

Report on

**UNIVERSAL ACCESS TO HEALTH AND
UNIVERSAL HEALTH COVERAGE:
ADVANCED PRACTICE NURSING SUMMIT**

Hamilton-CA

April 15-17, 2015

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Background

Universal Access to Health (UAH) and Universal Health Coverage (UHC) is an overarching goal of health systems and is based on the values of primary health care (PHC). It means that all people and communities have equitable access to comprehensive and guaranteed quality services that they need, throughout the life course, without financial hardship.

In the World Health Report, 2000, it was stated that human resources are the most important part of the health system. Currently, the primary focus is on how human resources for health can attain, sustain, or accelerate the advancement of UAH/ UHC so that all people can access, use,, and obtain the high quality health services they need.

The nursing and midwifery professions continue to evolve and their roles are influenced by local and global challenges. Nurses and midwives are prepared to respond and manage health care needs across the life span. Within the context of PHC and UAH/UHC, nursing and midwifery services contribute to reduction of morbidity and mortality, resulting from emerging and re-emerging health problems. Nurses and midwives are frontline professionals who use an integrated and comprehensive approach including health promotion, disease prevention, treatment, rehabilitation and palliative care.

However, the workforce of tomorrow must clearly be different from that of today to meet the challenges of health delivering on UAH/UHC.

In the 65th Session of the Regional Committee in the 52nd Directing Council of PAHO, the Resolution CD 52 13 was approved entitled “Human Resources for Health: increasing access to qualified health workers in PHC-based health systems.”

The resolution urges Member States, as appropriate within their particular context and taking into consideration their priorities to promote reform in health professions education, to support PHC based health systems and increase the number of seats in training programs for health professionals who provide PHC, such as advanced practice nurses.

The advanced practice nurse (APN) is defined by the International Council of Nursing as a “registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master’s degree is recommended for entry level.” The nature of the practice integrates research, education, practice and management; high degree of professional autonomy and independent practice; case management/one’s own case load; advanced health assessment skills; decision-making skills and diagnostic reasoning skills; recognized advanced clinical competencies; provision of consultant services to health providers; plans; implementation and evaluation of programs and recognized first point of contact for clients.

The APN is a well-recognized nursing professional in the United States and Canada with regulatory framework well established, but there is little evidence of APN education, practice and regulation in Central and South American Countries.

PAHO will promote discussion about broadening the scope of nursing practice in PHC in the Region of the Americas and how best to integrate the APN in Latin American countries to fulfill its 2013 mandate.

Strategies will be developed in collaboration with experts in a two day Summit sponsored by PAHO, the Canadian Government and with the support of McMaster University School of Nursing, PAHO/WHO Collaborating Center on Primary Care Nursing and Health Human Resources.

Goal and Objectives of the Universal Access to Health and Universal Health Coverage: Advanced Practice Nursing Summit

The overall goal of the Summit was to address the APN role in the promotion of primary health care in the Americas. The objectives included:

1. To define the scope of nursing roles and advanced practice nursing in primary health care in Pan American countries
2. To discuss the context in different countries' experience with nurses' changing roles and/or responsibilities (RN, APN) and access to primary health care, i.e., universal access, professional preparation, regulation, the scope of nursing practice and global strategy.
3. To develop strategies for the implementation of the APN roles in primary health care in Latin America and advance the role of APNs in the Caribbean to address:
 - Gaps in health services and unmet population needs
 - Changes to nurses' roles and/or responsibilities that can leverage APN expertise
 - Factors that might enable these changes in nurses roles and/or responsibilities.
4. To anticipate the impact of leveraging the APN role on population health and health systems in Pan–American countries.

Opening Remarks and Presentations



Dr. Carolyn Byrne, the Associate Dean of Health Sciences and Director of the School of Nursing at McMaster University provided a warm welcome to the Summit participants and brought greetings from the university's president, Dr. Patrick Deane. Carolyn indicated it was an honour to host the PAHO Summit and to share developments in McMaster University's advanced practice nursing education, scholarship, research and practice. "We are very excited about your participation in this PAHO Summit at McMaster University. Most of you were on field trips yesterday where you were able to see for yourselves our work in the community. I hope the site visits went well and that it allowed everyone an opportunity for insightful reflection and discussion (Appendix B). We have more than enough international talent in this room to generate some breath-taking progress in advanced practice nursing roles among our Pan-American colleagues."

Dr. Byrne introduced Dr. Andrea Baumann, Director, PAHO/WHO CC in Primary Care Nursing and Health Human Resources; Associate Vice President, Global Health McMaster University; Scientific Director, McMaster Site, NHRU. Andrea indicated that she was pleased to see all of the countries represented. "This is exciting for us, as Canada is proud of its universal health system. We're glad everyone is here, safe and sound, and we look forward to the dialogue over the next 2 days". Andrea acknowledged the pressure from governments and other agencies to provide evidence. This can be quite a challenge as the state of nursing is highly varied. Andrea then provided some context about the larger discussion of nursing workforce planning in her presentation on [**Nursing Human Resources: Evidence Required For Change.**](#)

The Scope of Nursing Roles and Advanced Practice Nursing

Three short presentations were provided by representatives of PAHO and/or WHO about the scope of nursing roles and universal access to health:

- **Universal Access to Health and Universal Health Coverage in the Context of Health Systems**: Reynaldo Holder, Advisor for Hospital and Integrated Health Care Delivery Services
- **The Scope of Nursing Practice in Latin America and Advanced Practice Nursing**: Silvia Cassiani, Regional Advisor for Nursing and Allied Health Personnel Development. PAHO
- **Towards a Global Strategy on Nursing and Human Resources for Health and Universal Health Coverage - Health Workforce 2030** Annette Mwansa Nkowane, Technical Officer of Nursing and Midwifery, Department of Health Systems, Policies and Workforce. WHO ([Video](#))

Two participants' questions were addressed by the speakers.

Q: *We spoke about essential core competencies. Midwifery has done a great job. How do we get to essential core competencies across the world that can be contextualized for each country?*

Reynaldo Holder: We are building a framework for core competencies for health care managers that are not linked to specific professions. This became a concern and we discussed it at a summit 4 years ago in South Africa. That framework is complete and will be launched in October, 2015 with a small launch this summer in Chile. This led to a consortium for Health Care Managers and has 16-17 organizations involved

Judith Shamian: The International Council of Nursing (ICN) has a document with core competencies. The work has been done by experts already.

Q: *What should the training include for APNs in primary care settings?*

Annette Mwansa Nkowane: Due to the multi-disciplinary nature of the teams, training needs to have participation from different groups. At the Masters level, the nurses already have experience. It is important that the professional has previous experience as a nurse so that they can get further on in the practice. If the country does not have that professional, they would have tutors and mentors for those nurses.



Country Experiences of Nurses' Changing Roles and/or responsibilities (RN, APN) and Access to Primary Health Care

Five presentations were provided by representatives of Pan American countries and Spain:

- **Canada**: **Denise Bryant Lukosius**, Associate Professor and Co-Director, Canadian Centre for Advanced Practice Nursing Research, McMaster University
- **Caribbean**: **Marcel Johnson**, Ministry of Health–Chief Nursing Officer in The Bahamas
- **USA**: **Joyce Pulcini**, ICN Nurse Practitioner/APN Network, Professor, George Washington University
- **Chile**: **María Consuelo Cerón Mackay**, Director of School of Nursing Universidad de los Andes
- **Spain**: **Maximo Gonzalez –Jurado**, President of the General Council of Nursing



The Context for Implementing Advanced Practice Nursing Roles

Following the presentations about the five countries' experiences, discussion groups addressed the following questions:

1. When you think about leveraging (influencing or optimizing) the use of APN roles and responsibilities in primary health care:
 - What are the common challenges across countries?
 - What are the common enablers across countries?
2. What are the gaps in health services and unmet population needs that could be addressed by APN roles in primary health care? (Where are the opportunities?)
3. In primary health care, what are the top 3 changes to nurses' roles and/or responsibilities that must take place to leverage APN expertise in Pan-American countries?
4. What factors might best enable Pan-American changes in nurses' roles and/or responsibilities?

The results of these discussions (Appendix A), provided a shared context for identifying planning priorities for optimizing the APN role over the next three years.



Planning Priorities to Optimize the APN Role

Two years ago a PAHO resolution informed member states about the need for an APN role. In order to follow up on the resolution, country representatives were invited to this Summit at McMaster University to develop an overall plan to guide implementation of the PAHO resolution across Pan American countries. Following several expert presentations and considerable discussion, five planning priorities were identified for optimizing the APN role:

1. Establish Master's Level APN education programs
2. Engage and influence decision makers, legislators and other key stakeholders
3. Focus APN service delivery on under-served populations with high needs
4. Establish a Pan American collaborative network to develop and implement the APN role
5. Define and optimize complementary RN and APN roles in new models of primary health care

Participants identified one priority for which they wanted to develop a first draft for the plan. For each planning priority, groups identified strategies for the next three years (April 2018). For each three-year strategy, expected steps for the next twelve months were listed (April 2016). The planning drafts were presented to the large group and validated, as follows. The strategies and steps affiliated with each priority are provided in the following pages.



A Pan American Plan to Optimize the APN Role

PRIORITY 1: ESTABLISH MASTER'S¹ LEVEL APN EDUCATION PROGRAMS

| Strategies for 3 years (April 2018) | Expected steps within 12 months (April 2016) |
|--|---|
| <p>1.1 Conduct an education and health care needs assessment across countries (broad picture) regarding resources and goals for education programs to meet health care needs</p> <ul style="list-style-type: none"> - Focus on curriculum that matches the health care needs of the country - Discuss different understandings of “Master’s”. (Lack of consensus on this) | <p>1.1.1 Identify stakeholders and interest groups (e.g., ICN), government and university and practice leaders and involve key people in the process</p> <p>1.1.2 Establish a committee to get to know the situation and needs and to identify a conceptual framework to develop guidelines and documents for government and universities</p> <p>1.1.3 Tailor the needs at the country level</p> |
| <p>1.2 Develop competency-based curriculum</p> <ul style="list-style-type: none"> - This would be a model that could be adapted | <p>1.2.1 Define primary healthcare in Pan America and what and how APNs can contribute to PHC</p> <p>1.2.2 2-3 countries (USA and Canada) work with Latin American countries’ representatives (just 2 or 3) to guide development of competencies and then curriculum</p> <p>1.2.3 Offer the program at a few universities that are well prepared to offer it: either some go there or those faculty go to other countries to offer programs</p> |
| <p>1.3 Develop faculty and APNs using universities in countries that are established and can move this forward quickly</p> <ul style="list-style-type: none"> - Use resources/ evidence/ programs that are already available - Focus on primary health care programs, have prototypes from the ready countries and share resources with others - Ensure no one has to ‘start from zero’ | <p>1.3.1 Raise awareness with educators, unions and others to unite to go to government – political action</p> <p>1.3.2 Influence universities and institutions to work together to develop documents to move this forward</p> <p>1.3.3 Influence interest groups (e.g., ICN & others) to work together to support faculty, students and others</p> |

¹ Concern expressed by one group member that “Masters” is not universally understood and consistently delivered. Member was from an area outside of Pan-America.

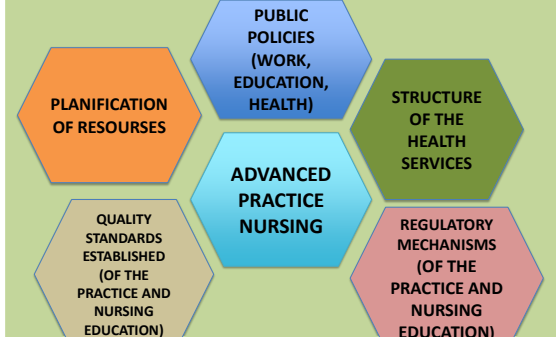
PRIORITY 2: ENGAGE AND INFLUENCE DECISION MAKERS, LEGISLATORS AND OTHER KEY STAKEHOLDERS

| Strategies for 3 years (April 2018) | Expected steps within 12 months (April 2016) |
|---|---|
| <p>2.1 Create agreement of key nursing groups (unions, associations, students, leaders) and build a coalition re APN</p> <ul style="list-style-type: none"> - Build awareness among nurses on what the new APN really is - After these meetings with APNs in various countries, develop the new image of the APN and make a document that can encapsulate the APN within the framework of the current legislation and globalization | <p>2.1.1 Host a national meeting of leaders</p> <p>2.1.2 The group from this meeting to develop slides to be used in national discussions with nursing groups (i.e., CCAPNR develop, PAHO translate into Spanish and Portuguese and distribute via listserv)</p> <p>2.1.3 Utilize nursing day and ICN documents</p> |
| <p>2.2 PAHO and Collaborating Centres (CC) work together to develop a compelling narrative based on the resolution on APN for country governments</p> <ul style="list-style-type: none"> - Develop standardized narrative that shows the value of proposing the implementation of APN, that all countries could use in the same way –without re-inventing, i.e., support areas that may not have science and expertise - These strategies have 3 stages – immediate, medium, long term. CC can be one of the groups that could generate research. Some have more resources than others but lots of organizations support research looking at the health of the community <p>Question: <i>Would the CCs have to take it on in addition to their current work and focus?</i></p> <ul style="list-style-type: none"> - All the CCs have Terms of Reference but they can add activities under particular areas for approval - As a CC, there are no funds. Expectations should not be too high for we do. - CCs have a work plan that requires reporting. At the same time, WHO does call up and invite the CC’s input. It is not adding to exchange expertise and knowledge. WHO asks the CC to support us, not add work | <p>2.2.1 Regulations for work of APN</p> <p>2.2.2 Scope of practice</p> <p>2.2.3 PAHO and collaborating centres have a draft of document (core group to move agenda)</p> |
| <p>2.3 Build relationships with nursing, PAHO, governments and other groups such as medicine, to increase awareness and advance the APN agenda</p> <ul style="list-style-type: none"> - When we talk about PAHO = offices at a country level as well as Washington. The relationship of the nursing community at the country level is critical | <p>2.3.1 Identify “friendly” stakeholders in government</p> <p>2.3.2 Utilize evidence /report from this meeting (in English and Spanish)</p> <p>2.3.3 Everyone in this meeting maintains communication</p> |

PRIORITY 3: FOCUS APN SERVICE DELIVERY ON UNDER-SERVED POPULATIONS WITH HIGH NEEDS

| Strategies for 3 years (April 2018) | Expected steps within 12 months (April 2016) |
|---|---|
| <p>3.1 Promote the use of systematic, evidence based approaches that engage stakeholders to conduct concise and comprehensive needs assessments to determine priority patient populations</p> <ul style="list-style-type: none"> - We know one of the most common barriers is lack of a needs assessment | <p>3.1.1 Establish a multi-disciplinary, multi-country task force to develop and lead the process</p> <p>3.1.2 Synthesize the literature about evidence based strategies (tools, resources) for conducting needs assessments to define the need and role of RNs and APNs</p> <p>3.1.3 Strengthen components to conduct relevant needs assessments through education</p> <p>3.1.4 Identify 2-3 centres as pilots to implement standardized tools to complete needs assessments</p> |
| <p>3.2 Define RN and APN roles and responsibility that are a good match for addressing health care service gaps and unmet service needs</p> <ul style="list-style-type: none"> - What do the roles need to look like | <p>3.2.1 Determine the core nursing competencies required to address unmet needs in PHC</p> <p>3.2.2 Increase awareness and understanding of APN roles and their impact among member countries (compare and contrast with RN role)</p> <p>3.2.3 Identify the effective and different models of PHC that optimize the role of RNs and APNs to meet the needs of patient populations</p> |
| <p>3.3 Promote the use of systematic approaches to APN role planning and implementation</p> <ul style="list-style-type: none"> - Plans that aren't well planned aren't well implemented | <p><i>To be determined</i></p> |
| <p>3.4 Increase capacity to monitor and evaluate the impact of APN roles</p> | <p><i>To be determined</i></p> |

PRIORITY 4: ESTABLISH A PAN AMERICAN COLLABORATIVE NETWORK TO DEVELOP AND IMPLEMENT THE APN ROLE

| Strategies for 3 years (April 2018) | Expected steps within 12 months (April 2016) |
|--|--|
| <p>4.1. Establish the network goals, structure and processes (PAHO to coordinate; link with strategy #2)</p> | <p>4.1.1 Establish a coordinating group (criteria for membership)</p> <p>4.1.2 Establish a consulting advisory group</p> <p>4.1.3 Develop goals for a network</p> <p>4.1.4 Identify mechanisms for network to communicate, e.g., website, webinars, meetings, regional meetings, email, phone, conference</p> <p>4.1.5 Establish the commitment buy-in from national stakeholders, e.g., ministries</p> <p>4.1.6 Develop a strategy to begin discussions in each country</p> |
| <p>4.2. Develop a strategy for the collection of data related to the RN/APN health human resources (use Laura Moran Pena's framework)</p> <div data-bbox="186 1024 738 1438" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p style="text-align: center; background-color: #f0f0f0; margin: 0;">FRAMEWORK</p>  </div> <p>Additional points from brainstorming:</p> <ul style="list-style-type: none"> - Propose plan of action - Implement/execute the plan - Look to partners/alliances to support implementation of the plan - Identify countries which have/do not have APN roles and share their experiences - Develop a data collection strategy to collect baseline data (describe commonalities and differences) - Enablers/barriers for APN implementation - Health human resources data - Factors influencing the development of APN role policy/legislation | <p>4.2.1 Create a common database to track changes over time (baseline done in 3 years)</p> <p>4.2.2 Develop a policy related to APN development and implementation</p> <p>4.2.3 Identify existing data</p> <p>4.2.4 Each country to review/check the data which then can inform that countries' plan for next steps</p> <p>4.2.5 Once APNs are established in one country, spread this approach across other countries</p> |

PRIORITY 5: DEFINE AND OPTIMIZE COMPLEMENTARY RN AND APN ROLES IN NEW MODELS OF PRIMARY HEALTH CARE

(Note: No one volunteered to write the draft for this particular priority – they preferred to contribute to developing the drafts for other priorities.)

| Strategies for 3 years (April 2018) | Expected steps within 12 months (April 2016) |
|---|--|
| <p>5.1 Articulate and describe in what areas RNs and APNs can work to meet primary health care needs (see 3.3)</p> <ul style="list-style-type: none"> - Not all are benefiting from the skills of nursing because they get training and go back into their old roles without new training being utilized | |

Anticipated Impact of Implementing the Plan's Strategies

Following the planning, participants were asked: ***If these strategies were fully implemented, what do you anticipate would be the impact on population health and health systems in Pan-American countries?*** Their individual responses are presented grouped under themes as follows:

Anticipated impacts related to patients/families/ communities / populations

- Better results in health
- Better customer satisfaction
- Significant decrease in our regions incidence of chronic, non-communicable disease, and infant mortality
- Improved access to health services and acceptability of services by the targeted population
- Improving access to primary health care in communities;
- Improvement in community health overall
- With more training for nurses at the primary health care level, the security and health of patients would improve. This is important for the profession and the population.
- Great deal of public benefit and satisfaction seen in the many aspects inherent in nursing care in terms of the emphasis on holistic care instead of just biomedical model
- Recognition of the work and its quality by the public.

Anticipated impacts related to structures of the health care system

- Increased efficiency in the system
- Through savings, funding would cover the costs of access to universal health care
- To reposition the value and attention to primary health care and well-being. At the same time, give the tools and information to the people who establish legislation
- Significant contributions to vulnerable populations by strengthening health funding for human resources and strengthening the autonomy and role of APN
- Reduction in health disparities as more people will have access to quality primary health care – this would improve health outcomes, including people in underserved areas
- Nursing focus would promote disease prevention and health promotion and hopefully over time give people the tools to better care for self
- Reversal of nurses working in the community in larger numbers rather than hospitals, preventing people from going to the hospitals if they do a good job in the community
- Ethical compromise of what services would be provided.
- Change in the assessment of the health care system – better value

Anticipated impacts related to Nursing as a profession

- Improvement of human resources in nursing. Better care, better quality with more visibility to the profession
- Better relationship within the nursing community in each country and because of that a better profile of nursing and relationships outside of nursing
- Contribution to changes in the vision that we have of practice of nursing and health
- Contribute to the development of the practice and broadening the scope of practice in the country

- Greatly empowered nursing work force and as a result see more people entering the field of nursing; long term effects on the population are really endless
- Strengthening professional image

Anticipated impacts related to health care teams

- Health team has more prestige
- Help formulate the position of nurses in multi-disciplinary groups
- Strengthened interpersonal relations
- Heightened self confidence

Anticipated impacts related to nursing education programs

- Universities and nursing schools would develop and teach the tools necessary to improve the health of the population

Next Steps

| | |
|--|--------------|
| Submit report to Planning Committee – Pitters Associates <ul style="list-style-type: none"> • Strategies will be included in the report • Identified steps are the first pieces of the implementation plan | May 8, 2015 |
| Committee provides feedback on report, changes made, report finalized | June 8, 2015 |
| Submit report for participants to review | |
| Distribute key messages about the Summit for participants to use | |
| Additional next steps will be identified by Ruta and Sylvia | |

Final Remarks

Ruta Valaitis

This has been a significant meeting that was necessary to advance primary care services across Pan America. The contrast and comparison of health systems of the seventeen country attendees has been critical in our understanding for nursing workforce strategies. Thank you for your contributions.

Carolyn Byrne

Thank you for bringing energy, leadership and new ideas to McMaster School of Nursing from across Pan America. We are very committed to capacity building in nursing services. Advanced Practice Nursing in Canada is evolving and the role is key in the delivery of health services across our country and across the world. I hope you have enjoyed your time here and I wish you a safe trip home.

Andrea Baumann

Thank you, PAHO, for letting us be your host for this very important meeting. The critical discussions have given us a greater understanding of workforce issues across Pan America; and, understanding nurses' roles is essential to provide data to inform governments for policy development and implementation. We know that universal health care is strengthened by effective nursing services. From a Canadian point of view, we're glad you came here to McMaster University.

Silvia Cassiani

Thank you all. It was not only PAHO that supported this event – the Ministries of Health and universities of the different countries that supported you all to attend. I want to thank Judith Shamian of the International Council of Nursing for your presence and contribution over the two days.

I think this is the beginning of more opportunities to collaborate. For the next days and months we are going to constitute the group and inform you in 2-3 months. McMaster University is going to develop and start a series of APN webinars. We will invite you and other professionals, universities, etc., that work with APNs. Through PAHO and Collaborating Centres (CC) we will develop activities and information so that you continue to have this information. The report will be translated to Spanish.

We have the challenge to share our experiences from all our countries, develop work, and join with others as a team. Each one of you is a leader – that is why you were invited. *(Projected an image of a light house)* We are this lighthouse. Joined all together, we can be this light that can shine on nursing and primary health care and will lead to better health for all people in Pan America.





Appendix A: Context for Implementing APN Roles

Following the presentations about the five countries' experiences, discussion groups addressed the following questions:

1. When you think about leveraging (influencing or optimizing) the use of APN roles and responsibilities in primary health care:
 - 1.1 What are the common challenges across countries?
 - 1.2 What are the common enablers across countries?
2. What are the gaps in health services and unmet population needs that could be addressed by APN roles in primary health care? (Where are the opportunities?)
3. In primary health care, what are the top 3 changes to nurses' roles and/or responsibilities that must take place to leverage APN expertise in Pan-American countries?
4. What factors might best enable Pan-American changes in nurses' roles and/or responsibilities?

The results of these discussions provided a shared context for identifying planning priorities for optimizing the APN role over the next three years (see page 10).

When you think about leveraging (influencing or optimizing) the use of APN roles and responsibilities in primary health care:

- What are the common challenges across countries?
- What are the common enablers across countries?

Common Challenges

The following themes were identified across the small group discussions (not in order of importance):

a) Role clarity and awareness:

- Defining Advanced Practice Nursing (APN) roles is still difficult and this gets mixed up when governments try to do quick fixes and create new roles; leads to difficulty comparing, measuring and collecting data
- Role clarity for Registered Nurses (RNs) and what is advanced practice; lack of clear scope of practice
- Articulating the Nurse Practitioner (NP) role to meet needs in primary health care - to show politicians the data re effectiveness, efficiency of APN
- Political awareness of the potential of nursing/NP in primary health care
- Nursing leaders are not politically involved
- Specialization in primary health care is not consistently available

b) Legislation:

- There are many aspects in the regulatory field that we should have solved but have not yet overcome - a shared weakness.
- Need for regulation of APNs
- Autonomy and collaboration difficult to establish, need legislation for nursing to expand scope
- Some governments pushing nurses and APNs to specialize

c) Education:

- Great diversity across programs creates obstacles
- Education systems differ across countries and are not consistently available
- Disconnect between what they learn and what they do - no clear implementation of advanced practice
- Need consensus between those who educate/train and those who hire
- Lack of capacity/faculty for graduate education and teaching advanced practice at some universities/countries

d) Funding:

- Perceived cost of implementation of roles
- Limited funding for APN development – research, education, and professional development

e) Resistance from other health care professionals

- Inter-professional power relations
- Some see APNs as a threat, e.g., physicians especially with prescribing, other nurses
- Breaking hierarchical teams
- Foreign trained physicians in rural and remote areas decreases opportunities for APNs
- Countries with high numbers of MDs

f) Migration of individuals after the investment in education and no career possibilities

- Prevent professional migration by: setting up satisfactory work environments; and, developing international agreements and human resources policies

Common enablers:

a) Education:

- Provides opportunity, it has evolved and opens up possibilities
- Competence and evidence based, culturally appropriate curricula in undergraduate education provides a solid foundation for APN, e.g., transcultural theory
- More universities offer APN courses

b) Legislation:

- Can enable and leverage the health system and the practice of advanced nursing
- Establishes competencies, self-regulation of nurses and provides expanded scope of practice
- Clarifies role of nursing

c) Common vision/focus moves forward:

- Across union, sectors, academic; Latin America has professional groups like unions that speak on behalf of the professionals and PAHO
- Recognize and appreciate the different needs and how it is enacted across countries
- Involvement, collaboration and cooperation between educators, regulators and providers
- Focus on primary health care in Latin America
- Global focus on universal health access
- Consensus across countries on the value of the role
- Partnerships allow people to leverage individual strengths
- Despite different countries being at different stages, there is a forward movement that continues
- NP approach to health is at all levels
- Political awareness of need to strengthen primary health care
- Nurse leaders as champions, advocates; some educators, legislators and associations speak on behalf of nursing

d) Evidence:

- Research success stories on what has worked that sets a precedent – “learning from others’ mistakes”
- Good practice outcomes – health, economic, patient satisfaction
- Look at evidence in practice to effect reforms; show evidence from other countries
- Cost of services – good quality of care at less cost
- Nurses with more skills and competence will produce safer care

e) Society accepts nursing as a recognized profession

- Relationships with the community
- Recognition of contributions in multidisciplinary/inter-professional teams, especially by physicians
- Increased public awareness of APN through videos and social media

What are the gaps in health services and unmet population needs that could be addressed by APN roles in primary health care? (Where are the opportunities?)

- Health promotion, education and disease prevention across the age spectrum for priority populations (marginalized, vulnerable populations)
 - Primary prevention – care/tests, blood pressure, screening
 - Access to immunizations and maternal child health
 - Obesity, nutrition
 - Communicable diseases
 - Chronic disease – HIV, cancer, cardiac, physical and mental disability
 - Environmental factors
 - Addictions, mental health and suicide
 - Accident prevention
 - Violence – domestic, urban, bullying
 - Different classes affect epidemiology
 - Adolescents, elderly – caring for older people at home with women working and smaller families
- Gap in service delivery models – need new models of universal health care that includes nursing, e.g.,
 - APN specialized in obstetrics
 - APN's bring something unique to the relationship with patients – trust, time they can give to hear patient needs
 - Recognition of existing scopes of practice and roles
 - Fill gaps in communities most in need - areas with low resources, e.g., indigenous communities, providers with insufficient qualifications
 - Move top down mandate and use it to leverage and fill the needs identified
 - Trusting relationships – physician, nurses, patient
- Access to services not guaranteed
 - Unable to get services (geographic, rural, remote, disadvantaged)
 - Not enough available
 - Lack of professionals/primary health care expertise
 - Shortage of resources – focus on cure and not prevention
 - Youth mental health and sexual health – prohibited by legislation
- Funding
 - Lack of human resources that leads to inequity between physicians and nurses
 - Physicians receive more salary and benefits
 - Look at how to pay for universal health coverage from systems level
- Professional development and career enhancement
 - Review and update of curricula, education standards and regulation
 - Use evidence, research
- Education across populations with focus on people with non-communicable diseases
 - Vary in quality
- Access to primary health care – need for providers to go out to centers in the community
 - Integrate care with social determinants of health focus – housing, education, poverty, gender employment

In primary health care, what are the top changes to nurses' roles and/or responsibilities that must take place to leverage APN expertise in Pan-American countries?

- First step is to change nurses' mind-set, e.g.,
 - From manager or hospital approach to primary health care provider
 - How we think about ourselves, our role and how that is delivered in the community; build assertiveness, confidence, leadership skills, political skills to build a culture of empowerment
- Define roles and understand the levels, e.g.,
 - Clearly defined roles of nurses and members of the healthcare team
 - Enhanced scope of practice
 - Leverage APN expertise
 - More autonomous roles, responsible for own actions, not needing permission (still collaborative)
 - Expand roles to more population based health and community development
- Develop team leadership and educator skills to influence policy and government, function better in collaborative teams and have the confidence to sit with decision makers
- Use best practices in education and training
 - More education of nurses so they are better able to translate knowledge based on evidence to people they provide care for
 - Knowledge and skill to understand and do the primary health care role
 - Improve knowledge base around chronic disease, health promotion, advocacy. Imbalance in systems that focus on specialized chronic disease rather than health promotion
 - Understanding multiple entry points and how to get into programs, e.g., develop bridging programs
- Motivate nurses to engage in APN research, e.g., build a research culture, collect data to look at the impact they are making, include knowledge translation strategies using one-pagers, infographics. APNs and nurses could be sharing these results through knowledge transfer, exchange and dissemination
 - Leverage best practices that are known to advance evidence-based practice
- Meet quality of care and performance indications
- Community and population approach to health
- Focus on quality of care and performance indicators

What factors might best enable PanAmerican changes in nurses' roles and/or responsibilities through system level change?

- Need for political influence and power – leadership varies by country, e.g.,
 - Establish partnerships between ministries of health and education system
 - Identify champions: organizations promote APN practice and include providers at local level to change
 - Strengthen and create new networks within and across countries
 - Generate a strong policy statement (white paper) out of this meeting that would keep the agenda moving forward. Each country could use this as a lever. Take a resolution to ministry to support change, accompanied by a proposal showing what the new role would contribute to the health of a country and what the expected outcomes would be, drawing on existing research.
- Harmonize education and training
 - General competencies, specialization, advanced practice, continued professional development program
 - Create internships in primary health care to see and expand scope of practice
 - Impact graduate courses, e.g., may need to change in Pan American countries; right now there is **one** NP program in all of the Central America and South American countries (Jamaica)
 - Include primary health care in clinical setting in education so people see it, role model to move it forward; start small, little steps
- Utilize research or lessons learned, outcomes of nursing practice and benefits of APN
 - Countries do research for local context; bring together findings to strengthen evidence
 - Ensure practice guidelines (based on evidence) are easily accessible
 - Identify performance indicators and benchmarks
- Define/focus on priorities
 - Start the role in under-served areas so that physicians and other providers don't feel that toes have been stepped on
 - Put supports in place in underserved places, so nurses aren't left on their own
 - Change nursing culture: “teamwork” within nursing and with others. We are not working alone within nursing and outside the profession. Nurses do not always support other nurses, e.g., lack of value on community vs. acute. Threat of APN taking away from undergraduate scope of work; every time we add a level, we threaten the other levels.
- Regulate practice, training and education so that it is consistent among countries
 - Create a regulatory framework (building on existing evidence-based materials) to address definition of APN, scopes of practice, standards, accreditation legislation. Do collaboratively, engage people from the top and at the front lines
 - Increase self-regulation – nurses need to be at the table and have bodies that define the nursing role and don't leave it to government
- Access funding – practice settings and equipment, incentives, salaries, research in nursing
 - Provide results based financing – PAHO could work with World Bank to create incentives for enhanced clinical care and cost effective care. Why they need to invest
- Build capacity in access – think about the whole team and how all nursing roles fit together to improve access using the best use of human resources – plan at the systems level.
 - Clarify roles in the team – opportunity to play a larger role to educate patients and providers; RN knowledge is there, but need more opportunities to use it
- Develop retention packages

Appendix B: Site Visits – Wednesday, April 15th 2015

Aboriginal Health Centre

678 Main St E, Ste 200, Hamilton, ON, L8M 1K2

<http://aboriginalhealthcentre.com/>

With a focus on providing holistic culturally-appropriate health care, the Aboriginal Health Centre provides a variety of programs and services based on primary health care values. A multidisciplinary team of healthcare professionals collaborate to improve the wellness of Aboriginal community members by providing mental health support, health education, and traditional healing services. In addition, advocacy and outreach programs promote empowerment within individuals to seek equitable access to services that respect the identities, values, and beliefs of the Aboriginal community.



Department of Family Medicine**McMaster Family Practice**

West End Clinic, Suite A
690 Main Street West
Hamilton, Ontario L8S 1A4

<http://mcmasterfht.ca/staff>

<http://mcmasterfamilypractice.ca/about-us/west-end-clinic>

Stonechurch Family Health Centre

1475 Upper Ottawa Street
Hamilton, Ontario
L8W 3J6

<http://stonechurchclinic.ca/clinic-info>

The two sites of the McMaster Academic Family Health Team are Stonechurch Family Health Centre and McMaster Family Practice Unit. Collectively, these two sites participate in the care of 33,000 patients and over 125,000 visits over the past year.

**McMaster Family Health Team (MFHT)**

The M-FHT is comprised of 32 family physicians, nurse practitioners, registered practical nurses, pharmacists, social workers, dietitians, system navigators, occupational therapists, a lactation consultant, psychologist, chiropodist—all “glued” together and tended by a team of like-minded, skilled and passionate support staff and administrators. The team is enriched by regular (weekly to monthly) sessional visits by a physical medicine specialist, pediatrician, psychiatrist, dermatologist and geriatrician.

This strong and diverse group meets the specific social, psychological and biological needs of our patients. This enrichment is the result

of several years of attention to the needs of our patients and communities, proactive advocacy with the MOHLTC regarding those needs, and careful and participatory recruiting of appropriate team members.

The clinicians of the MFHT are recognized as key participants in the education of learners from various professions. The clinical diversity of the staff is reflected in the diversity of the learners: residents, clerks, nurse practitioners, dieticians, pharmacists, social workers, occupational therapists and system navigators to name a few. The team is inclusive and draws on both the personal and professional strengths of its members with the goal of combining clinical excellence with robust caring and support. Through role modeling, trust and excellent communication within the team, the MFHT clinicians have achieved a level of expertise and trust that sets the benchmark for all FHTs. The quality of their care is evidenced by excellent outcomes with high patient and provider satisfaction.



Refuge: Hamilton Centre for Newcomer Health

183 Hughson Street South, Lower Level
Hamilton ON, L8N 2B6

<http://www.newcomerhealth.ca/>

John M. Perkins Centre

1429 Main Street East
Hamilton, Ontario



Refuge Hamilton Newcomer Health Centre provides client-centred, primary health care services to Hamilton's new immigrant and refugee populations.

Established in December 2011, the Centre was born out of the need to bridge a gap that existed in meeting the specialized needs of newcomers in this region. Through an early intervention, transitional model of care, the Centre addresses the unique needs of these populations immediately post-arrival.

Supported by an

interdisciplinary team of professionals, the Centre also provides easily-accessible, onsite specialty clinics ((pediatric care, cardiology, internal medicine, dermatology, and mental health) that would otherwise be difficult to access outside of the Centre.

The Centre operates mostly on volunteer participation and is funded through the generosity of the billings from clinicians.



Hamilton Family Health Team
123 James Street North
<http://www.hamiltonfht.ca/>

The Hamilton Family health team is one of the largest community health care teams and is comprised of 150 physicians, 135 Nurses and Nurse Practitioners, as well as registered Dietitians, mental health counsellors, psychiatrists and pharmacists. The focus of their practice is on the needs of families in the community. Their goal is to provide community members with access to family physicians. They provide client centered care, health promotion, educational services, and management services for chronic illnesses. In addition, the family health care team collaborates with other community organizations to improve health and quality of life.



123 James Street North is the new site for one of these practices. This site visit will include the following: Meeting a Nurse Practitioner (NP) working with Medically Complex Patient Outreach Team, who had previous experience in a Primary Care Practice. Also, there is the possibility of meeting members of the outreach team, including the Palliative Team members.

Sexually Transmitted Diseases Program (STIP)
Hamilton Public Health

The Sexually Transmitted Diseases Program (STIP) is delivered at Sexual Health Clinics, through the City of Hamilton's Public Health Services. The Sexual Health Clinic at 123 James Street North provides confidential clinic services on a walk-in basis. In collaboration with physicians and nurse practitioners, the Public Health nurse at the clinic provides health teaching related to safe



sex practices, sexual health, and birth control options. Furthermore, the clinic offers multiple diagnostic tests at no charge, including urine pregnancy testing and testing for sexually transmitted infections like HIV, chlamydia, gonorrhea, hepatitis, syphilis, and herpes. Condoms, as well as treatment for chlamydia, gonorrhea and syphilis are provided at no cost.

Hamilton Urban Core Community Health

71 Rebecca Street,
Hamilton, Ontario L8R 1B6
<http://www.hucchc.com/>

Hamilton Urban Core Community Health is a non-profit, charitable and community governed inner-city health centre that provides multi-disciplinary interprofessional care. The Centre's mission is to provide the community with primary health care, education and advocacy particularly to individuals who face barriers based on the social determinants of health. Furthermore, the Centre believes that focusing on the most disadvantaged will benefit the community as a whole.



Hamilton Urban Core has developed a number of programs including; chronic disease prevention and management care focused on diabetic care, health and wellness, therapeutic and supportive counseling, population health, client education and support, personal and community development, as well as parenting and support programs. The Centre provides Primary Health Care, Dental Care, Chiropody, Chiropractic, and Midwifery services.



Appendix C: Summary of Summit Evaluations

Using a scale from 1 to 5 where 5 is “Strongly Agree” and 1 is “Strongly Disagree”, participants evaluated the Summit in the following areas:

| Areas | Scale | | | | | Avg. |
|--|------------------------|---|---|---|---------------------|------------|
| | Strongly Disagree 1 | 2 | 3 | 4 | Strongly Agree 5 | |
| The Summit content was consistent with description in the agenda. | 0 | 0 | 0 | 2 | 12 | 4.8 |
| The Summit information will help me be more effective in my position. | 0 | 0 | 1 | 2 | 11 | 4.7 |
| I can use the information I learned right away. | 0 | 0 | 0 | 5 | 8 | 4.6 |
| Overall, the speakers for this session were knowledgeable. | 0 | 0 | 0 | 2 | 12 | 4.8 |
| Overall, the speakers for this session were engaging. | 0 | 0 | 0 | 4 | 10 | 4.7 |
| The Summit met or exceeded my expectations. | 0 | 0 | 1 | 2 | 9 | 4.6 |
| The topics covered were relevant, interesting and timely. | 0 | 0 | 0 | 1 | 13 | 4.9 |
| The sessions were interactive with significant audience participation. | 0 | 0 | 1 | 1 | 12 | 4.8 |
| The handouts and materials were useful. | 0 | 0 | 0 | 5 | 9 | 4.6 |
| Audio-visual aids were used effectively. <ul style="list-style-type: none"> • <i>Couldn't see them.</i> | 0 | 0 | 3 | 5 | 6 | 4.1 |

What participants would like organizers to know about the Summit and why:

- Excellent event organization and facilitation (5), e.g.,
 - Incredibly well facilitated - great (2)
 - The organization of the event was very professional. Very appropriate selection of people who could assist us
 - The hotel was great. The visits were great in order to understand more the rest of the two days of discussion.
 - Congratulations on the organization of this event. Thank you very much.
- Lessons learned, strategies to enhance APN and experience in APN (5), e.g.,
 - The fact that people are all so enthusiastic about APNs. Great energy – a wonderful start.
 - The experience in APN.
 - I really appreciate the focus on APN as they are an important group of health personnel that can move the agenda forward with regards to optimizing universal access to health/universal health coverage.
 - Research. Evidence-based practice. Policies.
- Exceptional participant engagement. Hope we can keep these conversations going (5), e.g.,
 - Great networking

- Though formal, the Summit was informal in a way because of the total engagement of all participants
- The interaction between people was dynamic and diverse
- Superb gathering of representatives – great networking and exchange of ideas

Participants overall impressions about the faculty at this session:

- Knowledgeable, engaging and well-coordinated; excellent, wonderful (11), e.g.,
 - Very interesting topics. Some faculty with much more experience about APN and other just to know
 - Everyone great at presentation, times, and general logistics. Also the documents were very helpful, as the information and discussions in groups
 - Outstanding – wonderful support and organization from the McMaster faculty, and great diversity of perspectives from faculty participants
 - Excellent, everything they did was well done. The situations that were not 100% to their satisfaction were probably out of their control
 - I want to thank you for the hospitality and generosity demonstrated by the community of this faculty. Highly competent professionals. This event was well organized with everyone's support
 - High quality
- A couple sessions, presenters were difficult to understand, even with translation.

Comments regarding whether or not participants would recommend this session for next year's conference agenda: why or why not?

- Yes I hope we do continue to meet – need to continue momentum (9), e.g.,
 - More health personnel need to be exposed to this type of discussion
 - I think that would help us in each of our countries to enable and push forward the APN program, and strengthen the primary health further than the hospital care
 - Patients speak about the programs
 - I would recommend a follow up be conducted in yearly meetings in order to identify the progress done and determine future commitments

Other comments:

- Suggestion - we don't like how the moderator synthesized the group's work.
- Viewing presentations was a challenge (4), e.g.,
 - Consider changing venues – too much light to view presentations
 - Needed PowerPoint handouts. They were impossible to see.

Appendix D: Participants

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