Abstract
The Interior Health Authority (IH) is one of six health authorities in British Columbia, whose goal of delivering the best possible healthcare services to its residents requires proven and innovative healthcare delivery strategies. The nurse practitioner initiative is one such strategy used by IH. The following paper describes marketing strategies and early evaluation results of the awareness and acceptance of the nurse practitioner (NP) role in IH. Multiple marketing strategies were used prior to and after NP hiring. Three evaluation questions focused on people's awareness of and willingness to be seen by a NP instead of a doctor for minor illnesses or health maintenance. Evaluation results were consistent with evaluation results of other provincial and national studies.
Introduction
Key elements of primary healthcare reform in Canada include enhanced access to care, increased emphasis on health promotion and disease prevention, and use of multidisciplinary teams including nurse practitioners (DiCenso 2007: 105). Nurse practitioners (NPs) are registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice (CNA 2009). In British Columbia, NPs are prepared at the post-baccalaureate, master’s level to meet the scope of practice identified by the College of Registered Nurses of BC.

The Interior Health Authority (IH) is one of six health authorities in British Columbia. IH covers approximately 215,000 square kilometres and serves a client population of 742,000 in several cities and a multitude of rural and remote communities. Within IH, services are delivered through one regional “network of care” that includes hospitals, community health centres, residential assisted living facilities, mental health housing, primary health clinics, homes, schools and other community settings. At the time of this report, IH provided service in four health service delivery areas (HSDAs). Interior Health’s goal of delivering the best possible healthcare services to its residents requires the adoption of proven and innovative healthcare delivery strategies. The nurse practitioner initiative is one such strategy used by IH. The following report describes the experience of one health authority in British Columbia that, blending evidence and strategy, implemented a NP initiative and early evaluation activities particularly related to a planned and deliberate marketing and communication strategy.

Employment of Nurse Practitioners
The NP role was formally introduced in British Columbia in 2005 though enabling legislation and regulation (Burgess and Sawchenko 2011). During the two years of educational preparation in the province, six NP students had clinical placements within IH. In fall 2005, the first nurse practitioners graduated and were registered and employed in British Columbia. Figure 1 represents the pattern of NP employment in IH by HSDA and shows a steady progression in numbers of full-time NPs employed in IH during the first five years.
Early in the NP initiative, IH nursing leaders recognized the need for a professional community of practice (CoP) for the nurse practitioners. The CoP addressed the need for this new group of clinicians to engage in discussion and problem solving related to the integration of their NP role and practice. The group convened several times a year in person or electronically and provided a venue for NPs to be supported, because many of them were novice NPs, working in new roles, spread across a large geographic area and often lacking mentorship in their own settings (CHSRF 2010). One of the early roles of the CoP was the development of communication tools, specifically key messages, related to the NP role that became the foundation for all communications and marketing (Sawchenko 2009). During the first five years of employment, there was 100% retention of the nurse practitioners within IH, a rate unique within the province.

**PEPPA Framework**

Introducing a new healthcare practitioner into a health system requires careful planning and strategic communication across multiple levels of the organization, community settings and the public. The IH chief nursing officer (CNO) and regional practice leader (RPL) responsible for NP integration recognized the importance of a framework to guide this implementation. The PEPPA framework (participatory, evidence-informed, patient-centred process of advanced practice nursing role development, implementation and evaluation) included elements that served as a roadmap for this IH initiative. Three elements of the framework were particularly helpful: (a) identification and involvement of stakeholders, (b) implementation strategies and (c) plans for evaluation.
Stakeholders included clients, NPs, physicians, other healthcare professionals, organizational leaders, support staff, the public and government agencies. Implementation strategies included decision-making based on the demonstrated need for and acceptance of a nurse practitioner in a given practice setting, regular and strategic communications within and outside the healthcare system and development of a CoP for the new nurse practitioners.

When a primary care setting applied to the IH for the integration of a NP into the practice, the facility was required to identify the needs of the population to be served, the gaps in its current service and how the integration of a NP would improve the care provided. Examples of identified gaps in service were frail elderly living at home, persons with complex chronic health challenges and underserved populations, e.g., homeless people and those living with mental health challenges. Likewise, when a new NP was introduced to the team, a similar process was used to describe and support the role of the NP in collaborative practice. This process became more important over time as more primary care settings requested a NP on their team. Stakeholders were engaged in the role development, and an outcome-based process provided the foundation for prospective evaluation of the role (Bryant-Lukosius and DiCenso 2004: 538).

**Marketing and Strategic Communication**

The CNO and RPL in IH anticipated the hiring of NPs into the health system, worked strategically and took a proactive role in communication and marketing. All IH communications related to the NP initiative were based on the following key messages with a focus on primary care:

- What is a NP?
- What can a NP do?
- How many NPs are in IH?
- Where are the NPs employed?

Because of the varying needs of different stakeholders, communications were tailored to ensure the relevance of the information for the intended readers. The information was targeted towards groups for whom it would have the greatest impact (Kreuter and Wray 2003); for example, a briefing to the CEO would read differently than the media release about the newly hired NP in a community health clinic.

Marketing and strategic communications included the following:

- Briefing notes to the chief executive officer, the senior executive team and the chief nursing officer related to the introduction of a new NP to the practice
community; report of pilot project introducing the salaried NP into a fee-for-service (FFS) practice setting as an alternative to working with salaried physicians; and updates on new projects.

- Presentations to senior executives and board of trustees on the new NP initiative and evaluation results related to public awareness and willingness to consult NPs in lieu of physicians.
- Memos to healthcare professional partners on introduction of the NPs in practice and ongoing practice patterns.
- NP brochure (updated and redistributed over time) in all clinics introducing the role (or where students were placed).
- IH newsletter profiling the new NP role in communities, e.g., new NP in a primary care clinic, renal care in a tertiary care facility and IH leading the way with collaborative practice.
- Website including regular updates on numbers, location and services provided by the NPs as part of collaborative teams of providers.

This focus on key messaging ensured consistency in the information shared through varied methods, communicators and venues of communication. All communications were designed to raise awareness and create a common understanding of the role of the NP. In addition to communications internal to the health authority, media coverage at the local, provincial and national levels added to the visibility and credibility of the NP initiative. For example, IH hosted “Celebrating NPs in BC,” a provincial conference intentionally bringing together students, faculty and NPs as well as key national and provincial stakeholders, e.g., a local MLA who had been health minister during the planning stages of the NP initiative, the CHSRF/CIHR chair in advanced practice nursing and the executive director of the BC Nursing Directorate. NP/GP teams also presented papers at provincial and national conferences, and a communication from CHSRF highlighted the IH model of collaborative practice (CHSRF 2010).

**Evaluation**

Nursing leaders in the NP initiative considered it critical to the long-term success of the nurse practitioner program to seek feedback from patients, physicians, nurse practitioners and other professionals regarding the NP initiative. These efforts were designed to help IH assess and continuously improve its nurse practitioner strategy. Early evaluation plans included two studies: a qualitative study of two primary care clinics and an initial survey of the public on awareness and acceptance of the NP role.

**Qualitative study of two pilot projects in IH**

A study of NPs salaried by IH and employed by FFS practices was completed by IH in 2008 (Hogue 2008). Patients reported improved access to healthcare
services, comprehensive care and a feeling that they were better informed about their health and were a part of the decision-making process related to their own care. Healthcare professionals reported an increase in job satisfaction (Hogue 2008; DiCenso et al. 2010). DiCenso and colleagues (2010) identified potential limitations of this model related to the perceived loss of income for physicians, e.g., patient seeing a NP instead of a physician, unreimbursed physician time providing consultation to NP, additional cost to funder if both NP and physician see patient. DiCenso and colleagues proceeded to address each concern in support of the model.

Public survey on awareness and acceptance of the NP role
Nursing leaders in IH also saw the importance of feedback on the public’s awareness of, and experience with, nurse practitioners. Nurse practitioners have a long history of practice in Ontario; in 2002, on behalf of the Ontario Ministry of Health and Long-Term Care, IBM Consulting Services administered a survey to 428 Ontarians about their knowledge about, use of and satisfaction with NP services (DiCenso et al. 2003). At the request of IH, BC Stats included select questions from the Ontario Nurse Practitioner Study (2003) in its monthly Community Health, Education and Social Services (CHESS) omnibus survey. Computer-assisted telephone interviewing by BC Stats staff was used to interview respondents and collect data. Respondents were informed that individual responses would be kept confidential (Statist Act, RSCB 1996) and that personal information would not be linked to responses or comments in any of the material provided to the IH. The sample included approximately 400 respondents within IH over each of the four survey administration periods: August 2005 ($n=403$), August 2006 ($n=402$), August 2007 ($n=400$) and August 2008 ($n=403$). Data were analyzed by BC Stats research staff.

Three questions focused on people’s awareness of the NP role and their willingness to be seen by a NP instead of a doctor for minor illnesses or health maintenance. Figure 2 represents the percentage of people who stated that they had heard of a healthcare provider called a nurse practitioner or NP. On average, over the four data sets, 48% of the respondents stated that they had heard of NPs.
On average, over the four data sets, 73% of the respondents stated that they were willing and 23% were unwilling to see a NP instead of a doctor for minor illnesses (see Figure 3). Four per cent stated that they were unsure.

On average over the four data sets, 68% were willing and 24% unwilling to see a NP instead of a doctor for support and advice on maintaining their health and well-being (see Figure 4). An average of 8% of respondents were unsure of their willingness to see a NP instead of a doctor.
Figure 4. Percentage of respondents willing to see a NP instead of a doctor for support and advice on maintaining their health and well-being

<table>
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<th>No %</th>
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<tr>
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NP= nurse practitioner.

Discussion

NP recruitment and retention

Three factors may explain the 100% retention rate of the NPs in the Interior Health Authority during the first five years: the use of the PEPPA framework, the support provided to the NPs through the community of practice, and the ongoing partnership of the chief nursing officer and regional practice leader.

- **Use of the PEPPA framework for substantiating the need for and place of a NP on the proposed collaborative team.** Questions included: Who is the population to be served? What are the needs of this population? What are the current gaps in service to this population? and How might a NP address this gap? Using such a framework ensures an initial niche for the NP and a readiness on the part of the collaborative team to welcome and support the NP.

- **Support provided to the NPs through the CoP.** Communities of practice provided significant support to each of the NPs who are generally working as practitioners in a new role and as the lone NP in a community (Sawchenko 2009). According to Burgess and Sawchenko (2011: 99): “The CoP helped NPs to build collegial and collaborative relationships, enhance practice learning and competence, extend and apply new knowledge, enrich professional identities, and shape health organizational policy and politics.”

- **Ongoing partnership of the CNO and RPL.** These two leaders provided consistent communication about the NP role directed at both key stakeholders within the system and the public. They also provided ongoing support to NPs within IH and their community practice settings.
Marketing and strategic communication

Marketing and strategic communication were identified in the Canadian Nurse Practitioner Initiative (CNPI) (CNA 2006; Schreiber et al. 2005) as critical to the integration of the nurse practitioner into the healthcare system. Concurrent with the activities of the CNPI at the national level (production of fact sheets, e-bulletins, proactive media relations, stakeholder forums and conferences) were activities at the local and provincial levels. Activities were targeted to specific groups, e.g., consumers, professionals, healthcare executives and policy makers, and were timed for maximum impact. The media represented a cost-effective intermediary to reach the public (CNA 2006: 34) and disseminate news on new appointments, fact sheets, awards and conferences. Consistency and constancy in messaging were the hallmarks of the marketing and strategic communication plan for the IH initiative.

Awareness

Of interest is the percentage of people who were aware of the NP role before NPs were actually employed in the Interior Health Authority. Several factors may account for this awareness: national media strategies in 2005 to introduce the public to the role of nurse practitioner (CNA 2006), and efforts on behalf of IH such as key messaging, the IH newsletter, NP brochure distribution, presence of NP students in practice settings and local media coverage of the NP role in the community.

In HSDAs 2 and 3, there appeared to be a progressive increase in awareness from 2006 through 2008 that may be explained by the number and placement of the NPs in practice, student placements and ongoing promotional activities within IH. Respondents in HSDA 1 remained relatively consistent in reported awareness of the NP. In this HSDA, NPs practise in a major city and the surrounding area and are employed in clinics that serve marginalized populations, e.g., homeless persons without primary care providers and Aboriginal communities. These NPs may not be as visible in the community as those in established primary care settings. As well, marginalized people may not have land phone lines and therefore would not be accessible for telephone interview. Consequently, these populations may not be well represented in the sample.

Respondents in HSDA 4 remained relatively consistent, as well, in reported awareness of the NP. This HSDA employed its first nurse practitioner in 2009 after the BC Stats surveys were completed. Discussions with IH staff indicated that there is at least one nurse in the area who was trained in another province and who referred to herself as a nurse practitioner, possibly accounting for the relatively high percentage of awareness in this HSDA.

The level of awareness in IH is consistent and, in some areas, increased over the five-year period of this study. The overall findings on awareness in the BC study
(48%) over four time periods are comparable to the findings in the Ontario study (46%; n=428) over one time period. This comparability is noteworthy because the NP role in British Columbia is relatively new and the numbers small compared to the role in Ontario. To have awareness levels equivalent to those in a province where the nurse practitioner has been practising for several decades is remarkable. This awareness speaks to the early and ongoing promotional efforts of IH, the presence of the collaborative practice of the NP with physicians and others and the appropriateness of the PEPPA framework (e.g., involvement of stakeholders).

Acceptance: Willingness to see a NP

Data on “willingness to see” were not categorized by HSDA, so the findings represent aggregated data for IH. The percentage of IH respondents willing to see a NP instead of a doctor for minor illness (73%) was slightly higher than in the Ontario study (69%). The percentage of IH respondents (68%) willing to see a NP instead of a doctor for support and advice on maintaining their health and well-being was nearly identical to that of the Ontario respondents (67%). The percentage of those IH respondents not willing (24%) compared to those in Ontario (32%) may be explained by the higher percentage of IH respondents who were unsure (8%) compared to those in Ontario (1%). Harris/Decima (2009) reported that three in four Canadians would be comfortable seeing a nurse practitioner in lieu of their family doctor. These findings may be explained by consistent strategic communication and a process that sought stakeholder feedback and involvement, thus helping people understand the role of the NP in the practice setting (from the patient’s point of view). Findings may also be explained by openness, on the part of the patients, to match their health needs with the skill mix of practitioners as reflected in the patients’ experience of being included in the healthcare team (Hogue 2008).

Conclusion

The Canadian Nurses Association (2009) progress report on the Canadian Nurse Practitioner Initiative identifies the importance of developing true collaborative practice models with appropriate and sufficient funding and continuing evaluation and marketing efforts aimed at clarifying the NP role. IH nursing leaders demonstrated their commitment to collaborative practice models, salaried NP positions, planned and deliberate marketing and communication strategies related to the NP role, and evaluation. The initial evaluation has provided evidence of a level of awareness and acceptance of the NP role within the professional community as well as among the public. IH marketing and communication strategies will continue with a focus on healthcare professionals and policy- and decision-makers.

The lack of stable, ongoing funding for new NP positions is a very real challenge in times of fiscal constraint. Full integration of the NP role can be achieved and will require vigilant and committed leadership at all levels of the organization.
(Stevenson and Sawchenko 2010: 17). The next phase of evaluation will further explore the impact of the NP role on access to care, patient-centred care, inter-professional practice and hospital utilization.

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References


