place of residence.		
Caty, Suzanne, Michel, Isabelle, Pong, R., Stewart, Dianne, "A profile of the 2001 cohort of applicants to the Ontario primary health care NP education program", Centre for Rural and Northern Health Research, December 2001, (unpublished). Ontario	The NP education program is funded by the MOHLTC and was funded for four years and in 1999 the funding was extended for an additional four years.	Examine the characteristics of the applicants, students, and graduates of the NP education program including how they view the program, identify factors that influence their practice locations and to examine their career plans and practice profiles. As well as monitor and analyze the NP human resources trends and issues.	Data were used from 2 sources: the standard application form of the Ontario Universities' Application Centre and data from an admission assessment process developed by COUPN as well as the review of the applicant's personal essay.	In 2001, 219 applied to the NP program. 97.7% of the applicants chose the NP program as their first choice showing commitment to NP studies. 82.2 applied to Northern universities and 17.8% applied to Northern universities. 18% of the applicants were from outside of Ontario. The mean age was 37 and 87.7% had attended university. 195 applicants were reviewed and 10 were Master's prepared, 4 reported to be aboriginal and 23 were from outside the province. 138 of the applicants were retained for the third step of the process and 81.2% were admitted. Of those 75% had a university degree and 25% had a college degree.	Very few differences have been identified with the applications over the years. Research team feels that the applicant component of the NP multi-year tracking study be eliminated because of the similarities in applications over the years. The number of applicants has increased by 22% in 1999 and 45% in 2000.
Caty, Suzanne, Michel, Isabelle, Pong, R., Stewart, Dianne, "The 1996-1997 cohort of graduates of the transition phase of the NP education program: their views and career activities", Centre for Rural and Northern Health Research, July 2000,	A transition phase was developed for nurses in Ontario practicing unofficially as NPs. This is the third report in a series. The first report was an exit survey and the second report was a follow-up survey.	Examine the characteristics of the applicants, students, and graduates of the NP education program including how they view the program, identify factors that influence their practice locations and to examine their career plans and practice	Follow-up questionnaire consisting of 15 questions graduates were requested to complete. Survey was sent in February 2000 and of the 40 graduates 26 returned it. Open-ended questions were analyzed by identifying themes.	80% of the graduates would still become a NP if they could start all over again. Graduates felt the program adequately prepared them for practice. 54% felt that the educational level should be a master's. 46% felt job prospects were good; however 46% felt they were bad. Table 2 shows views on issues pertaining to NP practice. Mean of 6.58 of 7 felt that NPs are not mini-doctors and 6.56 felt that their title should be protected. 96.2% were registered in the 'extended	The government has announced new NP positions that are being funded regionally in rural and urban communities that should increase accessibility to primary health care and NP services.

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(unpublished). Ontario		profiles. As well as monitor and analyze the NP human resources trends and issues.		class' with the College of Nurses and all belong to at least one nursing affiliation. 88.5% of the graduates were working as NPs at the time of the survey. 69.2% practiced in Southern Ontario and only 23.1% worked in Northern Ontario. Table 5 shows factors influencing practice location including the most influential; availability of NP employment and the opportunity to practice with other health professionals in a collaborative model. 50% practice in CHCs. Graduates earned on average $61,739 and ranged from $35,000 to $70,000. 96.2% report collaborating with a physician and 75% with other professionals as well. Table 11 shows the frequency of select activities. A mean 6.58 of a total of 7 indicates that the most frequent activity is to assess, diagnose, and monitor health status. 73.1% had been preceptors for NP students. Difficulties seen in Table 12 include; uncertainty of provincial government support for the NP role and coping with a rapidly changing health care system.	
Caty, Suzanne, Michel, Isabelle, Pong, R., Stewart, Dianne, "The 2000 cohort of graduates of the transition phase of the NP education program: their experiences, views and career plans", Centre for Rural and Northern Health Research,	In 1995, the Council of Ontario Programs in Nursing (COUPN) began offering a NP program.	Examine the characteristics of the applicants, students, and graduates of the NP education program including how they view the program, identify factors that influence their practice locations and to examine	Exit questionnaire to 2000 NP graduates. Minor changes were made from the 1997 exit questionnaire. 43 of the 51 graduates completed the questionnaire. Open-ended questions were analyzed by identifying themes.	A mean 4.57 of 7 shows that NP education program adequately prepared students for the challenges of NP practice. Most felt that the integrative practicum met expectations and adequately prepared them for NP practice. The most common practicum settings were CHCs (28) and in physicians practices (25). Means of the difficulties experienced while studying in the NP program shown in Table 6 include; maintaining	The primary care education program is well established and the employment situation of graduates has improved. However public policies to maximize the employment of NPs have been slower and needs to continue.

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May 2001, (unpublished). Ontario		their career plans and practice profiles. As well as monitor and analyze the NP human resources trends and issues.		employment while studying (5.41), and family obligations (5.4) of a total 7. Educational difficulties experienced in Table 7 include the means of adjusting to the demands of being a NP student (4.37) and isolation from other students (3.7). Most receive support from other NP students or partners. Opinions on the Canadian Health Care system include; Canadians should have the best possible health care whether they can afford it or not and the five principles of the present Canadian health care system should be maintained in Table 9. Opinions on NP practice in Table 10 show that the highest means are NP's title should be protected (6.74) and NPs are not mini-doctors (6.67). 25.6% were interested in education and 22.5% in research.58% felt the job prospects were good to very good and 34.9% felt they were poor. Job search strategies of graduates working as NPs included mostly using contacts from networking and from integrative practicum. 31.6% were working in a Northern location and 57.9% in Southern Ontario. Table 17 shows the factors influencing practice location include; opportunity to practice with other health professionals within a collaborative model with a mean 6.18 of a total 7 and availability of physician back-up 5.84. Graduates reported a gross income ranging from $45,000 to $75,000 and a mean of $65,033. 68.4% were on salary and 31.6% on an hourly wage. 52.6% were practicing in CHCs.	
Chenoy, N., Spitzer, W.,	The introduction of NPs to under serviced areas of	What is the level of acceptance of a	Qualitative in which questionnaires were	Physician/population ratio was 1:8300; 10 times lower than the ratio for Ontario	1. Adults responded positively to having a

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Anderson, G., "NPs in primary care II. Prior attitudes of a rural population", Canadian Medical Association Journal, 1973, 108. Ontario	Ontario could be one solution to filling gaps in health care.	nurse as a provider of health maintenance care and sickness surveillance; of a nurse as a provider of health care in worry-inducing situations, of a specialty trained nurse as a team member who functions with clinical supervision by a physician and who renders care at home?	distributed randomly to 400 dwelling and administered by interviewers to 1616 people who lived in the dwellings. Questions concerned attitudes towards the care they were receiving and perceptions of nurses' role in the provision of care.	or Canada. Over 80% of the respondents considered it acceptable to see a nurse if a doctor was unavailable; to receive advice from a nurse regarding medication, to seek advice from a nurse in addition to the doctor and to have a nurse readily available to answer their questions on the telephone. Majority were prepared to pay additional fees over their present health insurance premiums. For a minor headache, about 50% of the respondents felt they could manage with out a provider, 40% would choose a doctor. Less than 2% preferred the nurse regardless of the problem. 85% gave a positive assessment of the concept of specialty-trained nurses working under the clinical supervision of doctors to make home visits.	specialty-trained nurse provide care in health maintenance and sickness surveillance. 2. In 'serious' situations, the doctor was their professional choice. 3. Respondents were in favour of nurses working with a physician as a team.
Dunn, Earl, Higgins, Chris, "Health Problems encountered by 3 levels of providers in a remote setting", American Journal of Public Health, 1986, 76(2). Ontario	None of the communities are large enough to support a physician. 7 communities have a nursing station with 2 to 5 NPs. Physicians visit station 1 or 2 times a month.	Contrast the diagnoses and managements of physicians, NPs and indigenous health aides in a remote setting.	3-year period of analysis in Sioux Lookout Health Zone from 1978-1980. Quantitative approach: 139,618 patients encounters that were coded.	90% of healthcare in area provided by non-physician. Minimally trained practitioners made more signs and symptoms diagnoses and asked for help more frequently. Nurses did much of the preventative measures and made more diagnoses in the supplementary diagnostic class. Physicians diagnosed medically sophisticated conditions more frequently and order investigations.	Health service planners that must use less qualified personnel should concentrate on assisting practitioners to deal with undifferentiated illnesses and in handling the acute problems they diagnose. Unique to health care in Northwestern Ontario.
Goss Gilroy Management Consultants Inc, "Report on the evaluation of implementation of the role of NP-primary health care	Newfoundland and Labrador introduced the NP in a primary health care role in 1997.	Evaluate the implementation of the role, examine the extent to which NP's have integrated into the health and community system,	Survey of NPs from the first 2 classes, selected managers, health professionals and physicians. Key informant interviews with provincial level	Role implementation: • Began during a time when the recruitment and retention of physicians in rural areas was difficult. • Interest in health care reform that focused on collaborative models involving	Impact on service providers: • Decrease the workload of physicians but not for other providers. • Increase in complexity of physician work resulting in slight dissatisfaction. Impact on services:

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in Newfoundland and Labrador", 2001, (unpublished). Newfoundland		examine the impact of the NP role in the health and community system, and identify plans for future deployment of the NP.	organizers involved in the development. Collection of data on the services, workload, and activity patterns for each NP over a 1-week period. Literature review.	multidisciplinary health providers. Regional level factors affecting role: • Central direction; availability and usefulness of information provided to boards. • Management involvement; degree of local involvement in setting direction and priorities. • Strategies for NPs; extent that NPs took initiative to establish role and determine services. Role integration: • Collaboration viewed as highly effective as rated in surveys. • Reasons for less collaboration occur because of the unavailability of physicians and because the majority of the tasks for some NPs are within their scope of practice. • Role is less understood than accepted. Facilitators of implementation: • Legislation and regulatory framework legitimized role. • Funding a catalyst for health boards. • Work done by provincial health organizations resolved questions and issues. • Some physicians and site managers have actively helped define the NP role in their practice, and developed their skills. • The leadership of NPs in implementing their role and negotiating their practice. Constraints to implementation: • Lack of common understanding of the role	• No systematic collection of data by NPs to evaluate the impacts of services and this is needed. Recommendations: Leadership: • Develop an interest with senior management of governments with the NP role by reviewing this report and developing an action plan. • Develop guidance to assist regional boards in understanding the NP role, planning for new NP positions, and managing aspects of the role implementation. Understanding of the role: • Develop opportunities to discuss the future role integration of NPs at forums of regional boards and health organizations. Policy: • Require policy in the following areas: expectations for collaborative practice, legal liability for collaborative physicians and revisions to the diagnostic and prescriptive authorities of NPs. Human resources: • Prepare for the future development and employment of NPs. Funding: • Continue to seek remuneration approaches for primary care.

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				among providers. • Lack of acceptance of the role by physicians. • Lack of clarity in the relationships surrounding collaborative practice. • Lack of general primary health care plan. • Systematic issues including fee-for-service payment, and other payment policies.	
Grand, Kathryn, "Integrating the services of the NP in the inner city", Final Project Report, Grandeur Health Consulting Limited, 2000, (unpublished). Alberta	In 1998, data showed that 800 people were being turned away from Calgary Urban Project Society's health clinic due to funding constraints that reduced the health care services.	Examine the development of a collaborative primary care model that can increase access to quality health care by the poor and homeless, and demonstrate the relevancy and influence of a NP seen as a care provider between traditional nursing and medical roles.	Integrate a NP into the staff mix and describe and analyze the process, challenges and outcomes related to the integration of a NP into a collaborative model in one case study. 5 phases of design: • 10 'target conditions' were selected to monitor through the period of the project representing frequent patient problems. • Monitor degree of adherence to guidelines by different providers. • Completion of Encounter Form by participating	NP role can promote the development of trusting, collegial, and collaborative primary health care team. Role increases the collaborative team's ability to provide a coordinated, multi-level and cost effective approach to health care delivery. In the community setting, the NP fills the gaps between the medical and nursing roles and improves the quality of care of each role. NP offers access to an advanced level of care not available to inner city populations. High client satisfaction.	Future research needs to add to the findings to build supportive measures for full implementation of the role and affect legislative change that will allow a NP to practice in any under served community in Alberta.

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			patients during each of the 3 data collection periods. • Conduct survey of patients concerning information about ease of access, satisfaction with service, and perceived health status. • Interviews with providers about their observations, reflections and perceptions of the changes in clinical decision-making.		
Haines, Judith, "The NP", 1993, Discussion Paper, Canadian Nurses Association, (unpublished). National	Historical overview begins in 1965, the year the first NP program was implemented, and ends in the 1980s, when the NP program was cancelled all across Canada.	Historical overview and discussion of recent developments to the NP including the role, cost-effectiveness and the effort by the NPs' Association of Ontario to re-establish training programs.	Interviews with key informants and literature review.	Major issue concerning NPs is the confusion, which surrounds the term NP. Mix of enthusiastic support for, openness to and negative attitudes towards the renewed interest with NPs. Concerns surround the government's need for a quick fix, which could result in quick fix NP programs. Different opinions surround the level of preparation that would be appropriate and practical. Must define scope of NP practice so only those within the scope can call	Need to clarify the meaning of "NP" and "expanded" to discuss the future of the role.

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				themselves NPs. The implementation of the NP role in the 1960s was due to an undersupply of physicians; however now there is an oversupply. Focus on the need to move resources from institutions to communities.	
Hanrahan, Colleen, Way, Christine, Housser, John, Applin, Madge, "The nature of the extended/expanded nursing role in Canada", Consultants: Centre for Nursing Studies and the Institute for the Advancement of Public Policy, Final Report, March 30, 2001, (unpublished). Ontario, Saskatchewan and Newfoundland	In March 1999 the federal/provincial/territorial Advisory Committee on Health Human Resources Working Group on Nursing and Unregulated Workers sponsored a study to discuss the nature of the extended/expanded-nursing role in Canada.	Identify facilitators of and barriers to the effective delivery of primary care services by registered nurses working in extended/expanded roles and to recommend policy options that would facilitate more effective utilization of registered nurses working in NP roles.	Establish terms and definitions for he project. Contact representatives from nursing associations and ministries to develop a profile policy and legislative/regulatory framework. Conduct survey of key informants at sites within each province to construct a profile of organizational structures. Collect data at selected sites to measure physicians and RNs perceptions of EC nursing roles, to describe the experiences of nurses in the role and measure patient satisfaction with the services delivered by the EC nurse.	EC nursing role has evolved without a consistent policy direction and is highly dependent upon the circumstances present in the jurisdiction. Several titles are used across Canada from NP to regional nurse. Scope of practice is very consistent across primary care settings. Inconsistencies regarding the educational preparation for RNs for the EC role. Profile of extended/expanded nursing practice: content relates to different models of practice, lines of authority and quality of care initiatives and evaluation mechanisms for assessing organizational and client outcomes in different jurisdictions. Physicians and nurses had apprehensions about the adequacy of knowledge levels and practical skills of EC nurses when they first start the job. Role confusion by patients was a concern of physicians and nurses. Benefits and barriers perceived by physicians and nurses are identified individually. Observational findings show that EC nurses in all primary settings are involved in autonomous practice and perform a broad range of activities with a high degree of confidence.	Recommendations: • Introduce legislation to legitimize the EC role of the RN and facilitate access to resources within the health care system. • All relevant legislation be amended to facilitate access to necessary resources. • Develop core competencies and practice standards for EC RNs. • Support EC nurses with continuing education for the primary care aspect. • Nursing associations and stakeholders adopt consistent language and definitions. • Collaborative practice between physicians and EC nurses be the norm for all practice settings. • Mechanisms be instituted in all jurisdictions to ensure monitoring of quality and comprehensiveness or primary health services. • Establish alternative funding methods for physicians so they will be compensated for working with an EC nurse.
Irvine, Diane,	Health care outcomes can	Illustrate the use of	Description and review	The quality of nurses' independent role	The nursing role effectiveness model

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Sidani, Souraya, Hall, Linda, "Finding value in nursing care: a framework for quality improvement and clinical evaluation", Nursing Economics, 1998, 16(3). Ontario	be improved and reductions in system waste can occur when evidence-based practice guidelines, continuous quality improvement, and outcomes monitoring.	the nursing role effectiveness model in quality improvement and evaluation research activities.	of literature.	functioning can be assessed by collecting data including the: • Timeliness • Appropriateness • Accuracy • Completeness of assessment • Nursing diagnosis • Nursing interventions • Follow-up care Measuring the value of nursing care: • Clinical outcomes • Functional health outcomes • Satisfaction outcomes • Cost outcomes	can result in the development of a conceptual framework for studies evaluating new nursing roles.
Jones, Linda, Way Daniel, "Is there room for both NPs and MDs in a CHC". Visions and Voices- The NP Today, 102-118, 1997. Ontario	Southeast Centre for a Healthy Community serves an at risk population of 70,000.	Describe the NP-physician dyad, outline a model of collaborative partnerships, describe the effects of the NP project on the collaborative model and NP role, and the medical response to the project.	Case study description.	Physician-NP dyad guidelines: • Both providers recognize one another's situation and respect efforts to integrate that within responsible patient care. • Providers should have respect for each other's profession. • Mutuality of concern will result in moral autonomy to the other. Definitions within model: • Primary health care is the care received by the patient at first contact to prevent or solve a health-related problem. • NP is a specialist in primary care with advanced nursing knowledge, emphasizing patient centred, holistic care, health promotion, and disease prevention. • Family physician is the medical specialist, who has a distinct body of knowledge appropriate to the needs of diverse patients.	

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				• Client is the focus of primary health care activities. Model of collaborative partnerships: • Area of overlap equals the area of shared care. • Size of the area is dependent on: the knowledge and skills of the providers; the client characteristics, needs and wishes; and the work setting and its policies. Model under current legislation: • Under the previous Health Disciplines Act and the current Regulated Health Professions Act of December 1993, the NP role was dependent on medical delegation. Response to legislation: • Develop practice guidelines together, which resulted in the development of an algorithm was developed to assess what problems would need guidelines. Medical response to NP project: • Physicians feel threatened by NPs, and opposed changes to the regulatory scope of practice. Arguments against NPs: • Independent NPs will be more expensive to the system by duplicating services, and will not make the proper referrals causing higher costs to the system. • Findings that support the use of NPs are flawed because they are mostly American, the Canadian results are old, cost-effectiveness is not	

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				demonstrated in the literature, and a bias in age and sex of the NPs and physicians in the studies.	
Lees, R., "Physician time-saving by employment of expanded-role nurses in family practice", CMAJ, 1973, 108. Ontario	Studies indicate that patients are willing to accept the nurse in family practice having an extended role and more responsibility.	Quantify changes in the workloads of physicians and nurses in 5 medical practices, after the nurses took on an extended role.	Baseline data was collected and then the nurses were given on the job training and went to lectures at Queen's University. Measures include number of patients seen, time of contact, phone calls, performed lab tests, and patient logs. Two 10-day observation periods took place one year apart.	Generally office hours decreased and patient volume increased. The nurse saw fewer patients after the training and the physicians saw more patients. The contact times with patient decreased for all 5 practices.	All the physicians did achieve some measure of saved time varying from practice to practice.
MacDonald, Jane, Katz, Alan, "Physician's perceptions of NPs", Canadian Nurse, 2002, 98(7). Manitoba	In American and British studies, overall physicians were supportive of the NP role.	Aim to collect data about the physcains' knowledge and ideas about working with NPs.	Three focus group discussions were conducted with 8 resident physicians and 3 faculty physicians at Manitoba family residence training clinic.	Residents: • NP role is for filling gaps in areas where physcians are scarce (rural) • View scope as assessments, diagnosis, treatment and dispensing medications • NP role restricted to Northern remote areas and the need for standards and testing • Clarification of their liability concerns and ensure NPs practice within their scope Faculty physicians: • Complementary to physicians • Prevetative health, counselling, education • Any setting guided by the environment and capabilities of the NP and ready to work equally with NPs Both saw increased time with patient as an asset of the NP role.	

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				Sharing of ideas and seeing a different care philosophy would be positive.	
Mitchell, Alba, Blatz, Watts John, Susan, Guyatt, Gordon, et al., "Evaluation of graduating neonatal NPs", Pediatrics, 1991, 88(4). Ontario	The increased survival rate for low-weight infants and the shortage of physicians in the neonatal intensive care unit has created a gap that can be filled by neonatal NPs (NNPs).	Compare graduating NNPs with pediatric residents in terms of knowledge and problem solving, communication, and clinical skills to determine whether NNPs function at the level of alternative caregivers.	Graduating classes of 1987, 1988, and 1989 took part in the study. Knowledge was measured by multiple-choice questions. Problem-solving skills were measured by a semi structured oral exam. Communication skills were measured by case studies. The Objective Structured Clinical Examination measured clinical evaluation.	The oral examiner correctly identified 64% of the participant's background in 1987, 64% in 1988, and 46% in 1989. Observers that were rating communication skills correctly identified the participant's background 71% of the time in 1987, 60% in 1988, and 44% in 1989. The Clinical Exam observers correctly identified the participant's background 83% of the time in 1988 and 73% in 1989. In 1988, NNPs scored significantly higher than residents in clinical skills; however the skills were insignificant in 1989.	Findings suggest that NNPs can e used as an effective alternative to pediatric residents in the neonatal intensive care unit. Small sample size limits generalizability.
Mitchell, Alba, Watts, John, Whyte, Robin, et al., "Evaluation of educational program to prepare neonatal NPs", Journal of Nursing Education, 1995, 34(6). Ontario	To prepare nurses for the new NNP role, a neonatal stream was incorporated into the existing MHSc program at McMaster University.	Compare first year NNP students to graduating NNPs in terms of knowledge, problem solving and communication skills.	November of 1987, 1988, and 1989 with all 8 and 10 graduating students were involved in the tests. Tests were changed each year to avoid graduating students with having an advantage. Knowledge: Multiple-choice questions and radiographs. Problem solving: Oral examination. Communication: Scenarios with pseudo parents.	Graduating NNPs scored significantly higher on radiograph test and oral examination but not in the multiple-choice or communication skills. The 7 who participated as first years and graduates confirmed statistical significance in radiographs but not in oral examination.	Small sample size limits the precision of the study findings. However could be useful as a program evaluation model because it uses a combination of reliable methods.
Mitchell-DiCenso, A., Guayatt, G., Marrin, M., Goeree, R., Willan, A., Southwell. D., Hewson, S., Paes, B., Rosenbaum, P.,	Randomized controlled trial, which compared a clinical nurse specialist/neonatal practitioner team with a paediatric resident team in the delivery of neonatal	Comparison of care delivered between the two groups included. Measures compared included	Study period covered one year; 1991-1992; during that year admissions to the unit were randomized to one of the two teams; measures compared	In-Hospital mortality was similar; the proportion of infants in each group with complications was similar; ALOS was greater but not significantly different in the NP group; for 7 indicator conditions reviewed to assess process of care; NP group did better in 3, neonatologist	Care provided by both NP team and neonatologist teams are similar in all respects. The results have application as a method of dealing with HR shortages.

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Hunsberger, M., Baumann, A., "A Controlled Trial of Nurse Practitioners in Neonatal Intensive Care", Paediatrics, 1996, 98. Ontario	intensive care.	outcome measures, quality of care, patient satisfaction, and long term outcomes.	included: • Outcome measures (mortality number of complications, LOS, quality of care) • Satisfaction using a survey • Long Term Outcomes using a survey • Costs	group were better in 2 and there was no difference in 2. There was no difference in satisfaction; LOS was slightly higher for the NP group; slightly more tests ordered by the resident group and more procedures done; overall average health care costs were similar.	
Mitchell, Alba, Pinelli, Janet, Patteron, Chris, Southwell, Doris, "Utilization of NPs in Ontario", Discussion Paper, McMaster University, School of Nursing, (unpublished). Ontario	In February 1993, the Health Human Resources Planning Branch of the Ontario Ministry of Health asked this group to prepare a discussion paper about utilization of NPs in Ontario.	Discuss and define role of NPs. Review literature evaluating the effectiveness of NPs. Outline their history and current status in Ontario. Discuss reasons for promoting NPs at this time. Make recommendations regarding the implementation issues.	Literature review including documents by the federal and provincial governments; and published material. Interviews with 'key informants' and stakeholders, including 25 directors of public nursing.	Health care reform by the government proposes to find better ways to manage the health care system, invest more in community-based programs, redress inequities of system, and take a leadership role in preserving health care. Model to introduce NPs into health care setting where they were unsuccessful before: • Establish steering committee that represent all the stakeholders • Identify the settings in which there is a need for NPs; define the role • Identify and address potential barriers to implementing the role • Legitimize the role; determine the ideal number and mix of NPs, and other health care professionals • Define the educational required for the role • Develop performance indicators to allow for ongoing assessment. Regulated Health Professions Act builds	Recommendations: • NPs should be more utilized in primary care settings. • Public health nurses are ideal professional to receive the additional training to function as NPs. • NPs should be introduced to mental health, gerontology, LTC, oncology, cardiac care, and pediatrics. • Standards of practice should be developed. • MofH should establish a committee to provide overall coordination and funding to steering committee in the application of the model. • Setting-specific performance indicators should be developed and utilized for on-going assessment of quality of care by NPs. • All options for payment

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				an environment in which the scope of practice is more flexible than restrictive allowing NPs to have collaborative or independent functions. In the short-term NPs should work in the primary care settings that have salary or adequate reimbursement, underserviced areas and in the care of the disadvantaged and then expand to other settings. Other settings where NPs should be introduced were determined by the following factors: resident cutbacks, physician shortage, increased demands for service, and consistency with priorities of the health care reform agenda. Educational short-term goals include educating new NPs and training current NPs and the long-term goal is to have the title reserved for master's graduates.	models should be reviewed. • NPs should be viewed as equal partners in the system. • Scope of practice should include nursing and medicine. • College of Nurses of Ontario should negotiate with the regulatory bodies to ensure autonomy within the NP scope. • Ensure the protection of the NP title. • All NPs should be prepared at the graduate level. • Time-limited programs need to be developed to accommodate the needs of nurse with different levels of education. • Educate the public on the use of the services. • Future research should include determinants of health, evaluation of interventions and determination of appropriate mix of health personnel. • Implementation of NP role must avoid underutilization due to physician surplus and financial disincentives.
Newbery, Peter, et al., "Primary care and family medicine in Canada a prescription for renewal", The	Primary care services provided by family doctors and nurses significantly contribute to the quality of and cost-effectiveness of the healthcare system.	Describe the strategies and make recommendations involved in creating and sustaining the 'family practice	Propose strategies and makes recommendations to creating and sustaining the model.	Creating the model: Benefits: • Builds on strengths. • Improves patient access. • Ensures comprehensiveness and continuity of care. • Provides cost-efficiencies.	Creating the model recommendations: • All Canadians have a FP of their choice. • Providers should be encouraged to join family practice networks.

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College of Family Physicians of Canada, October 2000, (unpublished). National		network'.		• Enhances quality of care and facilitates integration of health care professionals. • Enables optimal use of health information and communications technology. • Supports rural and remote communities. • Meets both professional and personal needs of family physicians and other healthcare providers. Sustaining model: Commitment to: • Human resources needed to provide the services. • Training of future providers. • Research required evaluating outcomes. • Remuneration and funding strategies needed to support all parts of the system. • Collaboration and communications amount all key players will be essential.	• Establish interdisciplinary teams. • Model should serve all Canadians at point of entry for primary care. • Provide comprehensive continuing care throughout patient's lives. • Respond to patient's needs within each providers scope at all times. • No financial penalty for any of the parties if patients access primary care outside their network. • Discourage freestanding walk-in-clinics, unaffiliated with networks. • Direct government funding should be a remuneration option. • Government funding should increase for technology for the networks. • FPs are custodians of patient records and the records should move with the patient. • Formal patient registration should be an option for practices. Recommendation for sustaining the model: • Expansion of medical school enrolment. • Increase in residency positions. • Increases in other necessary programs. • CFPC should maintain clear set of core

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					knowledge and skills that are part of the curriculum. • CFPC should have accreditation standards for training programs. • Award of CCFP includes physician's competence. • Training opportunities for 'added skills'. • Programs should offer rural based training. • Integrated education and training programs should be supported. • Commitment to ongoing research. • Adequate funding for education. • FPs compensated for all the services they provide. • FPs remunerated by what responds to their needs. • Nurses need to be remunerated. • Define 'medically necessary services' and ensure they are provided. • Government must ensure all necessary services are publicly funded and ensure quality of private sector. • Conduct studies that measure impact on patient care. • Develop strategies to ensure accountability. • Ongoing collaboration.
Patterson, C., Haddad, B., "The advanced NP: common	The meaning of advanced practice in nursing is unclear and results in confusion within the	Examine the nursing literature to determine the meaning of	Literature review and analysis.	NPs are responsible for many indirect services, acting as consultants, educators and researchers. Flexibility is a vital characteristic of the	Advanced NPs have vision and flexibility. Research is an integral component due to advanced NPs quest for

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attributes", Canadian Journal of Nursing Administration", 1992. Ontario	occupation.	advanced practice. Discuss and compare the various roles for advanced NPs. Identify and explore some of the attributes and behaviours that characterize all advanced practitioners.		advanced NP role if goal of advanced NP is to develop and explore new avenues of the health care system. Advanced NPs must be identified by the way in which they function. Advanced NPs use theoretical background to focus on the region of the problem. Nursing needs a well-developed body of theory and control over nursing practice in different health settings. Nursing must develop a body of knowledge based on the nature of its practice.	knowledge and clinical expertise. Advanced NPs are major forces in moving profession forward because of their leadership attributes and ability to articulate.
Patterson, Chris, Pinelli, Janet, Markham, Barbara, "NPs in Canadian health care we're not out of the woods yet!", In: Visions and voices, the NP today, Patterson, Chris, 1999. National	The movement of the Canadian and American nurse practitioner movements began in 1967 and 1965 respectively. However, the nurse practitioner in Canada was unsuccessful.	Determine why the nurse pracititoner movement has been more successful in the US than in Canada.	Expand upon the 3 reasons resulting in differing success of the nurse practitioner: • Differences between countries in terms of health care funding sources • Organization of NPs • Levels of political will within governments to allow NPs to make headway into the legislative process	Funding sources: • US funding largely from private sector and Canadian from public sector • If physicians are paid fee-for-service then NPs will be viewed as an "add-on" expense to the system Organization: • Little government support in Canada supporting the expanded role • NPAO in Onatrio, but no national co-ordinated effort • Recommendations for non-physicin substitutes (NPs) to assist in the physician resource management problem Political: • Variations in educational qualifications potential threat • Organization for credentialing to allow freedom of movement within Canada, and promise competence • Need to monitor and react to legislative barriers to practice • Multiple titles for NPs cause	The question is not whether NPs are competent in practice because that has been proven, but whether the government and consumers will support and use NPs.

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				confusion over scope of practice	
Sidani, S., Irvine, D., and DiCenso, A. Implementation of the Primary Care Nurse Practitioner Role in Ontario, CJNL, 13(3), Sept/Oct 2000. Ontario	Reports on a survey to 166 nurse practitioners; the survey asked about professional characteristics, employment settings, scope of practice, practice patterns, and satisfaction levels.	1) Describe the characteristics of primary care NPs and of their employment settings, 2) the scope of practice in terms of role formalization, independence and prescriptive authority 3) their practice patterns in terms of the type of patients seen, services provided, patient assignment methods, and use of protocols to guide practice, 4) their satisfaction with their role.	Descriptive survey; the survey was validated for clarity, comprehensiveness and relevance and mailed to 227 NP; 166 were returned) 73 %)	Findings describing age, sex marital status, education, type of agency of employment and type of services provided are identified.	Primary care NPs are able to implement their role functions in primary care settings; NPs tend to be middle aged and female with post basic training at the baccalaureate level; about half were employed in CHC, and others in physician offices or HSOs; only 10 % were working in out post settings or nursing stations; Primary care NPs reported they were able to practice to their full potential; they viewed themselves as having a high level of independence and independence related to decision making re the care requirements.
Spitzer, W., Kergin, D., Yoshida, M., Russell, W., Hackett, B., Goldsmith, C., "NPs in primary care III. The southern Ontario randomized trial", CMAJ, 1973, 108. Ontario	Access to doctors in various areas is seriously hampered both by population dispersion and by a much lower ratio of physicians to persons.	How is job satisfaction of physicians and nurse affected? Are physicians' and nurses' views of each others' roles changed? How are clinical and non-clinical activities of physicians and nurses altered?	Controlled trial took place over a 12-month period. Nurses were trained as NPs for the experimental groups for the second evaluation 6 months after their position as NP. Questionnaire data collection method and 14 practices were involved for at least 6 months. Time motion studies were used for the question surrounding activities.	Satisfaction scores were high for all groups in all components of doctors and nurses. No major difference in the views of each other's roles. Exclusively- physician activities were lower in NP group and this decreased further into the study. NPs spent 50% more time in clinical work and half the time in clerical duties; however the shift in time was not at the expense of physician's time in clinical activities.	1. Job satisfaction does not decline for providers except for remuneration among physicians. 2. Roles that were exclusive to physicians are now delegated to NPs. 3. NPs spend 50% more time in clinical and 50% less time in clerical activities.
Spitzer, W., Sackett, David, et.	The number of family physicians is adequate.	Assess the effects of substituting NPs	From July 1971 to July 1972 a randomized	Both groups had similar mortality experience.	NPs can provide clinical care as safely and effectively, with as much

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al., "The Burlington randomized trial of the NP", New England Journal of Medicine, 1974, 290. Ontario	However, there is a surplus of well-trained, experienced nurses. Note: similar to Annals of Internal Medicine, 1974, 80(2).	for physicians in primary-care practice.	controlled trial was conducted. Qualitative and quantitative measurements were used before, during and after the experimental period regarding measurements of patients, clinician activities, and activities of the practice. 1058 families were divided equally between 2 doctors and the NP group.	The quantitative 'indicator-condition' approach rendered similar quality of care. 67% of all patient visits were handled by NPs. Satisfaction was high among patients and personnel. Cost effective for society point of view. However, the new method was not financially profitable to doctors because of current restrictions on reimbursement for NPs.	satisfaction to patients, as a family physician.
Spitzer, Walter, Kergin, Dorothy, "NPs in primary care I. The McMaster University educational program", CMAJ, 1973, 108. Ontario	Research indicates that there is a surplus of nurses and an undersupply of physicians in Ontario.	Describe the rationale, implementation and continuing evaluation of the NP program at McMaster University that was established in 1971.	Description of NP program at McMaster University.	Rationale: • Curriculum oriented towards additional skills in clinical problem solving. • Develop of NPs should take place in post-secondary. • Program should be interdisciplinary. Implementation includes: Admission procedures and criteria; curriculum; teaching and learning methods; and evaluation of students; costs. Continuing evaluation: Records are kept to identify whether NPs are practicing, in what modality, in what setting and geographic location.	Preliminary indicators of satisfaction, acceptance and financial viability suggest that programs will effectively serve health care expectations of the population.
Spitzer, Walter, Roberts, Robin, Delmore, Terry, "NPs in primary care. VI. Assessment of their deployment wit the utilization and financial index", Canadian Medical Association	The preceding article, part V, described the conceptual basis of and the procedures used in the construction of the Utilization and Financial Index (UF-Index).	Measure the impact of multidisciplinary teams that incorporate NPs on total use of health services using the UF-Index.	Data obtained from the Burlington trial and the Smithville project in primary care. Data was compared in terms of before and after the introduction of a NP, between patients of the two studies. Supplemented by practice-generated day	Burlington: UF-Index cost decreased from $325 to $290 (11%). 16% increase in costs for the remaining non-hospital categories suggests that there was an increase in outpatient services. Family practitioner lost $12,000 in income. After 2years the team had assumed responsibility for 41% more patients while increasing the volume of service	Data has provided part of the empirical evidence required to construct new reimbursement formulas for primary care in Ontario.

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Journal, 1976, 114. Ontario			sheets.	provided by only 24% and holding the cost of the provincial health insurance plan. Smithville: 19% increase in NPs at one location and a 522% increase in the family medical centre. Medical centre would have been judged unprofitable generating a deficit of $44,200. There were 2780 reimbursed episodes of care in the 1st year and 9725 in the final year.	
Spitzer, Walter, Russell, W., Hackett, Brenda, "Financial consequences of employing a NP", Ontario Medical Review, 1973. Ontario	The innovation of NPs will not be supported without financial viability regardless of medical or satisfaction outcomes.	Is the modified deployment of physicians and nurses profitable to a family medicine practice?	Southern Ontario randomized controlled trial. Standardized interviews with the physicians were conducted.	Net income of the 6 experimental practices was increased in 3, unchanged in 2, and decreased in 1. Of the 6 control practices, 4 were unchanged, 1 had an increase and 1 had a decrease. No significant financial differences between the 2 groups 4 of the 6 physicians thought the nurse increased productivity. Satisfaction with remuneration aspects of the work shows that 22% of NPs are more satisfied compared to he conventional nurses and 25% lower score by the physicians with NPs than those without. Physicians who hired NPs found its advantages sufficient to offset any perceived financial disadvantages. Doctors and nurses in the experimental group are satisfied enough to retain the new approach.	• Family practices with NPs are not adversely affected in financial performance. • Financial satisfaction tends to be higher in nurses and lower in physicians. • Physicians are satisfied with the use of NPs despite misgivings about remuneration.
Sweeney, G., Hay, W., "The Burlington experience: a study of NPs in family practice", Canadian Family Physician, 1973. Ontario	Increasing health care costs and maldistribution of doctors does not allow for a 1-to-1 ratio.	Is the introduction of the RN as a NP an innovation that is: medically safe, acceptable to patients, efficient and economically feasible, and satisfactory to the affected health	2 RNs were trained at McMaster to be NPs and were each randomly assigned 270 families from the combined practice. Randomized controlled trial using MDs as the control. Study took place from	Reviewers were unaware of which group patients had received care. No clinically or statistically significant differences between the 2 groups of patients. No significant difference in the dissatisfaction with the health services provided by the groups. 391 episodes were assessed and 69% were rated adequate for both MD and	Practices have grown for 2 years and this is mainly due to the addition of a NP.

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		professionals.	July 1971 to June 1972. Data collection includes household interviews, a day-sheet journal of activities, a financial analysis of practice records, time and motion studies and a clinical record review.	NP groups. Time created for doctors by NP allow for the 22% increase of the practice. Doctors were threatened at times by the patients' preference to see the NP. Increased efficiency allowed for more flexible practice with less duplication. NP can provide primary care at a lower cost.	
Van Soeren, M, Andrusyszyn, MA., Laschinger, H., Goldenberg, D., DiCenso, A et al Consortium Approach for Nurse Practitioner Education, Journal of Advanced Nursing, 2000, 32 (4). Ontario	A consortium of 10 Ontario university nursing programs has been used to deliver nurse practitioner education in Ontario since 1995; the results of an evaluation of the consortium approach was completed after the first year of the program.	A five-year project to evaluate the nurse practitioner program including program content, delivery methods, tracking of graduates, examination of practice patterns, and evaluation of the impact of the NPs on patient and health outcomes.	Qualitative approach using face to face and email interviews;	Strengths and limitations of this approach are identified in table form in the article; included as strengths are standardized curriculum, increased use of distance learning technologies, extensive program development with limited resources, increased access for students; enhanced acceptance of role of NP; Limitations include lack of course integration, insufficient time and resources for course development, complexity of communications and cumbersome consortium structure; lack of understanding of special needs of students in remote locations, difficulty in accessing clinical placements; inexperience and frustration with technology, prolonged decision making	Deans and directors wished to retain the consortium; regional co-ordinators indicated support for the structure but suggested a more manageable start-up time; there was a lack of continuity between program initiators and those who operationalized it. A university program without walls is an alternative to traditional program delivery.
Way, Daniel, Jones, Linda, "The family physician-NP dyad: indications and guidelines", Canadian Medical Association Journal, 1994, 151(1). Ontario	The team model is the most popular description of the family physician-NP relationship, but it has drawbacks when the team has a 'captain' and decisions are based on conformity.	Describe and analyze the family physician-NP dyad and practice guidelines in a community centre in Ontario.	Descriptive analysis of family physician-NP model and practice guidelines with case studies to illustrate relationship models.	Elements of family physician-NP model in Table 1. CHC has a catchment area of 80,000 people. Model is based on mutual respect, is a collaborative practice, client centred, with a holistic approach and strives for efficiency and cost-effectiveness by offering a provider appropriate for the care needed. Limitation in terms of efficiency may be the additional time needed to coordinate care between 2 providers. Guidelines are: a reference for medical practice, an information source for	

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				evaluating the NP after a probationary period, indicate to physicians what is expected of NPs, which removes the necessity each new physician to retest, and are 'standing orders' that allow the NP to care for most clients without the need for direct physician consultation.	
Way, Daniel, Jones, Linda, Baskerville, Bruce, Busing, Nick, "Primary health care services provided by NPs and family physicians in shared practice", CMAJ, 2001, 165(9). Ontario	A recent review indicated that there is substantial evidence supporting strategies to improve interprofessional collaboration in primary care.	Answer the following questions: What specific problems do NPs and family practitioners (FPs) address? What is the frequency of activity within each of the five domains of primary health care? To what degree do NPs and FPs share the care of their patients?	Baseline data from 2 rural Ontario primary care practices was collected to improve structured collaborative practice between NPs and FPs and compare service provisions between the two NPs and four FPs participated in the data collection of 400 patient encounters over a two-month period. Data included: reasons for visit, services provided during the visit, and recommendations for further care.	Most frequent reason to visit a NP was for a health examination (27%) and for a FP is was for a cardiovascular disease other than hypertension (8%). Delivery of health promotion was similar for the 2. Delivery of curative and rehabilitative services was lower for the NP. NPs provided more services related to disease prevention and support. Out of 79 referrals made while seeing a NP, 47 were to see a NP.	Results indicate medico-legal issues related to shared responsibility, lack of interdisciplinary education and lack of familiarity with the scope of NP practice.
Way, Daniel, Jones, Linda, Baskerville, Neill, "Improving the effectiveness of primary health care through NP/family physician structured collaborative practice", Final Report, University of Ottawa, March 31, 2001, (unpublished). Canada	Reduced financial resources will result in significant cost reductions through initiatives such as physician resource management and changes in primary health care delivery.	Develop, implement, and evaluate an intervention to support NP/FP structured collaborative practice, and develop postgraduate education for family medicine residents and student NPs.	Descriptive, quantitative and qualitative collection methods. Data collection included; pre and post intervention from health care providers, students and patients; and key informants post intervention. Evaluation methods included; monitoring of program implementation and progress as well as surveys and interviews of providers, patient	The provider using all of the learning modules and the creation of action plans for structured collaboration established intervention. A shift in the comprehensiveness and appropriateness of care provision was shown at the intervention site where patient encounter data was evaluated. NP intervention site provided more services in the curative, rehabilitative and supportive care compared to the NPs in the comparison site. Referral of patients changed; before the intervention NPs referred 19% of their patients to FPs and after intervention the NPs referred 8% of their patients. 75% of patients were satisfied with the	Recommendations: Broader introduction of structured collaboration in larger samples of Canadian sites. Other health professionals need to understand and assess their role and contribution to collaborative care. Undertake cost-effectiveness measures of collaboration. Future interventions must promote practice guidelines and be an adequate amount of time to measure patient outcomes to determine the contribution of collaborative care on quality of care. Develop resources to assist sites

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			surveys, patient encounter forms, key informant surveys, and a questionnaire and interview of students.	service provided before and after intervention. Providers at the intervention sites were more satisfied with their collaboration than before or compared to the comparison sites. Changes occurred in collaboration in respect to scope of practice, competence, control, and role distinction. One intervention site met their goals of collaboration in the curative services and another intervention site met goals in the monitoring of stable chronic illnesses. Student FPs and NPs were positive of the relevance of the content for the student intervention, and in their change of attitude and understanding of collaboration.	wishing to employ a NP. Assist sites that employ NPs and help define their role to support and improve their collaborative practices. Policy and health care system changes are required to supply reimbursement for NPs and the FPs who work in collaboration. Address medico-legal issues that prevent providers from working in collaboration. Research 7 elements of collaboration to determine each element's importance and create tools to assist implementation. Support implementation of recommendations of the Ontario Chairs of Family Medicine and the Council of Ontario University Programs of Nursing calling for continuing education on collaboration in clinical and classroom settings.
Way, Daniel, Linda, Jones, Busing, Nick, "Implementation strategies: collaboration in primary care-family doctors and nurse practitioners delivering shared care discussion paper written for the Ontario College of Family Physicians", May 18, 2000, (unpublished). Ontario	The OCFP identified some major issues regarding the establishment of collaborative models including the rigidity of adopting a single model for collaboration, funding mechanisms and the liabilities of physicians entering into a shared care relationship and established a Task Force with the RNAO to review the model.	Describe the seven elements that form the framework or structure found in successful collaborations and a process for determining the roles and functions of the collaborative partners based on role guidelines.	Literature review and case studies.	"Collaborative Practice is an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided". Essential elements for a successful collaborative practice: • Responsibility and accountability • Co-ordination • Communication • Co-operation • Assertiveness • Autonomy • Mutual respect and trust Deciding upon the role and functions of the practice partners: identify the needs of the practice population and the	

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				specifics of the practice setting and make clear decisions regarding the services that need to be offered by the groups, along with the services that will be provided by individual practice members. In reviewing the role and functions of the NP: the partners need to understand the distinct and duplicate strengths that both disciplines offer to the practice. Appendix 1 lists the activities associated by primary health services and identifies separate and shared functions. Process of identifying roles and functions of the collaborative model would include a review of the list of services offered by the group.	
Woodman, Mary, "Collaborative Practice: An example from the Rural Kingston Network", February 2002 Ontario	The Sharbot Lake Medical Centre is one of five sites forming the rural Kingston network. Since the start of the project in January 2000, one NP and two MDs have functioned as a team at this site.	To provide one example of a successful NP-MD collaboration.	It is a case study but only encompasses one site, with one NP and two MDs. It is only a brief overview of the project to date (the project continues until January 2003 and the study was done in February 2002).	NP's role includes, in addition to direct clinical care, some emphasis on community outreach care, and participation in regional health planning with other providers. MDs and NPs view this as a successful collaboration. Benefits included: • Improved quality of care with interdisciplinary teamwork • Extended hours and clinics due to addition of NP • Nursing perspective/community programmes new positive impact on patients and providers	Reasons for success included: • Physicians' past experience working with NPs • Foundation established in prior student/mentor roles • Mutual trust and respect • Exemplary communication between practitioners • NP's background, ability, motivation, insight into limitations • Patients and community receptive and responsive • Support staff facilitate the role Remaining obstacles included: • Funding and funding mechanism • Existing myths around the NP role • Power struggles • OMA fee schedule re consults • Recruiting/retaining NPs in isolated rural areas may be similar to issues of physicians