An Overview of Nurse Practitioners in Public Health Units Across Ontario

MIDDLESEX-LONDON HEALTH UNIT

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Executive Summary

Introduction

Purpose: To investigate and describe the role of Nurse Practitioners (NP) working in Ontario Public Health Units.

Background: For a number of years NPs have been working in public health in a variety of settings. Information from key informant interviews outlines administrative themes, practice environments, and outcomes.

Methodology

In July and August 2005, information was collected through telephone interviews from thirty-three Ontario health units, the Nurse Practitioner Association of Ontario (NPAO), and a Nurse Practitioner completing a thesis on the role of NPs in Public Health. Five evaluations were collected, four specific to evaluating nurse practitioner services. Other information collected included job descriptions, board proposals, presentations to boards of health, reports to the boards of health, funding proposals, and news reports.

Results/Findings

Thirty-two of the 36 Ontario public health units contacted completed an interview, a response rate of 89%. Of the public health agencies contacted twenty had nurse practitioner positions, seven health units have NP positions in more than one service area.

Thirteen of the public health agencies interviewed established that they do not employ NPs. Five of health units stated they have not seriously considered hiring a NP. The other eight health units have investigated hiring NPs or have submitted proposals to hire a NP but were unsuccessful. Reasons or struggles with establishing NP positions are discussed.

Close to twelve full-time equivalents (FTEs) are in sexual health programs, 9 FTEs are with the Prenatal Postpartum NP project and seven NP positions are responsible for primary care services for various populations across the age continuum. Some health units have considered expanding the NP role in the health unit to other service areas.

The majority of health units that employ NPs through their base-funding budget employ them in sexual health clinics (twelve of the thirteen FTEs). One health unit tops up a PHN position with additional municipal funds to run a primary health care clinic. Four health units have two NPs, one in sexual health and another NP with the PPNP project.

Administrative themes reviewed include NP salaries, overhead costs, recruitment and retention issues, and union involvement. NP salaries varied across the province. Recommendations for NP salaries and overhead costs are provided by the NPAO. These are compared with existing funding strategies and practice. There were differences in use of clerical support and other overhead costs. Many informants identified lack of clerical support impacted the NPs practice. Recruitment and retention issues included non-competitive salaries, limited scope of practice, and lack of on-site physician.

Different aspects of practice environments reviewed included target population, practice settings, practice models with physicians, and scope of practice. Most NPs worked in some form of a clinic setting using a variety of community locations. Target populations varied from those identified in Mandatory Health Programs and Service Guidelines to underserviced, isolated populations. Practice models with physicians depended on the NPs' practice. Both collaborative and consultative models were seen. Scope of practice was identified as linked to retention and recruitment of NPs. Many key informants explained NPs wanted to work in more areas than sexual health full time. Some programs varied and included NPs with a sexual health focus, prenatal and postpartum services only and primary care across the age continuum.

All health units employing NPs indicated that the NP services are successful. Interviews revealed benefits of NPs to the organization as well. For example, NPs were seen to promote evidence-based practice, provide consultation on clinical issues to staff, assist PHNs in critically review the research, improved team unity, and demonstrate commitment to best practices and research.

Twelve health units stated they participated in some form of evaluation of their programs with NPs. Some evaluations were specific to the role of the NP in that practice setting; others evaluated the program as a whole. One evaluation included assessing the relationship with the rest of the staff, professional skill-mix, and use of NP as a consultant for the PHN.

Conclusions

NPs offer excellent services in health education, health protection through primary and secondary prevention measures (i.e. early diagnosis and treatment), and accessing under serviced populations. NPs also are

seen as clinical nursing leaders and are consulted regularly by other professional nursing staff. Unfortunately, by the nature of funding Ontario public health units the benefits of NPs are often not utilized, unless additional funding is made available specific to hiring NPs. This poses a significant challenge to integrating NPs into public health.

Recommendations

If hiring a NP:

- When hiring a NP consult with the NPAO regarding possible funding requirements, including wage, employment agreements, practice agreements, operating expenses and capital budget. This will contribute to an effective work environment and assist with recruitment and retention of NPs.

- Sexual health services in the provincial mandatory programs evidently encompass a NP's skills. However, NPs prefer to work within their full scope of practice. Incorporating NP services into other program areas contributes to job satisfaction, development of skill base, and potential to meet community needs.

- To be successful in utilizing NP services the NP needs to be fully integrated into the public health unit and the community. Support from community physicians and other NPs is important for quality of service, retention and recruitment of NPs. The target populations understanding of the NP's role also contributes to their success.

If no NP:

- There should be collaboration with existing community NPs on a regular basis regarding services available, gaps in services, changes in programming, and current information on health protection, promotion and education. Some health units without NPs explained that considerable effort was spent with NPs in the community to ensure public health programs and services were part of the NPs knowledge base. This allowed the health unit to acquire some of the benefits of NP services for their community and the NP benefits with current information on public health services.

Introduction

Purpose

To investigate and describe the role of RN(EC)s working in Ontario Public Health Units.

Background

The *Expanded Nursing Services for Patients Act* and other relevant legislation were amended in 1998 to allow registered nurses to work within an expanded scope of practice. A registered nurse in the extended class [RN(EC)] has the legislation to make diagnosis, prescribe medications, and order diagnostics (e.g. blood work and ultrasound) within the scope of practice of the RN(EC) and within the predetermined medication, lab, and diagnostic lists.
"RN (EC)s have the advanced knowledge and decision-making skills in health assessment, diagnosis, therapeutics (including pharmacological, complementary and counseling interventions), health care management, and community development and planning" (CNO, 2004, 3). A primary health care NP's scope of practice includes: "assessing and providing services to clients in all developmental stages, and to families and communities; and providing comprehensive health services encompassing: health promotion and education, prevention of diseases and injuries, treatment, rehabilitation, continuity of care, and support services" (CNO, 2004, 3).

NP is a familiar term with the public and in many health care settings. A RN (EC) fulfills the role of a NP. However, NP is not yet regulated by the College of Nurses of Ontario, and therefore is not a protected title (CNO, 2005).

History of NPs in Ontario Public Health Units

Major funding initiatives for NPs have contributed to the evolvement of the role in public health.

- In 2000, 5 NP positions were funded for the Cervical Cancer Screening program. The Nurse Practitioner Cervical Screening Pilot Project was designed to increase women's access to cervical screening and other health and wellness services. Five northern public health units participated in this project. This two-year project concluded October 31, 2001.

- Ten positions were created in 2001 through the Early Childhood Development (ECD) Initiative for a Prenatal and Postnatal Nurse Practitioner (PPNP) program. This initiative is scheduled to conclude at the end of 2006. The aim of the PPNP program is to increase access to prenatal and postpartum services for populations in under-serviced areas of Ontario.

- The Nurse Practitioner Demonstration Project began in 2003 for communities with no or too few family physicians. Primary Health Care (PHC) NPs were placed in these communities. One health unit identified two positions in their agency through this project. This project is funded annually.

- Two provincial grants, The Primary Health Care Transition Fund and the Primary Care Nurse Practitioner program fund two positions in two different health units.

Under the Mandatory Health Programs and Service Guidelines (1997) NPs began working in public health agencies, primarily through sexual health programs. Under these guidelines sexual health clinics include:

- a client's health assessment;

- contraception counseling, provision of prescription and other contraceptives;

- screening for cancers of the cervix with appropriate client referral;

- pregnancy tests and comprehensive pregnancy counseling;

- post-abortion counseling;

- education and counseling on reproductive and sexual health choices, with appropriate client referral to programs and other health and social service agencies and groups;

- provision of hepatitis B vaccine at no cost, according to Ministry of Health eligibility criteria; and

- development of a management plan appropriate to client needs, including discharge planning and referral where necessary to health care and/or social agencies.

Other services may include clinic services for peoples infected or possibly infected by sexually transmitted infections (STIs) including HIV/AIDS.

In addition, NPs incorporate interventions in primary and secondary prevention through lifestyle counseling. This demonstrates how NPs practice holistically.

Methodology

In July and August 2005, telephone interviews were conducted to determine the current role and use of nurse practitioners in Ontario public health units. Managers, directors, senior nurse leaders, nurse practitioners, and program evaluators were interviewed. Interviews were recorded by hand during the interview and reviewed within 24 hours post interview. Participants were provided the opportunity to review the answers to ensure the information captured was as intended. For a list of survey questions please see Appendices A and B.

Information from the interviews was supported and compared with the literature and other key informants. The Nurse Practitioner Association of Ontario (NPAO) and a Nurse Practitioner completing a thesis on the role of NPs in Public Health were contacted.

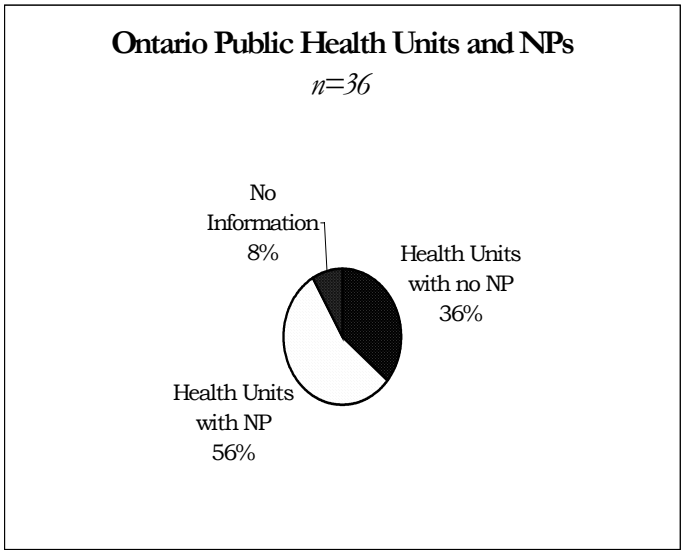
Five evaluations were collected, four specific to evaluating nurse practitioner services. The other evaluation investigated a service that a nurse practitioner participated in. Other information collected included job descriptions, board proposals, presentations to boards of health, reports to the board of health, funding proposals, and news reports.

Information was collated and aggregated using both qualitative and quantitative methods, mainly descriptive statistics. Information on NPs was included in the data analysis if they were employed as NP. Some health units indicated they had NPs registered with the College of Nurses of Ontario in their public health unit but were employed as a Public Health Nurse (PHN). Their roles, responsibilities, and pay reflected that of a PHN and were not included.

Findings/Results

Information on employment of NPs was confirmed for thirty-three public health units. Thirty-two of the 36 Ontario health units contacted completed an interview, a response rate of 89%. Of the health units contacted twenty health units had nurse practitioner positions; seven of these health units employ NPs in more than one service area. Thirteen of the health units interviewed confirmed that they do not employ NPs. Information could not be collected with three public health units.

Figure 1:



Public Health Units without NPs

Close to forty percent (n=13) of the public health agencies interviewed did not employ NPs. Five of these health units stated they have not seriously considered hiring a NP. The other eight health units have investigated hiring NPs or have submitted proposals to hire a NP but were unsuccessful. Reasons or struggles with establishing NP positions in the public health agency include:

- creating another role/job classification with the union;
- difficulties between union and non-union pay scale;
- lack of a collaborative physician;
- some health units stated they currently collaborate with NPs in community and feel hiring a NP would be a duplication of service;
- other health units decided that it would be more economically efficient to use PHNs and medical directives in sexual health programs;
- lack of agency support; and
- some health units had their proposals denied for a NP and without the additional funding could not support the NP.

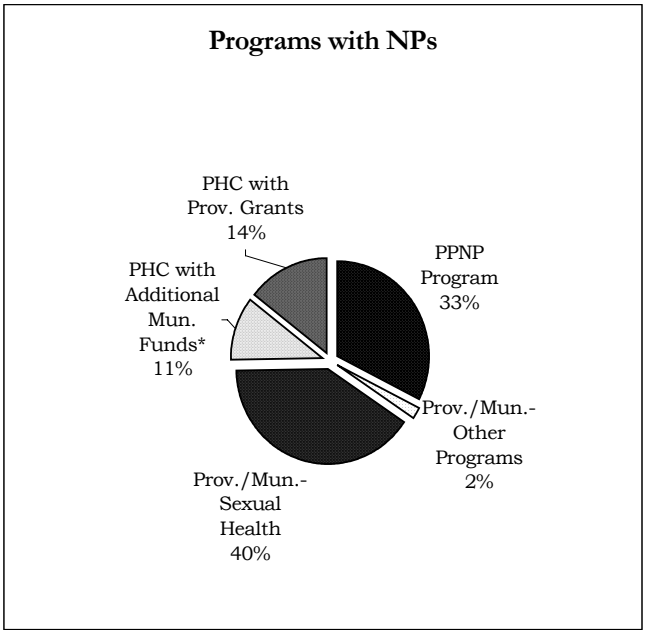
More information is found in Appendix C.

Public Health Units with NPs

For a summary of health units employing NPs see Appendix D.

Position Characteristics/Practice Content: Approximately 27 FTEs were identified in twenty health units. Close to twelve FTEs (11.65) are in sexual health programs, nine FTEs are with the PPNP project and seven NP positions are responsible for primary health care services for various populations across the age continuum. Some health units were considering expanding the NP role other service areas. These considerations were all in the informal stage and no proposals or reports had been developed. One health unit has expanded a NP role with sexual health programs role to include 0.2 FTE for in-depth immunization, travel clinics and some Tb follow up. Another health unit uses some time from the sexual health NP for their 'Health Bus' services. The 'Health Bus' is a mobile public health clinic. Services are provided to the homeless, vulnerable, and geographically isolated people. Some of the services include treatment for minor medical conditions, mental health counseling, dental screening and referral, immunization, sexual health services, and general health assessments.

Figure 2:



*Additional municipal funds ranged from 100% funded to increasing an existing PHN salary to that of an NPs [Municipal (Mun.), Provincial (Prov.), Primary Health Care (PHC)]

Settings for NP practice. Practice settings include clinics at the health units, various community agencies such as Ontario Early Years Centres, YMCA, the Salvation Army, physician offices, churches, and schools. If needed, some NPs offer home visits. NP programs use innovative methods to meet the needs of the target population. For example, in a population that did not use telephones the NP scheduled home visits through a drop-in box at the community's church (Snelling et al., 2005).

Clinics were the main practice setting. By-appointment clinics were seen most often for PPNP NPs, those working in sexual health and STI clinics, and NPs offering primary care services to a broader population. Three health units in the PPNP program indicated that their NPs could visit clients in the home if needed. One health unit felt it was not practicable to offer home visits as it was not "the best use of her time". In contrast the Report on the Integration of PHC NPs in Ontario (2005) found close to half (47.8%) of the surveyed NPs working in primary care services in Ontario conducted home visits.

This survey did not identify any health units where the NPs had on-call responsibilities. This provincial report (2005) found 12.9% NPs surveyed participated in on-call services.

The NPAO stated they support a variety of models of primary health care delivery. For example, models that incorporate community governance such as community health centers and alternatives that involve NPs in governance and management (e.g. NP led clinics).

Funding Methods: A variety of funding methods were identified to support NPs. Ten health units were granted funding through the PPNP project using funds from the Early Childhood Development Initiative. One health unit decided to withdraw from the project due to an inability to recruit a NP. Another health unit was also unsuccessful in recruiting a second NP; they already employed a NP in sexual health, for their PPNP project. In order to provide service for the PPNP program the current NP works 0.5 FTE in sexual health and 0.5 FTE in the PPNP program. For more information on recruitment please see recruitment and retention on p. 8.

The majority of health units that employ NPs through their base-funding budget employ them in sexual health clinics (twelve of the thirteen FTEs). Two health units top up a PHN position with additional municipal funds, one NP position is to run a primary health care clinic and the other position is in sexual health. Four health units have two NP positions each, one in sexual health and another NP with the PPNP project.

Two health units who have NP positions through annual provincial funding stated there is difficulty in sustaining their programs related to inadequate reimbursement for overhead expenses. This is consistent with results from the Report on the

Integration of PHC NPs in Ontario (2005). "Most sites reported that their overhead expenses related to NPs exceed the $10,000 allocated by the Ministry for overhead. Some sites reported that the NP position is not sustainable unless additional money is received for overhead, including monies for secretarial support and a consultation fee for physicians" (p. 14). The Evaluation of Prenatal and Postnatal Nurse Practitioner Services Initiative: Interim Report (2005) also identified struggles with maintaining the program due to insufficient funds for additional expenses. Overhead expenses include clerical support, capital expenses, medical supplies, and consultation fees for physicians. More information on operating expenses on p.6.

Sustainability with Provincial Grants. Two health units with the PPNP project have started to develop sustainability plans if funding does not continue beyond the end of 2006. Both of these public health units have started negotiating with future Family Health Teams. Five other health units with the PPNP project stated they are relying on the ministry to continue to support the program. Information was unavailable from two of the health units participating in the project. The interim report evaluating the PPNP project (2005), identified from interviews the importance of continued funding to sustain the program (Snelling et al., 2005). This evaluation recognized that not having permanent funding could lead to other problems with the program. For example, community partners and potential participants did not want to invest a lot of time and resources in the program if it will not be continuing. The short-term funding also made it more difficult to recruit NPs to the program, specifically in the north. The possibility of discontinuing the service, even short-term, to search for more permanent funding was seen as potentially disruptive to participants, which could affect participants trust in NP services (Snelling et al., 2005). There are also religious and cultural beliefs in some communities that limit the community members' involvement in public appeals or campaigns to sustain programming (Snelling et al., 2005).

Annual Funding: One health unit employs four full-time NPs. Two NPs are for primary health care services for the more vulnerable populations through 100% municipal funding. One of these clinics has been active since 2002. At the time of the interview the health unit is pursuing having the province finance these positions. According to this health unit the province's current position is to work towards integrating NPs into Family Health Networks and there is little or no interest in funding these positions independently. However, the health unit was concerned that the Family Health Networks will be established in more central urban locations, which would not be addressing the lack of services in the more rural and remote communities. Another concern discussed was the time that would be required to establish these networks, and creating a potential gap in service until the Family Health Networks are established.
Health Units that employed NPs in the sexual health programs did not identify concerns with inadequate funding.

The Nurse Practitioner Demonstration Project is spearheaded by the Nursing Secretariat. This project places NPs in under-serviced communities to provide primary health care (Nursing Secretariat, 2005). This same health unit states they employ two other NP positions through this project. Although the project is based on annual funding the health unit commented on the funding being insufficient to fully support the NP. The funding has not increased over the years and does not cover additional expenses such as clerical support and an education budget. The health unit reported a $20,000 deficit for the two NP positions.

Operating Expenses: NPAO recommends to include in the budget, annualized expenses per year per NP for Primary Health Care NPs in Family Health Teams of about $32,000-$42,00 per year (NPAO, 2005). This includes some contribution for support staff (clerical/RN), supplies, rent, utilities, travel expenses, patient information materials, communication and information technology, professional development, adequate professional liability coverage, recruitment and retention bonuses and other general administration costs. This exceeds the $10,000-$15,000 a year currently allocated by the MoHLTC for overhead expenses (2005). However, health units have a different funding and operational infrastructure compared to family health teams and overhead costs would be different (NPAO, personal communication, September 30, 2005).

Clerical Support: One public health agency that employed a NP for the PPNP program stated the 0.2 FTE of clerical support hired was not sufficient, at least 0.6 FTE is needed. The PPNP interim evaluation reported that NPs with full-time or two-thirds clerical support were satisfied with their level of support (Snelling et al., 2005). One health unit that employs a NP full time in sexual health reported the NP did not generate enough additional work to support more clerical hours. Three health units that employ NPs in primary care settings employ at a minimum of 0.5 FTE clerical support for each position. Two of these positions had full time clerical support. One NP had a RPN to assist with the clinic.

Professional Development: The NPAO recommends $1500 annually and up to 10 days for professional development activities (NPAO, 2002). The report on the integration of PHC NPs (2005) shared that 11.1% of NPs working in Public Health received no reimbursement for educational expenses. NPs working at other community nursing agencies (e.g. CCAC), nursing outposts, and mental health/rehabilitation agencies all

reported being reimbursed "all to some" of their educational expenses (p. 124).

Practice Models with Physicians: Practice models involving NPs and physicians are identified in the Report on the Integration of PHC NPs (2005). Two of these are elaborated on here.

Collaborative Approach A collaborative approach is described as working together with the joint vision of excellent patient care. Communication and decision making are completed jointly while respecting each professions' skills and abilities (Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario, 2005). Both disciplines benefited from the other professionals' work. Physicians benefit from help with work load and service provision to certain populations. The NP benefits from the physicians' expertise in the medical model of health care. Of the health units using NPs in their sexual health clinics the majority of the clinic physicians also collaborated with the NP. In the PPNP program one health unit identified that the relationship between the NP and physician as a collaborative partnership with 'give and take'.

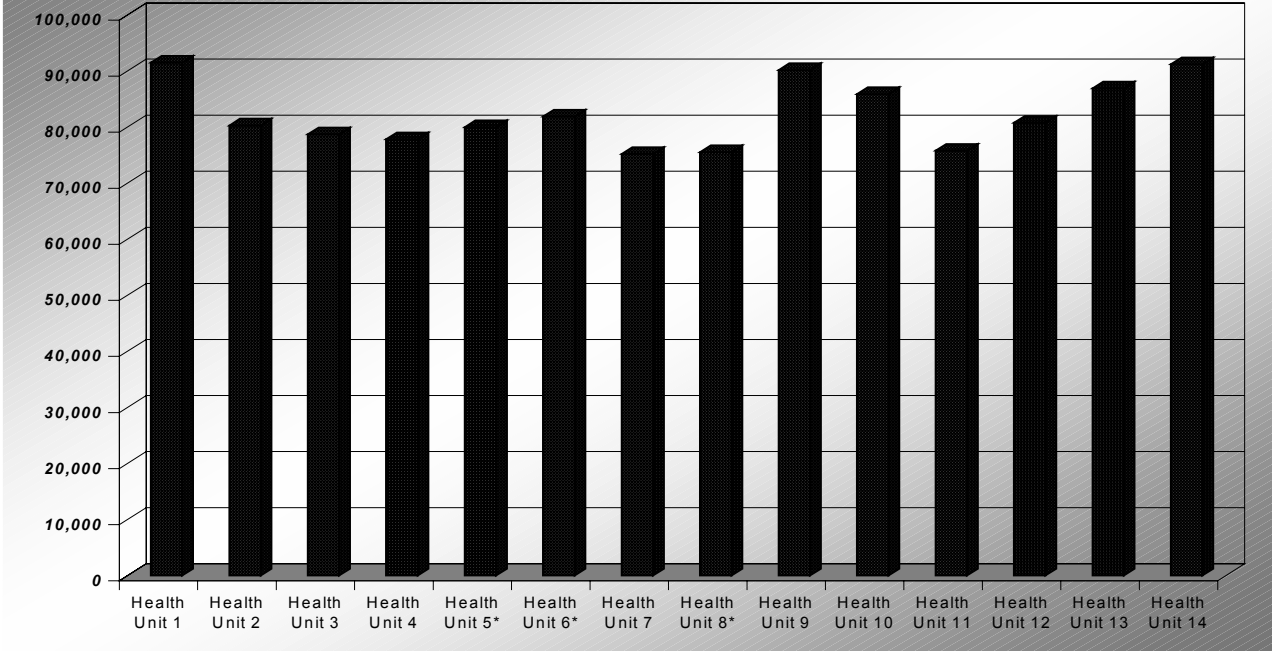
Consultative Approach – this practice model involves the NP calling the physician as required. There is a more formal communication system in place. According to this report a key difference between the two approaches is the physician does not have a formal established relationship with the patient population and the physician may receive payment for their consultation time (2005). Of the physician-NP relationships identified, through telephone interviews eight working relationships appeared to be based on the consultative model. A wide variation in fees charged by physicians was also seen. Seven health units were charged some sort of consulting fee. One health unit was going to be charged a consistent rate of $1000 a month for consultation. However, not all physicians charged a fee in this model but the degree of contact with the client population and nature of communication on a 'as needed' basis suggests these are still consultative approaches to practice. This is reflected in this report (2005) where the consultative practice model was found more often in public health units compared to other community health care settings.

Salary: The NPAO suggests in their discussion paper on Strategies for Successful Integration of PHC NPs in Family Health Teams (NPAO, 2005) that starting salaries are "$85,000-$105,000 per year commensurate with experience and with consideration of remote/under serviced practice setting" (pg. 5). NPs would have the option of "being paid a percentage of salary (20%) in lieu of benefits".

Annual pay for a NP at each health unit, using 2005 contract grid information, was collected based on hourly rates up to two decimal points (unless indicated otherwise), multiplied by a thirty-five hour workweek. Quoted salaries do not include benefits. Information is shared based on the top of the pay scales.

One health unit employed the NP as a joint

Figure 3: Annual Income of NPs Based on Top Hourly Rate Offered at Each Health Unit.



Hourly wage given was not to two decimal places

NP/supervisor role, and no salary information was provided. Other health units were completing negotiations and could not provide current information. The lowest wage was $72, 800 (not calculated from two decimal points), the next lowest salary was $75, 227. The highest salary is approximately $91, 510. Using health units with most accurate information available (n=14) the mean annual wage was calculated at $76,787.20. For more information see Figure 3.

Union: Of the public health units with NPs 85% of the positions are unionized, only three positions were not unionized. One position is not unionized because it includes supervision of staff. Another health unit does not employ the NP through the union and admits that this is a "problem with the union". The third health unit stated no concerns with the non-union position. However, this Health Unit employed two NPs for a total of 0.1 FTEs.

In contrast, *Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario* (2005) found only 16% of NPs working in primary care in Ontario are unionized. Those that were unionized expressed less satisfaction with their role in decision-making (p. 14).

Interestingly, the NPAO suggests in their position statement on Program Funding for Primary Health Care NPs (2002) that one of the necessary conditions for successful implementation of a primary health care NP is to exclude NPs from union contracts. This is to "support autonomous and collaborative practice" between NP and physician and not to create an employee-employer relationship.

Retention & Recruitment: Of the health units that provided information on recruitment and retention (n=15), ten stated they had challenges with recruitment. One of the reasons identified was the location of clinics in small rural areas. Interestingly, a health unit that employs two NPs in remote areas attributes their success at retention by supporting the NPs to work within their full scope of practice (more information on the full scope of practice on pg. 8). Physicians in the community who are very supportive and available to the NP was also seen as a strength to retention. One of the NP practices started from a need identified by a group of pediatricians for basic primary health care service for well infants and children in the area.

Lack of direct collaboration of the NP with a physician and other NPs was stated as a concern for a new practitioner in one Health Unit. These opinions on retention follow the provincial report on the integration of PHC NPs. "The top two factors determining NPs' willingness to consider relocation to a rural or remote area are the ability to work within their full scope of practice and the availability of physician support" (Report on the Integration of PHC NPs into the Province of Ontario, 2005, 15).

Challenges with recruitment include short-term or time limited positions, and non-competitive salaries. Often more than one issue was described; i.e. maternity leave replacement in a small rural area. One health unit was unable to hire a NP on two separate occasions because of failure of both applicants to pass the certification exam. Another health unit described their struggles were related to low enrolment in the NP program at the university. The graduates of the program preferring to work in an environment where there is a physician on site, other NPs to collaborate with, and at one clinic site. The top three reasons non-practicing NPs stated for leaving their Ontario practice was inadequate salary, limitations imposed by employer, and long distances between home and work setting (Report on the Integration of PHC NPs into the Province of Ontario, 2005).

Two health units who did not have recruitment issues hired more than one NP for less than 1 FTE in sexual health clinics. It is likely that these health units recruited NPs who were looking for stable but not time intensive work in sexual health clinics. Some health units recognized their success in recruiting and retaining NPs came from supporting the NP to work within her full scope of practice.

Scope of Practice: Being limited in their work and not working within in their full scope of practice was cited as an issue more than once. The Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario (2005) identified NPs working in public health as being less satisfied with their scope of practice compared to NPs in other practice settings (p.20). NPs working in public health units (89%) represented the highest percentage of NPs who identified limitations to their practice ($p<.01$) (2005). NPs ranked their ability to work within their full scope of practice as a positive aspect of their job third. According to this report "NPs working in a public health units are on average seven percentage points less satisfied with their scope of practice than NPs working in other practice settings" (p. 173).

One health unit informant stated their health unit was considering hiring more NPs but were concerned about limiting the scope of practice to only sexual health programs. Other health units would have liked potential NP positions to include roles and responsibilities with a range of public health programs such as Health Babies, Healthy Children, vaccine preventable disease, and school services. As mentioned before, one health unit addressed the narrow scope of practice for the NP by seconding the NP to a 'health bus'. Another expanded the role from sexual health to include some time with in-depth immunization and other services.

Two health units explained one of the reasons they struggled with recruiting a NP was that the practice setting was not a PHC 'clinical setting' or limited to one clinical program only. Two health units felt they were able to recruit and retain their NPs by structuring the practice setting to allow the NP to work within their full scope of practice.

A couple of health units discussed previous use of NPs in schools. This was seen as very successful. However, according to one evaluation and an informant, the service in both areas was mainly regarding sexual health issues.

Position Development: One NP suggested that one possible reason previous proposals for NPs in her community were not successful was because a NP did not write or collaborate on the proposal. This was supported by the report on integration of PHC NPs in Ontario (2005). This report identified one of the facilitators to integrating primary care NPs is to involve them in developing their position description.

Target Group: The PPNP initiative was designed to reach pregnant women and families with newborns in Ontario that have difficulty accessing health care services. Health Units selected to participate in the PPNP program identified gaps and barriers to accessing pre- and postnatal services due to geographic isolation and/or under servicing (e.g. physicians). Populations include immigrant families, those without health insurance, families of certain faith groups, and other isolated communities. A concern on providing care to certain members of the family outside these targets arose during a number of conversations, particularly with the NP. For example, NPs often found it difficult not to provide health care to fathers or older children. However, many health units made exceptions to this and treated these family members for episodic illness. Some followed them on a longer term basis.

NPs working in STI clinic and sexual health clinics aimed to serve the populations identified in the Mandatory Health Programs and Service Guidelines and address community needs.

Health Units providing primary care clinics to communities chose to target populations to be considered 'at-risk' for poor health. Populations included those without a primary care provider, rural/remote/isolated communities, a demonstrated lack of physicians in the community, populations participating in 'at-risk' health behaviors such as sex trade workers, those without health insurance, immigrant families, and other marginalized populations.

All health units employing NPs stated they were able to reach their target population. Some health units explained part of their success in reaching the target population was a result of the work the NP completed.

Success of NPs: All health units employing NPs indicated that the NP position was a success. When asked if the NP was successful in meeting the needs of the target population comments such as the "community has really embraced her", "you have no idea how successful", and "you get the best of both worlds" were shared. Many health units indicated that they had to modify their service delivery model from drop-in appointments or home-visits to appointment only clinics as a direct result of this success.

Other benefits of the NP role in Health Units identified include:

- promoting evidence based practice,
- consultation on clinical issues,
- assisting PHNs in critically review the research,
- improved team unity in sexual health clinics with NP (NP more aware of policy, understands nursing practice, attends team meetings),
- commitment to best practices and research,
- supportive in delivery of excellent care, and
- clients were more comfortable with NP, and the NP being female.

One health unit explained that by having the NP in the sexual health clinic "you get the best of both worlds". The NP can provide diagnoses, treatments and prescriptions for routine health issues, in addition to the skills of a nurse in health education, counseling and an understanding of behavior change.

A number of health units reported the characteristics of the NP in their health unit contributed to the success of the program. Such characteristics included ability to effectively communicate with the target population, the ability to connect with the physician community and other community agencies, and the clinical skills to lead to improved health outcomes for the population. The report on the integration of PHC NPs in Ontario (2005) shares similar findings on the success of NPs. The implications of this are explained further in this report. "While this is positive for the particular individual concerned, there seems to be doubts that the skills that 'their' NP contributes can be applied to NPs in general. This is likely a public education issue. Once the role that NPs play is more widely understood by the population in general, the particular skills that an NP brings may be better accepted as a factor of the profession rather than an individual." (p. 240).

Evaluations: Of the nineteen health units with information on project evaluation, twelve health units stated they participated in some form of evaluation of their programs with NPs. Some evaluations were specific to the role of the NP in that practice setting, others evaluated the program as a whole. One evaluation included assessing the relationship with the rest of the staff, professional skill-mix, and use of NP as a consultant for the PHN. Another health unit

explained they use ongoing performance appraisals, reports to the MoHTLC, statistical review, and observations to evaluate the program. All evaluations gathered were completed in the past five years.

Overall, the evaluations varied from two pages of clinic data to more in-depth information gathering using quantitative and qualitative methods. Eight of the health units surveyed participated in a provincial evaluation of the PPNP project conducted by the Sudbury & District PHRED department. Four of these health units also participated worked with the Community Health Research Unit at the University of Ottawa evaluating changes in barriers to accessing prenatal and postnatal services.

Seven health units responded that no formal evaluations have been completed. Five of these health units use NPs in sexual health clinics. A health unit that employs a number of NPs in primary care settings stated no formal evaluation had been completed. One health unit has not conducted any evaluations at this time, citing that the program has just started to be implemented. For more information on evaluations please see Appendix E.

Discussion

A lot of what was discovered from the interviews was reflected in the report on the Integration of PHC NPs in Ontario. However, some discrepancies were also identified such as the level of unionization. NPs in public health units have a much higher rate of unionization compared to what was reported in primary health care settings in Ontario. The issue of unionization is interesting. The majority NPs working in health units are unionized, despite the NPAO not recommending this and NPs in other community health agencies generally not having the NP in the union. One health unit mentioned their main barrier to employing a NP was the differences between the union and non-union pay scale.

Public health is different in a number of ways from other community health agencies as to how they utilize NPs. There are stricter funding requirements with the provincial mandatory programs and guidelines, which limits the NP scope of practice and a lack of clinical physicians on site. Unionization and salary also appears to be inconsistent with NPAO recommendations.

One health unit decided not to pursue a NP position with base funding as they "didn't want to pick up the slack due to shortages in the primary health care system without future funding". However, the same health unit explained they applied for the PPNP project but did not succeed. This health unit currently collaborates with existing community groups that offer NP services.

One response to the question regarding NPs working in public health was "having access to health care is a basic health need. NPs are able to service the unique high needs of a population more effectively". Another health unit based their board presentation and proposal for a NP in sexual health based on the equal access requirement in the mandatory programs.

There is some evidence to suggest that both the MoHLTC and the MCYS feel NPs fit with public health. Currently nine health units are funded to provide maternal/child services in geographically isolated and/or under served areas until 2006. A variety of other MoHLTC grants currently fund NP positions in health units.

Some health units saw secondary prevention, also identified with the PPNP project, as fitting with public health. Here PHC NPs were seen to fit on the public health agenda by both management and NPs. The most obvious fit with the provincial mandatory programs is with the sexual health and family planning clinics. One health unit that just started having a NP offer primary health care discussed the role of the NP with the health unit. Both the manager and NP admitted to struggling with fitting the NP services with the mandatory service and program guidelines.

Recommendations

<u>If hiring a NP:</u>

- When hiring a NP consult with the NPAO regarding possible funding requirements, including wage, employment agreements, practice agreements, operating expenses and capital budget. This will contribute to an effective work environment and assist with recruitment and retention of NPs.

- Sexual health services in the provincial mandatory programs evidently encompass a NP's skills. However, NPs prefer to work within their full scope of practice. Incorporating NP services into other program areas contributes to job satisfaction.

- To be successful in utilizing NP services the NP needs to be fully integrated into the public health unit and the community. Support from community physicians and other NPs support is important for quality of service, retention and recruitment of NPs. The target populations understanding of the NP's role also contributes to their success.

<u>If no NP:</u>

- There should be collaboration with existing community NPs on a regular basis regarding services available, gaps in services, changes in

programming, and current information on health protection, promotion and education. Some health units without NPs explained that considerable effort was spent with NPs in the community to ensure public health programs and services were part of the NPs knowledge base. This allowed the health unit to acquire some of the benefits of NP services for their community and the NP benefits with current information on public health services.

Conclusion

There appears to be challenges with incorporating NPs into public health within the mandatory guidelines outside of sexual health. All health units who utilize the services offered by a NP have found them to be beneficial in moving forward the public health agenda. NPs offer excellent services in health education, health protection through primary and secondary prevention measures (e.g. early diagnosis and treatment), and successfully accessing under serviced populations. NPs also are seen as clinical leaders and are consulted regularly by other professional staff. There are however some challenges with incorporating NP services. For example, the implementation of Mandatory Health Programs and Service Guidelines widely varies across the province leading to different utilization of NP services. By the nature of funding Ontario public health units the NPs are often not utilized unless additional funding is made available specific to hiring NPs. This poses a challenge to integrating NPs into public health. Excluding NPs in sexual health programs, only two health units funded NP positions from base funding. Others rely on project or MoHLTC funding opportunities. Funding structure changes will need to be reexamined if NPs are to become integrated into the role of public health across the province.

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Appendix A

Survey Questions for Health Units With RN(EC)

Date:

Health Unit:

Contact Person:

Length of call:

Possible Questions:

1) Do you currently employ RN(EC)?
If yes, How many?

1) In what capacity? (Sexual Health, Immunizations, Maternal/Child Health, or in the schools.)

2) How is the position funded? How long will the funding last? When was it funded?

3) Area (rural vs. urban) served?

5) Salary range?

6) Do they belong to a union?

7) Can you send me a copy of your job description?

8) How many hours are they employed a week?

9) How is their time divided?

10) What areas of Mandatory programs are covered through their work?

11) How has the program been evaluated? By staff, the public, management? Can you share your results?

12) What is the success of the NPs? Are they busy; being utilized?

13) Are you reaching your planned or proposed target audience?

14) What is their work setting? Do the NPs home visit, work by appointment, drop-in clinics, in collaboration with PHNs or other health care professionals?

15) How do you see the NPs fitting into the public health agenda?

16) Issues with recruitment and retention?

17) How did you get the NP approved by the board? Proposal? PowerPoint? Can you share that?

18) Who is the collaborative MD? Is it the MOH? What is the consultation rate?

Information that will be sent:

Appendix B

Survey Questions for Health Units without RN(EC)

Date:

Health Unit:

Contact Person:

Length of call:

Possible Questions:

1) Do you currently or have you in the past employed RN(EC)?

2) If not why not?

3) Have you ever considered hiring a NP?

4) What did you learn?

Appendix C

Summary Table of Health Units Not Employing RN(EC)

Considered hiring RN(EC)?	Comments
Considering contracting a NP for sexual health rather than employing.	Considering contracting because hiring would require new job role/classification, inclusion in the union and "different rate".
Have not considered hiring an NP at this time.	Have had conversations with MOH on this but currently the Health Unit is not organized at this time for a NP. Require a family physician. Would require a position that can travel through the counties.
Have discussed this at length. Did apply for the ECD funding with the prenatal-postnatal project 2-3 years ago. Did not succeed. Did consult with the board but they decided to stick with their mandate. Waiting to see what happens with Family Health Networks.	Discussed ++ with board of health and senior management but "not looking at picking up the slack due to shortages in the primary health care system without extra funding". Have collaborated with community groups and do have a NP in the area but not with HU or other mandated initiatives. But will continue to work with and support the primary health care system. Plan to wait to hear/see what the Public Health branch and Public Health advisors say about use of that role. Not going to be doing anything else anytime soon
Not in parent /child. Applied for ECD project, was denied	- If separate funding system became available would consider. Currently have project with the Community Health Centre (CHC) and the Ontario Early Years Centre (OEYC) where NP is secounded to OEYC once a week. PHNs can refer to NP. This program is esp. popular with immigrant population. Would not consider hiring with 50/50 because of duplication of service - have 2-3 PHNs trained as NPs but choosing to work as a PHN
Yes	Not to say might not. Don't have a category for a NP at this time. Have not had one because there hasn't really been a need. Other priorities taking time. One issue is seeing how NPs fit in with the contract union salary scale. Would be using more in sexual health- looking to expand those services.
Yes, but too expensive.	Too expensive, did not make proposal to board. Unsure if could use RN(EC) in enough programs to make it worthwhile.
Yes informally	Considered it, not moving forward with it at this time. Unsure of support throughout agency.
Too expensive. Using PHNs in clinical model with medical directives.	Not using RN(EC) in any other area and have not considered in maternal child health. Do not plan to at this time.
Yes but no position was created	Work with an NP in the community as an informal liaison only. NP may use their space at the Health Unit.
Not seriously	Have PHNs enrolled in the education NP program part time. Not considering hiring a NP at this time.
Yes but had difficulties between union and non-union pay scale.	- Decided to hire a policy and research analyst. - Had troubles with capturing an NP under the collective agreement. Would have liked it as a non-union position for the flexibility. Currently in the collective agreement there is a position as supervisor that includes decision making/judgement.

Considered hiring RN(EC)?	Comments
	- With NP salaries at >$70,000 this puts them at a level between supervisor/management which means they would need to supervise 10 staff which is a full time job in itself and the reason for hiring the NP is to use them as a clinician. So decided to have PHNs work under medical directives doing pap's, STI smears, dispensing of medications, gestational sizing. Some clinics are PHN only model some are combined PHN/MD model.
Don't feel it is needed at this time.	Have a number of NP in the community, feel services provided there. Don't feel an NP is required to complete programming at this time.
Not with HU mandated programs. Part of director's responsibilities with CHC.	Use NP in CHCs only not with provincial mandatory programs or ECD and used for rural/remote areas.
Have put forth a number of requests for NP in child/family health, clinical services and sexuality and family planning clinic. Proposals have not been accepted.	No additional information was provided.

Appendix D

SUMMARY TABLE of HEALTH UNITS EMPLOYING RN(EC)

Area of Work	Funding	Salary	Union (Y/N)	Work Setting	Collaborative MD & Rate	Recruitment & Retention	Success of NPs	Fit with PH
1 PPNP 1 Sexual Health								
1 PPNP 1 Clinic Services (VPD, STI, Travel, Tb f/u) started 2003	ECD until 2006 Clinic – Base Funding	Will be negotiating soon	Yes	ECD- @ OEYC - Protocol for DI with PPNP esp. important. Work with PHN with in-services/ consultations, PHNs refer to her. - by appt. only, will see urgent Drop-In	Currently MOH was a family physician initially but was going to $1000/mo		Yes, definitely. To the point where appoints were the only option	
1 primary health care	PHN position topped up with municipal funds	77,422.80 to 91,409.60	Yes	Working on how program fits with mandatory programs. By appt. only. Seniors to newborns. Primarily women, see some men. As a new NP did not want to work only in sexual health. Has administrative support	Acting MOH – No fee	Had two PHNs that just graduated from the program that applied. NPs were interested because it did not include only sexual health	Getting better, one sex h. clinic outside town. Did newspaper article with not a huge response. Word of mouth, pres. to community programs	Mgr. – not sure, huge need for primary care in area. This is a way to get additional health information out to certain populations NP – see it as a good mix. Tricky with PH mandates outside of Sexual Health. I.e. Well baby clinics, PHN can do it, and can't start auscultating infants, esp. if they have a family MD. Same with immunizations. Resources and education materials should and can be done by PHNs and communications

Area of Work	Funding	Salary	Union (Y/N)	Work Setting	Collaborative MD & Rate	Recruitment & Retention	Success of NPs	Fit with PH
								dept. - NP position hard to sell with staff; tried to answer to staff how primary care fits with public health
1 ECD	ECD	64,227.80 – 80,298.40	Yes	Clinic, mainly appt, does some drop in, no HV b/c pop. Does not have phone. No administrative assistant (AA) so does some secretarial duties and administration work	$0 – It is a collaborative partnership, not a way to make more money	Took time to recruit because in small rural area and not in clinical setting.	Yes – with in weeks of opening clinic filled. Pop. saw benefit that NP was female, esp. with Low-German	Connections with other HU programs, CAPC, HBHC, and community organizations: OEYC and immigration agency
1.6 Sexual Health	Base funding	70,288-81,900	Yes	Not sure of break down. Mainly sexual health clinic and secounded to "health bus"	Medical consultant at HU 17.5 hrs/week. Part of hourly rate	Not a problem	Get best of both worlds; the dx/tx/rx for routine health issues and the skills of a nurse with education, counseling and understanding behavior change	RE: health bus "Some days yes, some days no" A lot of the health bus is looking at lifestyle, eating behaviors, smoking cessation, behavior change etc. Does there need to be an NP for this or could it be a PHN? Have been instances where having a NP has been beneficial to the clients. Works well with sexual health
1 PPNP 1 Sexual Health, STI AA 0.5 FTE	ECD Base funding	2005 - $33.25-$43.26; ($78,322) 2006 - $34.08-$44.34; ($80,698)	Yes (has some comments)	Both in clinics ECD NP may go into home, unsure if she has done this.	Community physicians with no charge.	Recruitment for a mat. Leave has been a real issue. Unable to do so. Current NPs commute from Hamilton and Brantford	Yes – really hopes program continues, the community is very much behind this project,	

Area of Work	Funding	Salary	Union (Y/N)	Work Setting	Collaborative MD & Rate	Recruitment & Retention	Success of NPs	Fit with PH
							there is such a need for basic health care in this community .	
Sexual Health 0.4 FTE	Base funding	Not given, being renegotiated "on the low side of other health units"	Yes	Sexual health clinics only- by appointments but see drop ins if not busy	STD/Sexual clinic medical director	No	Yes appts booked	
1 PPNP	ECD	As of Dec 2004 7 Grid - $32.78-$42.77 $59,659 - $77,841	Yes	Clinics in Mennonite/ Amish communities. Does some HV especially initially through PHN. Requests through schools, clinics at schools.	1 informal consultation, 1 MD in Palmerston charges $100 a month	- had to start at top of grid despite no experience because of the market	Extremely busy. Not too difficult getting to community Worked with PHN first - very successful with school program which was primarily sexual health and birth control. PHNs now in high schools with medical directives	Really interested in NPs in high schools primarily around sex. Health. Reasons students went to clinic was mainly s. health, STI, relationship issues, other reasons included: - pregnancy testing - alcohol consumption counseling - smoking cessation - depression, stress and mental health - nutrition for BMI <20 - illness, pain, and injury - skin care/personal hygiene - self esteem

Area of Work	Funding	Salary	Union (Y/N)	Work Setting	Collaborative MD & Rate	Recruitment & Retention	Success of NPs	Fit with PH
0.25 FTE Sexual Health 1 FTE (vacant) primary care	Base Funding One time grant	$65,520-$79,989	No (includes supervision)	Sexual Health – by appt. clinic only	Community physician, no payment. Contacts once every 2-3 months	Yes, lack of NPs available and enrollment in programs minimal. Those who have graduated wish to be with a physician on site. Lack of other NPs to collaborate with.	- 5 week waiting list	NP's comments "Like a glove". Provide very personal and dedicated care. Enable people to have a choice.
1 Sexual Health no extra AA support	Base Funding – took PHN position and topped up to NP salary	$41.31/hr $75,227/ year What local CHC is paying	Yes	By appt. clinics; accept walk ins - 10-15% no show rate	Current Medical Director, consultant, and clinic physician		Yes – an increase in the number clients seen in clinics	NP – really see it fits Building on skills of PHN: critical thinking, community development, my scope takes in 90% of services. NP scope is 60-80% of primary care NP student with hx HBHC – well baby clinics, expanded scope - Immunizations order various tests, referrals. Maternal child, scope of NP is especially relevant. Used in preventative role. Preconceptual health, prenatal f/u in early months, prenatal classes, immediate long-term, 1st week appt i.e. BF problems, assess better coping and

Area of Work	Funding	Salary	Union (Y/N)	Work Setting	Collaborative MD & Rate	Recruitment & Retention	Success of NPs	Fit with PH
								feelings, obtain resources, adjustment at home-counseling, well baby visits – 1 wk-18 months
1 PPNP	ECD	$67,267-$75,548	Yes	Clinics, home visit rarely, only if necessary. Some work on policy and procedures and participate in some research in the community	2 community physicians – no consultation rate	Trouble with recruitment b/c 1) rural area, 2) supply of NP especially with Family Health netowrks coming, 3) salary (lost 1st one), 4) NP did not pass exam – happened twice	Yes – spread by word of mouth very quickly	Depends on what they do, certainly to meet needs of certain populations, starting to get into primary care. "Start to slide past Mandatory Programs". Feels can fill primary care gap quite well, feel pretty big gap. Area of caution not to slide into primary care only.
4 in primary care Pediatric clinic has 1 FTE AA 1 Rural NP has 1 RPN FTE	2 NP in demonstration project 2 currently 100% municipally funded	8 levels in grid $40.66-$49.54 $74,001-$90,162	Yes	By appt. clinics only, no HV; one downtown, two rural areas, one ped.	$10,000/yr stipend	No troubles, believe because able to use full scope of practice	Yes – 20,000 roistered that don't have MD. The downtown clinic had 200 people roistered in 2 days	Access to Health care is a basic health need. NPs are able to service the unique high needs of this population more effectively. Typically family physicians don't always accept them. However, the NPs seem to be able to work with them, provide a whole different service
1 sexual health 1 PPNP Has AA help	ECD and Base	$64,318.80 - $85,885.80	Yes	Clinics – 50% PPNP and 50% sex. H clinic	$100/hr	Had to split two positions because could not fill one. Related to PPNP project not permanent	Slow, could be busier, just started PPNP clinic related to recruitment issues	Not really, more of an acute care. Works well with s. health; allows her to work without MD. "Is it truly Public Health? Probably not"

Area of Work	Funding	Salary	Union (Y/N)	Work Setting	Collaborative MD & Rate	Recruitment & Retention	Success of NPs	Fit with PH
1 Sexual Health	Base Funding	$35.84-$41.65 $65,228-$75,803	Yes	Wherever there are s. health clinics. Also participate in staff education and practice issues, policies, medical directives. Interest in evaluation and research. Required to travel	Physician is HU employee not contracted out. Part of work hours up to 7h/week is used for NP consultation. Increased to about $133/hr with all the usual deductions for staff OHIP billing for STI clinics only paid to the agency, no the MD Pay for physician meeting time have supported attendance at one conference Believed that we needed to support NP practice by providing MD consultant	Recruitment for part time is a challenge. Salary is also a challenge	Oh yes – no issues	Reasons for going to NP: - looked at cost to expand clinic services and it was more feasible to employ a NP - Physicians availability is limited - MDs practice choices change from one to another - NPs are very committed to Best Practices and research NPs support us in excellent care - This is different with NPs who are HU employees and sit in on team meetings - Don't have to explain nursing practice to an NP - NPs more aware of policy, becomes more of a unified group
1 PPNP 1.5 Sexual Health/HIV/AIDS/STI Outreach AA defiantly needed, does charts, scheduling,	ECD Base Funding (vacant)	$38.64-$44.38 $70,415-$80,771	Yes	PPNP has two sites downtown and HU. A need for expansion but have not related to time, distance and money. City has more of a shortage then outside the city limits. Sexual Health Outreach	The collaborative physician with the PPNP project is a family physician with one hour of time per week, our annual	Recruitment yes	Yes would like extension on ECD funding. Very well utilized and successful; we are in a position of	Mgr–absolutely, clinic service and children's' programs NP- fits well with health unit because of sexual health, pregnancy tests, no MD referred to NP and HBHC. School nurses with teen

Area of Work	Funding	Salary	Union (Y/N)	Work Setting	Collaborative MD & Rate	Recruitment & Retention	Success of NPs	Fit with PH
clinic supplied, stats and data entry				provides outreach to populations within our city and district that have limited access to services Modeled after the Women's Wellness program. Flexible schedules that includes weekdays, evening and weekend clinics	budget is $5,200. The collaborative physician with the Outreach Program is a family physician within our Sexual Health program. Also budget $5200 for this program.		managing waiting lists.	pregnancy, and cervical screening. Fills the gap in service, esp. with social determinants of health
2 with Community Health Centre 0 with HU	CHC	$83000	Yes	Clinics at CHC	Physician with hospital outreach covered by MOHLTC because part of CHC funding	Unable to recruit for ECD NP		
1 PPNP 1 AA	Alternative funding project – 2002/03 Was initially part of cervical screening project	$82,000	No– problem with union	Almost exclusively clinic; 5% health promotion, such as collaborative work with eating disorders unit at hospital, but this is very minimal	Currently MOH will change to sexual health MD		"You have no idea" would see "upwards of 25 people a day if we let her"	
1 NP sexual health supervisor	Base funding	Paid same rate as supervisor	No	Sexual health clinics (one night a week), staff education, supervision/admin.	Sexual health MDs	Concern with limiting scope of practice to sexual health only	Role fits well with staff education and is used frequently for consultation from PHNs	Do see them in public health. Felt developed a good ability to critically review of literature. Trying to promote evidence based practice or best practice. Nurses coming to her with literature and advice developed a strong

Area of Work	Funding	Salary	Union (Y/N)	Work Setting	Collaborative MD & Rate	Recruitment & Retention	Success of NPs	Fit with PH
								consulting role. Have a lot of input in policies and procedures and on going education needs.
2 Sexual Health (STI only) 4-5/hrs/wk since May 2003	Base Funding; Use budget for causal nurses to fund the positions	$32-$40/hr $58,240-72,800 if 1 FTE	No	Clinic	Sexual Health MDs, included as part of their role	No	Absolutely, no concerns.	Would like to use them more. Would like to try more in sexual health, clinic settings and quality assurance for RNs
1 Sexual Health for past three years	Base Funding	$86,905	Yes	Schools/clinic 2.5 days high schools and 2.5 days in clinic	MOH on record but generally sexual health MD at $85/hr	Yes – NPs do not want to become trapped in one program - location also a problem	Yes –lower pregnancy rate with clinics in schools. Since 1989 Slightly less busy than MD	
1 PPNP	ECD	Up to $50.13/hr $91.236	Yes	By appt. clinic	Sexual Health MD at $100/mo + $100/hr prn	Took 5-6 months to hire a NP	Two clinics, both are filled and booked	If funding does not continue, clinics will be closed. Definitely thinks the board would not approval a position because not part of Mandatory Programs. What is in Mandatory Programs a PHN can do.

Appendix E

SUMMARY TABLE of EVALUATIONS

Title	Completed By	Project Description and Objectives	Method	Findings
Evaluation of the Prenatal and Postnatal Nurse Practitioner Services Initiative: Interim Report	Public Health Research & Education Department (PHRED) March 2005	Main objectives: - to increase access to early prenatal and postnatal health care services, - and early identification intervention of potential complications for mothers and infants One of the criteria for site selection was identified gaps and barriers to accessing pre- and postnatal care due to geographic isolation, under serviced, or other issues identified by the Board of Health.	- Interim Report - Qualitative and quantitative data was used to answer these questions: 1) What prenatal and postnatal services have been provided to these under serviced populations? 2) Have access barriers to prenatal and postnatal care been reduced or eliminated through this program in these locations? 3) What community partnerships and linkages have been established by the program? 4) What factors are in place to contribute to the programs long-term sustainability?	- Nine programs were operational and evaluated. - Women who had difficulty accessing pre- and postnatal services were given health services through the PPNP program. Such barriers included geographic isolation, low income, minimal education, low literacy, cultural or linguistic barriers, and no health insurance. Many women struggled with more than one barrier. - The interim report states "The program has provided needed services where none existed before, has improved service coordination, has provided health promotion and prevention services through accessible, free, and convenient service delivery models" (Snelling, 2005, vii). - Many informants for the interim report stated that having the NP services linked with the public health unit lead to referrals to many health unit programs such as Healthy Babies, Healthy Children, immunization clinics, and sexual health clinics. - Links with external agencies included emergency departments, maternal/infant wards at hospitals, midwives, and physicians. Referrals also came from many other external agencies. - All sites agreed that the program was worth continuing. In fact suggestions were made on expanding the service to include persons beyond the target group, additional locations, more support staff and include other health professionals. - The main challenge identified for sustaining the program includes long-term, permanent funding from the Ministry, a flexible funding base, and funding to allow recruitment of NPs to isolated communities.
Assessing Access in Nurse Practitioner-	Community Health Research Unit	This report was completed to add to the evaluation of the PPNP program.	A descriptive qualitative exploratory design was used. Information was collected from four sites. PPNP clients and	The CHRU concluded, "the PPNP program seems to have reached the target groups it was designed to reach, and it is serving those it intended to serve. Further, from the perspective of the community, it is serving them well.

Title	Completed By	Project Description and Objectives	Method	Findings
Provided Prenatal and Postnatal Care: Perspectives of Clients and Community Leaders	Authors: Lynne MacLean, Alma Estable, Mechthild Meyer, Wendy Peterson, and Abebe Engdasaw April 7, 2005	Specifically the authors were evaluating the success of the PPNP program in reducing barriers for women and infants requiring pre- and postnatal care.	community leaders from each site were interviewed.	Community members feel the services are vital, and want to see them sustained, and, preferably, expanded" (MacLean et al., 2005, vii).
Evaluation of the Sudbury & District Health Unit Women's Health and Wellness Program	Sudbury & District Health Unit PHRED Prepared by Susan Snelling June 2003	The funding for the project began February 2001. The program was an "outreach project that provided primary health care and women's wellness services (including cervical screening, clinical breast examination and sexual health services) to women who experienced barriers to accessing these services. Services were provided by a Nurse Practitioner" (Snelling, 2003, i).	The evaluation plan was developed with the program logic model as part of the proposal process. The key outcome to be assessed was the health of women who had barriers accessing regular health care. Data collection methods included chart reviews, clinic logs, questionnaires from clients, and project staff and committee members.	Significant findings include increased access to services for a large number of women and increased knowledge and awareness of NP role within the health unit and physicians. One of the community partners in the project was successful in obtaining funding to continue the project in the community. Lessons learned from the project included clients preferring clinic sites that had a 'clinic-like' appearance, rather than temporary clinic set ups at familiar locations. Neutral sites, locations that could serve many purposes, were preferred for anonymity and confidentiality. However, higher risk clients' preferred to be met on familiar ground initially.
Huron County Health Unit School Profile	Huron County 2001	Clinics at high schools staffed by a Nurse Practitioner. Client profile and services provided were assessed.	Not provided	- 59.5% of the students that accessed the clinics did so more than once. Majority of the clients were female (109 female and 7 male). - Reasons for accessing clinic include birth control and other sexuality related issues (80% of visits); HIV and other STIs (5%); and relationship issues (5%). Other reasons included pregnancy testing; alcohol consumption counseling; smoking cessation counseling; depression, stress, and other mental health issues; nutrition counseling for underweight Body Mass Indices (<20); illness, pain, and injury; skin care and personal hygiene; and self esteem issues.