

**Stakeholder Participation in Primary Care System Change:
A Case Study Examination of the Introduction of
the First Nurse Practitioner-Led Clinic in Ontario**

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Abstract

Purpose: To examine stakeholder participation in the primary care system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario.

Design: Qualitative case study guided by the principles of stakeholder and system change theory.

Setting: Northern Community in Ontario, Canada.

Participants: Purposeful sample of healthcare providers, healthcare managers and health policy stakeholders.

Procedures: This case study was bound by place (Sudbury), time (January 2006–January 2008), activity (stakeholder participation), and process (introduction of an innovation, the first Nurse Practitioner-Led Clinic in Ontario, during a primary care system change). Semi-structured individual interviews were conducted with participants who represented the clinic, the local community, and the province. Public documents, such as newspaper articles published during the 2 year time boundary for this case and professional healthcare organization publications, were also examined. Interviews were analyzed using qualitative content analysis and public documents were reviewed for key messages to complement the interview findings. Field notes written during data collection and analysis were used to provide additional depth, contribute insights to the data, and ascribe meaning to the results.

Main Findings: Sixteen interviews were conducted with key stakeholders. Twenty public documents which yielded the most specific information relevant to the case study time boundaries and activities were selected and reviewed. Six main themes are reported: *felt need*, *two visions for change* (one for a Nurse Practitioner-Led Clinic and one for Family Health Teams [FHTs]), *vision processes* related to ensuring the visions became or continued to be a reality in Ontario's healthcare system (*shaping, sharing, and protecting the vision*), *stakeholder activities*, and *sustaining and spreading the vision*.

Conclusions: In this case, stakeholder participation influenced policy decisions and was a key contributor to the primary care system change process to introduce the first Nurse Practitioner-Led Clinic in Ontario. Stakeholders are motivated by various needs to engage in activities to introduce an innovation in primary care. One of the most common needs felt by both those who supported the introduction of the first Nurse Practitioner-Led Clinic and those who were opposed to it was the need for improved patient access to primary care.

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Chapter One: Introduction

This chapter introduces the importance of primary care reform and stakeholder participation in this reform, which led to the development of three research questions regarding stakeholder participation in primary care reform. A preliminary discussion of NPs in leadership roles in team-based healthcare delivery models is also provided.

Primary care is usually the first point of contact an individual has with the healthcare system and is inclusive of community-based healthcare models (Aggarwal & Hutchison, 2012). Appropriate access to primary care is crucial to improving patient health outcomes while decreasing utilization of other services, such as emergent and acute care (Khan, McIntosh, Sanmartin, Watson, & Leeb, 2008; Macinko, Starfield, & Shi, 2003; Starfield, Shi, & Macinko, 2005). Significant investments in primary care transformation have been made over the past decade in Canada yet it continues to lag behind other affluent countries in its ability to realize the essential features of a high-performing healthcare system, including access to primary care. Building on the past 20 years of research and experience in the area of primary care, experts now concur that it is time for a “thoughtful and determined approach to system transformation” (Aggarwal & Hutchison, 2012, p.2). Stakeholder participation in this approach to system transformation is essential.

Stakeholders are those individuals who are affected by a particular change and also have the potential to directly or indirectly influence decision-making or implementation regarding that change (Freeman, 1984; Grundy,

1997). This influence can be used to support, suppress, or modify the course of the change process (Ruhe, 2010). Stakeholder participation contributes to the success of system change initiatives (Canadian Health Services Research Foundation [CHSRF], 2011; Horev & Babad, 2005; Strumpf et al., 2012).

Stakeholders, such as healthcare providers, policy makers, and citizens, need, want, and expect primary care reform (Aggarwal & Hutchison, 2012; College of Family Physicians of Canada, 2000; Delamaire & Lafortune, 2010; Hutchison, Levesque, Strumpf, & Coyle, 2011). However, securing stakeholder participation in initiatives to influence primary care reform continues to be a challenge and their engagement in system change processes in Ontario has relied heavily on their voluntary contributions (Strumpf et al., 2012). To date, we know very little about why stakeholders initiate and sustain participation in healthcare system change initiatives.

As Canada's action plan for healthcare reform, *A 10-year Plan to Strengthen Health Care* (Health Canada, 2004), nears expiry, there is renewed interest in and awareness of the need to introduce innovations in primary care to support the sustainability of the healthcare system (Council of the Federation, 2012; Mable & Marriott, 2012). Until recently, primary care practices were influenced by an acute care model with physicians taking the lead role in the provision of primary care services (Crabtree, et al., 2011; Wagner, 1995; Wagner, Austin, & Von Korff, 1996). As healthcare costs soar and patient demand for improved access to high quality primary care takes centre stage in several countries (Australian Government Department of Health and Aging,

2009; Drummond, 2012; Health Care and Education Reconciliation Act, 2010; World Health Organization [WHO], 2008), healthcare funders are embracing innovation and want to create new ways to deliver primary care. For example, in its first report, *From Innovation to Action*, the Health Care Innovation Working Group, established to identify innovations in healthcare delivery in Canada, describes team-based healthcare delivery models (Council of the Federation, 2012). Team-based healthcare delivery models are defined as teams of healthcare professionals from different disciplines who work together to provide primary care that is responsive to the needs of the patient (Virani, 2012). These teams encourage all healthcare professionals to work to their full scope of practice (Council of the Federation, 2012).

Healthcare systems are complex adaptive systems (Institute of Medicine, 2010; Sturmberg, Halloran, & Martin, 2012) comprised of multiple components, one of which is primary care. The sustainability of healthcare solutions is influenced by the interconnectivity of these components (Doebbeling & Flanagan, 2011). Therefore, the introduction of innovations in primary care in Ontario has the potential to have an effect on large system transformation in healthcare to support major policy development and strategy focused on patient-centred care.

Large system transformation in healthcare are interventions aimed at coordinated, systemwide change affecting multiple organizations and care providers, with the goal of significant improvements in the efficiency of healthcare delivery, the quality of patient care, and population-level patient outcomes. (Best et al., 2012, p. 422)

One of the major goals for primary care reform in Ontario, as outlined in *Healthy Change: Ontario's Action Plan for Health*, is to increase access to high quality primary care services (Ministry of Health and Long Term Care [MoHLTC], 2012a). Healthcare systems with improved access to high quality primary care services are more efficient and will be better able to meet current and increasing demands (Browne et al., 1999; Hutchison, 2012; Starfield, 2011; WHO, 2008). Improving primary care services in Ontario continues to be one of the greatest challenges facing the healthcare system. Numerous reports outline recommendations for structural improvements, e.g., *Building on Values: The Future of Health Care in Canada* (Romanow, 2002), *Integration of Care: The Perspectives of Home and Community Providers* (Change Foundation, 2011), and *Quality Improvement in Primary Health Care in Ontario: An Environmental Scan and Capacity Map* (McPherson, Kothari, & Sibbald, 2010), and evidence supports the use of current reform initiatives, such as the introduction of team-based healthcare delivery models (Glazier, Zagorski, & Rayner, 2012; Virani, 2012).

In addition, it is being recognized globally that a shift from provider-centred care to patient-centred care is necessary to ensure improvements in the quality of the overall patient experience within the healthcare system (Hutchison, 2012). Yet, despite increasing resource allocation, fewer than one half of all Ontarians are able to see their primary care provider within two days of becoming ill, and many still need help to find a primary care provider (Delamaire & Lafortune, 2010; Ontario Health Quality Council, 2011). Up to 850,000 Ontarians are not

registered with a primary care provider (Laupacis & Born, 2011). Recent projections estimate that between 840 and 1559 additional physicians are needed to meet the increasing demand for primary care in Ontario (Simoens & Hurst, 2006; Singh et al., 2010). These factors influence the degree to which Ontarians have access to healthcare.

Stakeholders, such as healthcare providers, policy makers, and citizens, can make valuable contributions as our healthcare system transforms towards improved access with an emphasis on patient-centred care. The potential benefits of the inclusion of stakeholders in system change initiatives, such as primary care reform, are well-documented (Kickert, Klijn, & Koopenjan, 1997; Teisman, 2001; van de Kerkhof & Wieczorek, 2005; VanKersbergen & van Waarden, 2004) and it has been proposed that focusing on stakeholder participation is a better indicator of system change performance than focusing on the social problem in general (Clarkson, 1995). The healthcare literature acknowledges the importance of stakeholder participation in the adoption of innovations as part of healthcare system change. However, few studies have examined stakeholder participation in primary care reform in Ontario (Carr, Howells, Chang, Hirji, & English, 2009; Hunter, Shortt, Walker, & Godwin, 2004) and little is known about how individual variables influence stakeholders' decisions to participate in this process.

The introduction and continued implementation of various NP roles in Ontario and abroad has been reviewed extensively (CHSRF, 2010; Edwards, Rowan, Marck, & Grinspun, 2011; Kaasalainen et al., 2010; Sangster-Gormley,

Martin-Misener, Downe-Wambolt, & DiCenso, 2011) yet examination of stakeholder participation in the introduction of NPs in Ontario, or in the primary care system in Canada, has been limited. NPs are now assuming primary leadership roles in team-based healthcare delivery models (Heale & Butcher, 2010). The Nurse Practitioner-Led Clinic in Sudbury, Ontario, the first of its kind in North America, represents a significant deviation from the status quo in primary care delivery and from the direction Ontario was taking to ensure realization of a vision for healthcare transformation. Nurse Practitioner-Led Clinics represent an “innovative model for delivery of comprehensive primary healthcare in Ontario and Canada” (Pogue & Grinspun, 2008, p. 1) and were proposed as an approach to enhance primary care access for all Ontarians as part of the government’s *Family Healthcare for All* initiative (MoHLTC, 2008a). In 2007, the first Nurse Practitioner-Led Clinic opened (MoHLTC, 2009). That same year, the Ontario government announced 38 million dollars in funding to support 25 more Nurse Practitioner-Led Clinics to begin operations by 2012 (MoHLTC, 2008a). At the end of 2012, all 26 clinics were in some phase of their operational plan.

The purpose of this single case study was to examine stakeholder participation in the primary care system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario. This study examines input from stakeholders from the healthcare and government policy sectors that supported or opposed the introduction of the clinic and seeks to answer the following three questions.

Research Questions

1. How did stakeholders participate in the system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario?
2. Why did stakeholders participate in the system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario?
3. How did stakeholders identify and respond to barriers and facilitators during the system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario?

Study Significance

The healthcare system change literature suggests that stakeholder participation is important, but stakeholder characteristics and their relationship to participation in primary care system change have been relatively ignored. Stakeholders have different perceptions of system problems and innovations based on their individual characteristics (knowledge, attitudes, and motivations). These perceptions will influence their level of participation. However, in spite of stakeholder perceptions and characteristics, stakeholders' concerns may pose barriers to actualizing participation in primary care system change. This study will examine stakeholder participation in the system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario. Characteristics that influence stakeholder participation in primary care system change initiatives, and the role the concerns of stakeholders play as barriers and facilitators to their participation, have yet to be studied. This case study will increase knowledge of

stakeholder participation in primary care system change so that stakeholder engagement in future initiatives aimed at improving ailing healthcare systems can be facilitated.

Chapter Two: Literature Review

Chapter two provides an overview of the literature pertaining to stakeholder theory, characteristics, and participation in healthcare system change. Key concepts relevant to stakeholder participation (stakeholder characteristics and barriers and facilitators) are defined and a unique framework, based on a synthesis of the literature, is presented to guide the inquiry. The advancement of the healthcare system change literature is reviewed. Then the evidence relating to the process, structure, and outcomes of the primary care system in Ontario is described.

Stakeholder participation is recognized increasingly for its potential to make key contributions to policy decisions, such as the introduction of innovations in primary care. Policy decisions are made in response to contextual factors (Jewell & Bero, 2008) and context is an important factor in stakeholder participation in change initiatives (Scott, Estabrooks, Allen, & Pollock, 2008). This literature review had two objectives. The first objective was to examine the stakeholder and healthcare system change literature for the purpose of understanding stakeholders and their participation in healthcare change initiatives in a meaningful way. The second objective was to explore and describe the process, structure, and outcomes of primary care in Ontario – the context in which policy decisions are made – as movement continues towards primary care reform to build a sustainable future for healthcare in Ontario

The literature was retrieved through a search of peer-reviewed and grey literature. Three electronic databases (Ovid MEDLINE, ProQuest, and CINAHL)

were searched using a comprehensive strategy. A broad search was completed originally using the search terms “stakeholder,” “participation,” and “healthcare” from 1998 to 2008. A total of 18 database searches were completed using these terms and combinations of these terms. The results of this search and additional details on the literature search procedure can be found in Appendix A.

The searches of the grey literature were conducted in early 2008 and included a review of several professional healthcare organization websites with an interest in both the introduction and implementation of NPs and healthcare system transformation. A comprehensive list of relevant websites is included in Appendix A. In addition, personal communication with experts in advanced practice nursing research (e.g., Dr. Alba DiCenso, CHSRF/Canadian Institute for Health Research Advanced Practice Nursing Chair) and health policy development (e.g., Josette Rousell, Canadian Nurses Association [CNA]) took place over a three-year span (2008 – 2011) during the proposal development and conduct of the study reported in this dissertation. The literature review was updated at the completion of the data collection process to include the most recent studies related to the introduction of primary care teams in Ontario between 2008 and 2012.

The first section of this chapter summarizes the stakeholder and healthcare system change theoretical literature and provides definitions of “stakeholder” and “stakeholder participation.”

Stakeholder Theory

Stakeholder theory offers an approach to examining the processes of primary care system change, including the introduction of innovations in primary care, such as Nurse Practitioner-Led Clinics. Stakeholder theory was first defined and described in the works of Rhenman and Stymne (1965), and further developed at the Stanford Research Institute (1982) in the United States. However, Edward Freeman was the first author to articulate a comprehensive account of stakeholder theory in his seminal text, *Stakeholder Management: A Stakeholder Approach* (1984). Freeman cautioned that the business environment was changing and if managers wanted to be successful they would need to “take into account all of those groups and individuals that can affect, or are affected by, the accomplishment of the business enterprise” (Freeman, 1984, p. 25).

Stakeholders

Three key characteristics of stakeholders were identified by van de Kerkhof (2006). First, stakeholders can be both individuals and groups. Second, the interests of each stakeholder are not always clear, and stakeholders may have different perceptions of their own and each other’s stakes; these stakes may change over time. Third, relevant groups of stakeholders may change over time. There is no fixed number of stakeholders and new stakeholders will become involved as others leave (van de Kerkhof, 2006).

Stakeholders are “any group or individual who can effect or are effected (sic) by the achievement of the organization’s objectives” (Freeman, 1984, p. 46).

Stakeholders in the healthcare system include the public, healthcare providers, government regulatory and supervisory agencies, budgeting and financial authorities, various commercial or business groups, and policy elites or scholars (Horev & Babad, 2005). This study will focus on the perspectives of healthcare providers, healthcare managers, and health policy stakeholders.

Stakeholder theory was selected to inform this study for two reasons. First, the empirical literature of stakeholder theory is robust enough to advance knowledge of the concepts identified as important to this inquiry. Second, despite the importance placed on the identification and inclusion of stakeholders in healthcare system change processes, a comprehensive theory of stakeholder participation in the primary care sector, in particular, has yet to emerge in the healthcare literature.

Stakeholder Participation

The empirical and theoretical knowledge related to stakeholders and their participation in change initiatives is limited mainly to the business, educational, and communication literature. This academic literature acknowledges the importance of stakeholders and the benefits of stakeholder participation (Bordia, Hobman, Jones, Gallois, & Callan, 2004; Bordia, Hunt, Paulsen, Tourish, & DiFonzo, 2004; Coyle-Shapiro, 1999; Edmondson, Bohmer, & Pisano, 2001; Horev & Babad, 2005; Levin & Fullan, 2008; Lewis, 2006; Lukas et al., 2007; Nutt, 1987; Sagie, Elizur, & Koslowsky, 2001; Sagie & Koslowsky, 1994).

There are several known advantages to stakeholder participation in system change. First, stakeholder participation can increase public awareness

and acceptance of society's problems and the need for measures to solve these problems (Kickert et al., 1997). Second, stakeholder participation may lead to better decisions regarding system change, by including relevant viewpoints, information, and interests about the problem that may not have been included if stakeholders were not engaged in the change process (Teisman, 2001). Third, stakeholder participation increases the legitimacy of the change. As stakeholders participate in the change process they become co-responsible for the decisions made during the process, and for the actions taken (Van Kersbergen & van Waarden, 2004). Finally, stakeholder knowledge of the problem, possible solutions and conflicting views, and interest are enhanced through participation in the process (van de Kerkhof & Wieczorek, 2005). Stakeholders may accept or reject the proposed change and participate in or inhibit activities required for the success and sustainability of system change (Kontos & Poland, 2009; Rogers, 2003).

Several studies examine the adoption of health service innovations by stakeholders. However, most of these studies focus on the stakeholder's "positive attitude to research," "belief in the value of research," and "organizational support" of stakeholders (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004), and not on their active engagement in healthcare system change processes. In essence, most studies of system change in the diffusion literature have focused on the types and sources of information that are available to stakeholders. Much less attention has been given to stakeholder

characteristics and the activities they undertake as part of their contribution to the system change process (Wejnert, 2002).

The success of healthcare system change depends on the strengths and interests of different stakeholders and their participation during the implementation of healthcare reform (Horev & Babad, 2005; van de Kerkhof, 2006; Vellinga, 2001). Horev and Babad (2005) analyzed stakeholder activities with respect to Israel's 1995 healthcare reform. They were particularly concerned with stakeholder identities, their relative power, and the effect of their roles and actions. Their study provided interesting insights into stakeholder participation in healthcare reform. Some stakeholders played more prominent roles in healthcare reform than one would expect, while others did not contribute at all. For example, a government stakeholder, notably the Ministry of Finance, was the most active stakeholder in Israel's healthcare reform. The public at large did not contribute to the reform, and it was hypothesized that this was due to lack of information and dissatisfaction with the healthcare services that they were currently receiving. Imbalance of power resulted in deviations from the planned reform which in turn had an effect on the ability of the reform to improve access to healthcare services for the most vulnerable groups in the country. Horev and Babad (2005) recommend that additional studies examine stakeholder participation in healthcare reform in other contexts to guide future important social movements to improve healthcare systems.

The literature pertaining to stakeholders and their participation in Ontario's primary care reform initiatives has been limited to the implementation of

innovations (Carr, Howells, Change, Hirji, & English, 2009; Jack, Sheehan, MacMillan, Kurtz Landy, & Wahoush, 2010; Terry, Giles, Brown, Thind, & Stewart, 2009). This literature has not yet addressed stakeholder activities to design and introduce healthcare innovations in primary care. For example, Carr et al. (2009) explored the use of information management and information technology which integrated communication, adoption, and training as a driver of stakeholder engagement, following the decision to implement Ontario's *Wait Time Information Strategy* (Kramer, 2005). They recognized the level of stakeholder engagement required to deploy and sustain a complex change initiative aimed at capturing wait time data regarding clinical procedures (such as cancer surgery, cataract surgery, cardiac surgery, hip and knee replacement surgery, and MRI and CT scans) for the first time directly from clinicians' offices. This data would be used to support improvements within the healthcare system and would require the engagement of thousands of stakeholders across the province. The project team sought stakeholder engagement through the use of three steps: creating awareness (communication), building support (adoption), and making change real (training). The project rallied the support of practice leaders at 82 hospitals and 2,600 clinicians who had to use the "Wait Time Information System" (Kramer, 2005). These stakeholders were able to help the government deliver on its promise to report and reduce wait times in less than two years. This case study reports on the exploration of stakeholder engagement and demonstrates the potential for using strategies to engage stakeholders once the decision to introduce change was made (Carr et al., 2009). However,

stakeholder engagement occurred after the *Wait Time Information Strategy* had been designed and the decision to introduce the change was imposed from above.

In recent discussions among stakeholders, such as the McMaster Health Forum, *Strengthening Primary Healthcare in Canada (Dialogue 2)* (Lavis & Shearer, 2010), the lack of attention given to change-management processes was recognized. Stakeholders have articulated the need to shift their focus from the “what” to the “what and the how to” of system change (Lavis & Shearer, 2010). Knowledge of stakeholder participation in healthcare system change, specifically primary care system change, would be an important addition to the existing literature. Measurement of the process by which stakeholder participation occurs in system change management has the potential to address that gap in the literature. The next section examines system change literature in the context of healthcare.

Healthcare System Change

Experts recognize that primary care system change is hard work (Crabtree et al., 2011) and healthcare has been recognized as the most entrenched, change-averse industry in some countries (Christensen, Bohmer, & Kenagy, 2000). Change within healthcare systems requires the cooperation and involvement of multiple stakeholders within a complex network of multi-providers (Blair & Buesseler, 1998; Rotarius, Fottler, & Blair, 2003). Understanding the process of healthcare system change is important to multiple stakeholders, including funders, healthcare providers, and citizens (Barr, 2008; Iglehart, 2008)

and healthcare systems need to be flexible in their approach to change (Ruhe, 2010). This section describes the process of healthcare system change from its origins to more current perspectives based on knowledge to action in organizational and large system transformation.

The change process has been studied at length in various fields, such as agriculture (Rogers, 2003), rural sociology (Ryan & Gross, 1943), medical sociology (Coleman, Katz, & Menzel, 1966), communication (DeFleur, 1987), marketing and economics (Ashford & Blinkhorn, 1999), evidence-based medicine (Grol, 2001), and organizational change (Damanpour & Evan, 1984). More recently, change processes have been examined in complex adaptive healthcare systems (Sturmberg et al., 2012) as diffusion, dissemination, and sustainability of innovations (Greenhalgh et al., 2004), and knowledge to action (Best et al., 2012; Graham et al., 2006).

In a systematic review of the literature on diffusion, dissemination, and sustainability of innovations in health service delivery and in organizations Greenhalgh et al. (2004) found that the research literature on innovation adoption overlaps conceptually and empirically with general change literature. The authors defined innovation as “a novel set of behaviours, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or user’s experience and that are implemented by planned and coordinated actions” (p. 582). Diffusion was distinguished from dissemination as spread vs. efforts to encourage stakeholders to adopt the innovation. Sustainability was defined as establishing the behaviour until it reached

obsolescence. They identified 1,200 full-text papers and over 100 books and book chapters in the healthcare, health services research, organization and management, and sociological literature that possibly were relevant. Four hundred and fifty of these were included in the report (Greenhalgh et al., 2004). They concluded that there were clear gaps in research on the system change process, and recommended that research relevant to the identification and enhancement of processes for introducing and sustaining innovations in health service delivery be undertaken (Greenhalgh et al., 2004). One of these processes is stakeholder participation.

Several authors have proposed frameworks and models for the process of healthcare system change (e.g., Graham et al., 2006; Greenhalgh et al., 2004; Nutley, Walter, & Davies, 2003). For example, the Knowledge Translation Theories Research Group reviewed a number of planned change theories to identify the relative strengths and weaknesses of each theory (Graham, Tetroe, & KT Theories Research Group, 2007). A database containing over 60 planned change theories is available at http://www.iceberg-grebeci.ohri.ca/research/kt_theories.mdb.

The *Knowledge to Action* framework was developed in response to the need to address challenges associated with improving the quality of care provided by healthcare systems and the opportunities that exist to improve the safety of that care. Key decision-maker groups were struggling to use evidence to inform their decision-making processes. These key decision-makers included healthcare providers, patients, informal carers, managers, and policy makers.

Graham et al. (2006) identified eight common activities described in planned change theory models. These common activities have been placed into a “knowledge to action framework” that includes the following steps: (a) identify a problem that needs addressing; (b) identify, review, and select the knowledge or research relevant to the problem; (c) adapt knowledge or research to local context; (d) assess barriers to using knowledge; (e) select, tailor, and implement interventions to promote the use of knowledge; (f) monitor knowledge use; (g) evaluate the outcomes of using the knowledge; and (h) sustain ongoing knowledge use (Graham et al., 2006). Several of these activities have been described and explored in the nursing literature with a goal of explaining and improving the use of evidence by nurses to enhance their practice (Ciliska, 2006; Thompson, Estabrooks, Scott-Findlay, Moore, & Wallin, 2007; Titler, 2007). The main focus of this body of literature has been on changing individual behaviour and recognition of the effect that context has on individual behaviour (Cummings, Estabrooks, Midodzi, Wallin, & Hayduk, 2007; Scott et al., 2008).

A more recent realist review of large-system transformation in healthcare as a component of the *Knowledge to Action for System Transformation* (KAST) project was initiated in response to a request from the Saskatchewan Ministry of Health. This Canadian Institutes of Health Research (CIHR) funded project was undertaken to guide four major policy development and strategy initiatives in Saskatchewan’s healthcare system (Best et al., 2012). These included patient and family centred care, primary healthcare improvement, “lean” management for healthcare, and shorter surgical wait times. Initial discussions with policy maker

stakeholders from the Saskatchewan Ministry of Health determined there was broad agreement that there was a high degree of stagnation within the system and large-system transformation was required. Stakeholders perceived a lack of motivation for change and were interested in strategies to influence, support, and sustain healthcare system transformation in their province (Best et al., 2012).

The findings from this review suggest there are five “simple rules” which are likely to enhance the success of system transformation initiatives: (a) blend designated leadership with distributed leadership (engaging individuals at all levels in leading the change; (b) establish feedback loops; (c) attend to history; (d) engage physicians; and (e) include patients and families.

Studies of primary care system change processes, such as financial reform and the introduction of incentives in primary care, have been undertaken in other countries, including the United Kingdom (Bain, 1994; Glennerster, 1998; Leese, 2002; Wilkin, Dowsell, & Leese, 2001); the United States (Weiner, Gillam, & Lewis, 2002); New Zealand (Majeed & Malcolm, 1999); Ireland (Walley, Murphy, Codd, Johnston, & Quirke, 2000); and Australia (Del Mar, Freeman, & Van Weel, 2003; Marjoribanks & Lewis, 2003). These studies have focused on describing primary care policies and reform outcomes, new tools, and attitudes towards the reform, but the issues related to change management as a component of primary care reform are only partly assessed (Longo, 2007). The design of innovations to address primary care challenges is discussed, but not the effectiveness of the change process to implement these innovations (Longo, 2007), nor the inclusion of stakeholders in the introduction of these innovations.

Primary care system change for the purpose of this study is the introduction of an innovation so that an alternative for the first point of contact to healthcare may be offered to the public. Little is known about why stakeholders participate in primary care system change processes and how stakeholder characteristics influence their initial and sustained participation in change initiatives.

Preliminary Conceptual Framework

After a thorough review of the stakeholder and system change literature and an evaluation of five conceptual frameworks (Bowen & Zwi, 2005; Campbell et al., 2000; Graham et al., 2006; Greenhalgh et al., 2004; Gunderson & Holling, 2002) I concluded that the literature did not fully and adequately address the concepts that needed to be examined in this study. To inform and guide this study a framework (Figure 1) based on a synthesis of the literature was developed. Key concepts included in the framework are: stakeholder characteristics (knowledge, attitudes, and motivations); stakeholder participation (initial and continued); and barriers and facilitators to stakeholder participation. These concepts are discussed through the lens of both stakeholder theory and system change theory.

Stakeholder participation is defined for the purpose of this study as the active involvement of individuals or groups who have the potential to influence primary care system change. Stakeholder participation includes an individual's or group's decision to begin to participate in a primary care system change and their continued participation in its planning and implementation in response to their experience of the process. Stakeholders' decisions to initiate active participation

or to continue their engagement in the planning and implementation of primary care system change, in this case the introduction of the first Nurse Practitioner-Led Clinic in Ontario, is influenced by their characteristics (knowledge, attitudes, and motivations). Barriers (presence of concerns, top-down approach) and facilitators (absence of concerns, motivation, commitment, knowledge, moral responsibility) influence initial and continued stakeholder participation and may be the same or different during each phase of the process.

Stakeholder characteristics.

Several characteristics of stakeholders have been described in the literature (Greenhalgh et al., 2004; LaPlume, Sonpar, & Litz, 2008; Rogers, 2003; Winn & Keller, 2001). This section outlines three qualities with the potential to influence stakeholder participation: knowledge, attitudes, and motivations. Knowledge, attitudes, and motivations are key determinants of stakeholder participation in the adoption and diffusion of an innovation, both in healthcare settings and in general, and are directly related to stakeholder actions (Anderson, Shepherd, & Salisbury, 2006; Andrews, Manthorpe, & Watson, 2003; Gillespie, Florin, & Gillam, 2004; Greenhalgh et al., 2004; Rogers, 2003).

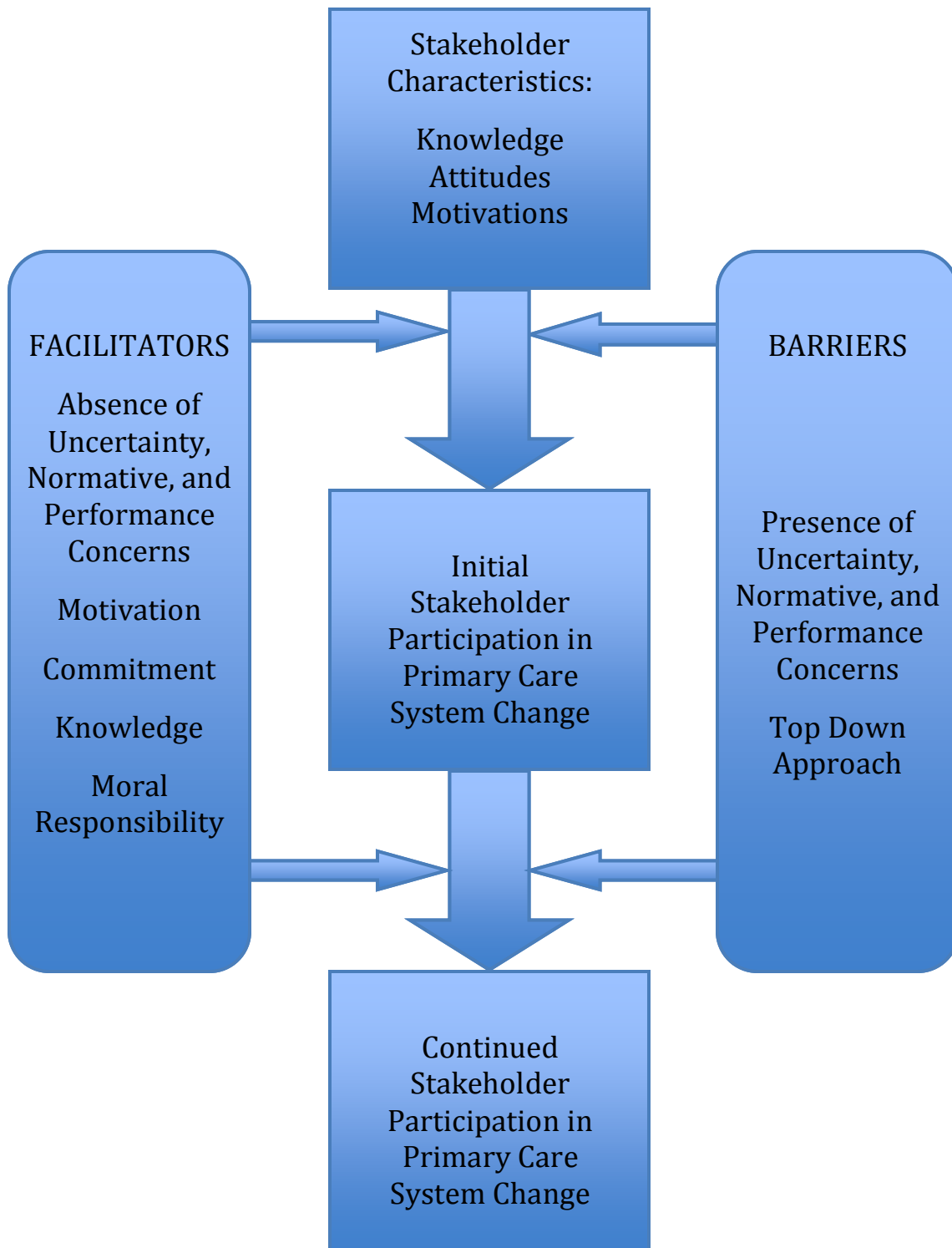


Figure 1: Stakeholder Participation in Primary Care System Change

Stakeholder characteristic: Knowledge.

Stakeholders seek and process different types of information before adopting a new practice or innovation. Prior conditions, such as a perceived problem, may motivate stakeholders to seek and obtain knowledge about the innovation. The first step in the change process is problem identification, which often involves stakeholders identifying that there is a problem that deserves attention (Graham et al., 2006). If stakeholders already possess or have sought knowledge of the problem, they may form an initial perception of the change situation prior to formal participation in change initiatives (Lewis, 2007).

Stakeholders may become aware of the problem by accident, in which case they play a passive role in the problem identification stage (Hassinger, 1959; Rogers, 2003). Other stakeholders may actively gain knowledge about a problem through behaviours that they initiate (Rogers, 2003).

After problem identification, some stakeholders seek knowledge of an innovation to solve the problem. Questions such as “What is the innovation?”, “How does it work?”, and “Why does it work?” provide motivation to seek information (Rogers, 2003). The successful diffusion of innovation in healthcare systems is highly dependent on stakeholder knowledge of the innovation (Meyer & Goes, 1998). Rogers (2003) identifies five attributes of innovations, as perceived by stakeholders, that have the potential to influence the rate of adoption: relative advantage, compatibility, complexity, trialability, and observability. Relative advantage is the degree to which the innovation is perceived to be better than the current state. Compatibility is the degree to which

the innovation is perceived to be consistent with existing values, past experience, and needs of the stakeholder. Complexity is the degree to which the innovation is perceived as being easy to understand and use. Trialability is the degree to which the stakeholder can experiment with the innovation on a limited basis. Observability is the degree to which the results of the innovation are visible to others. Stakeholder perceptions of the first two attributes, relative advantage and compatibility, are particularly important in explaining the rate of adoption (Rogers, 2003). Attitudes toward an innovation are formed after the stakeholder obtains knowledge about the innovation (Rogers, 2003). Stakeholder perceptions of, and attitudes towards, an innovation have been attributed to a willingness and openness to change (Armenakis, Harris, & Mossholder, 1993; Cunningham et al., 2002; Miller, Johnson, & Grau, 1994).

Several studies have examined individual knowledge needs, use, and preferred format for receiving information about problems and innovations (Dobbins, Rosenbaum, Plews, Law, & Fysh, 2007; Elliot & Popay, 2000; Sibbald & Roland, 1997). Healthcare stakeholders need pragmatic knowledge (knowledge for application) in addition to explanatory knowledge (Sibbald & Roland, 1997). Stakeholders use knowledge to make decisions in healthcare, however, application of this knowledge frequently is limited by financial constraints, timelines, and decision-makers' experiential knowledge of the problem or innovation (Elliott & Popay, 2000). Sustaining dialogue with stakeholders using interactive, collaborative strategies aimed at fostering relationships is an important component of sharing knowledge about healthcare

problems and innovations (Dobbins et al., 2007; Elliot & Popay, 2000; Sibbald & Roland, 1997). Healthcare stakeholders, such as decision-makers, practitioners, and policy makers, prefer to receive information from websites, health-related journals, electronic mail, and conferences or workshops (Dobbins et al., 2007). This information is best received in the form of executive summaries, abstracts, or original articles (Dobbins et al., 2007). For the purpose of this study, stakeholder knowledge is defined as stakeholder identification of a system issue that needs to be resolved and the information the stakeholder has about the innovation to address the system issue.

Stakeholder characteristic: Attitudes.

Attitudes reflect a stakeholder's personal opinions or general feelings about the innovation (Graham et al., 2007). After forming an attitude towards the innovation, stakeholders will make a decision to adopt or reject the innovation (Rogers, 2003). If stakeholders make a decision to adopt the innovation, they are faced with the challenging task of implementation. For the purpose of this study, stakeholder decisions to adopt or reject innovation and their decisions to implement an innovation are included as a component of their initial participation in primary care system change.

The importance of stakeholder perception and critical reflection during the decision-making process to participate in the implementation of an innovation has yet to be recognized in current change models (Kontos & Poland, 2009). Stakeholder theory assumes that most individuals have a deep emotional commitment to initiatives that they decide to undertake (Jensen, 2002). Negative

attitudes of healthcare professionals toward proposed innovations have been found to inhibit change (Bell, McElnay, Hughes, & Woods, 1998; Gastelurrutia et al., 2009; Odedina, Segal, Hepler, Lipowski, & Kimberlin, 1996; Rossing, Hansen, & Krass, 2001; van Mil, de Boer, & Tromp, 2001). Stakeholder attitudes regarding the introduction of NPs in primary care settings have been varied (Martin-Misener, McNab, Sketris, & Edwards, 2004), and support from stakeholders in other areas where NPs have been introduced, such as acute care, has also been inconsistent (Micevski et al., 2004). Once stakeholders obtain knowledge and form attitudes about an innovation, they may or may not be motivated to influence the plans for diffusion (Baker et al., 1999).

Stakeholders' decisions to participate are strongly connected to their interest and whether that is in line with the intended outcome of the change. Stakeholders' decisions to participate are also strongly determined by their individual need or perceived priority of the innovation (Savage, Taylor, Rotarius, & Buesseler, 1997; Wejnert, 2002). Needs or priorities can contribute to individual motivations to participate. To date, research into stakeholder attitudes and the barriers and facilitators to stakeholder commitment to participate in healthcare change is limited.

Stakeholder characteristic: Motivation.

Achievement of system change is only possible if enough stakeholders are sufficiently motivated to participate (Levin & Fullan, 2008). Most accounts of motivation for stakeholder participation in change initiatives are based on expectancy theory (Lewis, 2007). Stakeholders are motivated to participate in

change as a result of some type of identifiable reward. For example, Vroom (1964) described motivation for personal behaviour change as individual willingness to participate in activities related to the perception of a positive reward – a reward will be given if an individual achieves a change in behaviour. The motivation and reward for stakeholders, such as healthcare providers, to participate in healthcare system change may be attached to one's career, job security, personal esteem, or reputation (Lewis, 2007). Stakeholders may be less motivated to participate if the alternatives to participation are seen as more desirable (Lewis, 2007) or less risky. Motivation improvement takes time and building motivation is multi-faceted (Levin & Fullan, 2008).

A recent comparative case study examined healthcare provider readiness to implement a team-based healthcare delivery model (patient-centred medical homes) in Michigan (Wise, Alexander, Green, Cohen, & Koster, 2011). Motivation was included as a component of readiness for change and it was defined as “the collective willingness and commitment of organizational members – in this case, a primary care practice team – to implement the desired organizational change” (Wise et al., 2011, p. 401). Stakeholder motivations varied and were related to the perceived value of the change, financial incentives, understanding of the requirements for the change, and overall commitment to change. The authors concluded that understanding the perception of stakeholder motivations was an important component of the change process. Although this study contributes to the understanding of motivations for primary care system change, it is specific to 16 pre-established

primary care practices which were changing their organizational structure as opposed to the introduction of a new model for practice that is significantly different from the status quo.

Stakeholder knowledge, attitudes, and motivations have the potential to influence stakeholder participation in the introduction and diffusion of an innovation as a component of primary care system change. Additional research is required to ascertain stakeholder motivations for participating in primary care system change, specifically within the context of Ontario. The skills these stakeholders use to influence system change and the activities they undertake as a component of their participation in system change initiatives will provide valuable information for the introduction of innovations as our primary care system continues to transform.

Initial stakeholder participation in primary care system change.

Engagement of a broad range of stakeholders, including health care providers and healthcare consumers (patients), is essential to the implementation of primary care system change (Aggarwal & Hutchison, 2012; Strumpf et al., 2011). Stakeholder participation, for the purpose of this study, includes individual or group activities undertaken to influence the primary care system change process which led to the introduction of an innovation, the first Nurse Practitioner-Led Clinic in Ontario. Stakeholder activities may include, but are not limited to, obtaining knowledge about the innovation so that the problem or innovation may be communicated to others.

Once a stakeholder has made a decision to participate in primary care system change there may be barriers and facilitators to actualizing this participation. In addition to understanding how stakeholder characteristics, including knowledge, attitudes, and motivations, influence participation in system change, identification of the critical barriers and facilitators to their initial and sustained participation will be important to future primary care system change initiatives in Ontario. The following section describes the barriers and facilitators to initial stakeholder participation in change processes.

Barriers and facilitators to initial stakeholder participation.

The identification of barriers and facilitators is recognized as a key step in the implementation of planned change initiatives (Graham et al., 2006) including the introduction of innovative NP roles (Bryant-Lukosius & DiCenso, 2004), such as in Nurse Practitioner-Led Clinics. Stakeholder participation is cited frequently as a facilitator to implementing change (Bazzoli, 1999; Davies, Edwards, Ploeg, & Virani, 2008; Hroschikoski et al., 2006; Maggi, Stergiopoulos, & Sockalingam, 2008). The barriers and facilitators included in this study's conceptual framework are based on stakeholder responses to change that may influence their participation in system change initiatives. These barriers and facilitators are directly linked to the presence or absence of uncertainty, normative, and performance concerns (Lewis & Seibold, 1996).

Lewis and Seibold (1993, 1996) argue that stakeholder responses to change are deeply rooted in their concerns. These concerns arise from a disruption in the system and have been classified as uncertainty concerns,

normative concerns, and performance concerns. Several studies (DiFonzo & Bordia, 1998; Fairhurst, 1993; Gallivan, 2001; Kramer, Dougherty, & Pierce, 2004; Kuhn & Corman, 2003; Levin & Fullan, 2008; Lewis, 2007; Tourish, Paulsen, Hobman, & Bordia, 2004) have substantiated the validity of these concerns since the original conception of the Lewis and Seibold model.

Uncertainty concerns are defined as a stakeholder's "heightened state of awareness of, or anxiety regarding one's own and others' information access and information use" (Lewis & Seibold, 1996, p. 135). Uncertainty concerns generate a sense of doubt about future events, and about cause and effect relationships in the environment (Lewis, 2007), such as the relationship between an individual's participation and the success of the initiative. Issues important to uncertainty concerns include: clarity and unity in stakeholder perceptions of the purpose of the change, vision for the change, and plans for implementing the change (DiFonzo & Bordia, 1998; Fairhurst, 1993; Gallivan, 2001; Kramer, Dougherty, & Pierce, 2004; Kuhn & Corman, 2003; Levin & Fullan, 2008; Tourish, Paulsen, Hobman, & Bordia, 2004). Also important is the perceived level of stakeholder control established through the possession of knowledge (Bordia, Hobman, et al., 2004; Bordia, Hunt, et al., 2004).

Normative concerns are defined as a stakeholder's "heightened state of awareness of, or anxiety concerning, one's congruency in beliefs, actions, and values with other members of social groups with which he or she strongly identifies" (Lewis & Seibold, 1996, p. 135). Issues important to normative concerns include: values and ideology (Amis, Slack, & Hinings, 2002; Kabanoff,

Waldersee, & Cohen, 1995; Palgi, 2002; Van Wagoner, 2004); trust, fairness, and justice (Kickul, Lester, & Finkl, 2002; Lusch, O'Brien, & Sindhav, 2003; Morgan & Zeffane, 2003; Paterson, Green, & Cary, 2002); emotion (which may be expressed by a stakeholder to achieve either personal or organizational gain) (Dorewood & Benschop, 2003; Garrety, Badham, Morrigan, Rifkin, & Zanko, 2003; Zorn, 2002); and identification of social networks (Chreim, 2002; Griffin, Rafferty, & Mason, 2004; Kuhn & Nelson, 2002; McGrath & Krackhardt, 2003). These issues relate to stakeholder identities and the relationships in and within the changing system (Lewis, 2006).

Performance concerns are defined as a stakeholder's "heightened state of awareness of, or anxiety about, his or her ability to perform" (Lewis & Seibold, 1996, p. 135). Performance concerns include issues of capability, assessment, successfulness, and self-competence. These concerns may contribute to stakeholder feelings of doubt about one's knowledge of the system change process (Lewis, Schmisser, Stephens, & Weir, 2006) or one's ability to perform in the new system state (Lewis, 2007). Issues important to performance concerns may be related to "uncertainty regarding job security, promotion opportunities, changes to job roles" (Bordia, Hobman et al., 2004, p. 511). Previous personal knowledge of system change has the potential to influence stakeholders' tolerance for change and their level of enthusiasm for system change efforts (Lewis, 2007). These concerns influence stakeholder response to change and potentially may be barriers to stakeholder participation in primary care system change. For example, healthcare providers' concerns about their ability to meet

the needs of the system as change unfolds may inhibit their participation in supporting the proposed system change. These concerns may be related to perceived changes to job security or income.

The recognition of barriers and facilitators is an important component of both implementation strategies to achieve change and stakeholder engagement. Recognition that individual perceptions of concerns are important to the classification of issues as a barrier or facilitator will be an important differentiation. Stakeholder concerns can act as barriers to participation in activities such as effective dialogue to achieve change (Campbell & Mark, 2006). The effect of stakeholder concerns as they relate to participation in primary care system change has yet to be studied.

Continued stakeholder participation.

Real system change requires ongoing engagement and active participation by multiple stakeholders throughout the change process (Levin & Fullan, 2008), and this can be challenging. Continued stakeholder participation for the purpose of this study is not simply the last phase of the system change, but it is seen as an ongoing, cyclic involvement of stakeholders to ensure that change occurs and continues to diffuse across the system. Continued stakeholder participation is influenced by three factors: a stakeholder's positive stance with a focus on motivation (Levin & Fullan, 2008); commitment to the change (Lewis, 2007); and knowledge of the change process (Lewis et al., 2006). These stakeholder factors may be directly related to their characteristics of

knowledge, motivations, and attitudes, for example, stakeholder knowledge of the change process.

Barriers and facilitators to continued stakeholder participation.

Continued participation in system change initiatives is challenging (Jansen et al., 2008) and evolves through the social process of human interactions (Berwick, 2003; Rogers, 2003). Stakeholder perception of the innovation and the problem will evolve over time (Grol & Grimshaw, 2003). As with the initial stakeholder participation phase, barriers and facilitators may influence individual and collective abilities to continue participation in primary care system change. Barriers to continued participation in change initiatives can develop from the approach used to implement the change, such as the strategies used to communicate the change to be implemented. Facilitators to continued participation can include stakeholder motivation, commitment, knowledge, and the moral responsibility to see the change through. Stakeholder motivations were previously described in this chapter. Commitment, knowledge of change strategies, and moral responsibility will be described in this section.

First, studies show that a stakeholder's commitment to change can influence their behaviours to support the change (Herscovitch & Meyer, 2020; Hill, Seo, Kang, & Taylor, 2012; Neves, 2009; Parish, Cadwallader, & Busch, 2008). Commitment to change has been defined as a "force (mind-set) that binds an individual to a course of action deemed necessary for the successful implementation of a change initiative" (Herscovitch & Meyer, 2002, p. 475). Commitment to change is especially important in engaging stakeholders when

the change represents a significant deviation from the status quo (Greenwood & Hinings, 1996), such as in the case of the introduction of the first Nurse Practitioner-Led Clinic.

Second, knowledge of effective change strategies, including information exchange, must be shared with stakeholders and implemented in a way to engage their idealism and professional commitment (Fullan, 2006; Levin, 2001). For example, the downward dissemination (top down approach) of information exchange can be a barrier to continued participation (Lewis, 2007). The use of a top down approach makes it difficult for stakeholders to feel they have a voice in the change – the change is imposed as opposed to being made collaboratively. It is this lack of collaboration that can contribute to the stakeholders withdrawing their participation from the change initiative.

Finally, an appeal to the sense of moral responsibility and belief that reform is about improving the system for all, especially the public, can be a facilitator of continued stakeholder participation (Levin & Fullan, 2008). Moral responsibility can be defined as an internal or external force that compels an individual to take action. It may be personal so that individuals feel they are obliged to take certain actions (Lopez, 2010). For example, a qualitative study aimed at determining the degree to which a teacher's moral responsibility influences their participation in educational change found that when teachers feel a sense of responsibility to the organization they are more likely to take on roles as change agents roles (Lopez, 2010).

Healthcare systems are context-dependent and the development of a country's primary care system is determined by its context (Kringos, Boerma, Hutchinson, van der Zee, & Groenewegen, 2010; Ros, Groenewegen, & Delnoij, 2000; van der Zee, Boerma, & Kroneman, 2004). The following section provides a summary of the primary care context in which the introduction of the first Nurse Practitioner-Led Clinic, and implementation of an additional 25 clinics throughout Ontario, occurred.

Primary Care Context

The concept of primary care as the hub of a country's healthcare system was first introduced by the United Kingdom in the Dawson Report in 1920 (Starfield et al., 2005). However, until the early 2000s there was very little interest in improving or changing the delivery of primary care in Ontario (Aggarwal & Hutchison, 2012). A new policy environment has emerged and we are entering a period during which several opportunities exist for a potentially transformative change (Hutchison et al., 2011). The context in which this potential for change has been made possible is the focus of this section of the literature review. The literature is organized using an evaluative framework (Donabedian, 1966), which describes structure, process, and outcomes. Donabedian's framework was subsequently used by Kringos et al. (2010) to report the findings of a systematic review of the primary care literature to examine the breadth of primary care by identifying its core dimensions. A detailed description of the local case context during the time boundaries for this case (January 2006 – January 2008) is found in Chapter 4.

Structure.

Structure refers to the setting in which the care is delivered (Donabedian, 1966, 2005). The structure of primary care consists of three dimensions: governance, economic conditions, and workforce development. Governance refers to the vision and direction of a system's health policy. Economic conditions refer to the funding system and expenditures. Workforce development refers to the profile and position that healthcare providers assume in the healthcare system (Kringos et al., 2010). For the purpose of this review, healthcare providers include physicians and NPs.

Governance: Transforming primary care in Ontario.

Since 1880, the Ontario Medical Association (OMA) has held a monopoly on the delivery of primary care in Ontario and the government has been careful to seek its approval for efforts in primary care reform (OMA, 2013). Several countries (Canada, United States of America, United Kingdom) are in the process of reforming their primary care systems, and a consistent theme of their reform initiatives has been an emphasis on the importance of including a variety of providers as members of team-based healthcare delivery models to improve access to high quality healthcare (Australian Government Department of Health and Aging, 2009; Drummond, 2012; World Health Care Organization [WHO], 2008). For example, decision-makers, such as administrators of Health Maintenance Organizations (HMOs) in the United States, believe that NPs have the potential to make a positive effect on access to primary care services and to

reduce costs associated with work that was once reserved only for physicians (Kelley, 1994; Mullinix & Bucholtz, 2009). Ontario, along with British Columbia, Quebec, and Alberta, has been recognized for making the greatest progress in primary care transformation in Canada to date (Aggarwal & Hutchison, 2012) and has been recognized for its systematic approach to this reform over the past five years (“An Update on Primary Care Reform in Canada,” 2008). Ontario’s approach to reform has included financial subsidization of physicians for the implementation of electronic health records, rostering of patients, blended capitation, and financial incentives to physicians for after-hours care in primary care settings, and integration of healthcare services through the use of team-based healthcare delivery models (Naylor & Naylor, 2012).

In 2006, the introduction of Nurse Practitioner-Led Clinics was proposed by Ontario’s Liberal government as a component of their “Family Healthcare for All” strategy. The goal of the “Family Healthcare for All” strategy was to provide timely access to high quality primary care for all Ontarians. Nurse Practitioner-Led Clinics are expected to register for services those patients who currently do not have a primary care provider (otherwise referred to as “unattached” or “orphan” patients). (MoHLTC, 2008a).

Ontario’s current vision for healthcare transformation includes the development of a sustainable system with a focus on health maintenance. A system which allows all Ontario citizens to access high quality healthcare services when and where these services are needed focuses on better access, better health, and better value (MoHLTC, 2012a). The Ontario government views

the continued implementation of Nurse Practitioner-Led Clinics as a means to an end in the accomplishment of this goal.

Economic conditions.

Most healthcare in Canada, including in the province of Ontario, is publicly funded but delivered through private agencies (Hutchison et al., 2011). Under the Canada Health Act, Ontario is required to provide funding for primary care services to all its citizens (Government of Canada, 1985). The cost of providing healthcare to 13.3 million people living in Ontario was expected to be 47.6 billion dollars in 2011-2012 (Government of Ontario, 2011a, 2011b). Hospitals, otherwise known as tertiary care organizations, consume the largest share of the provincial healthcare budget, but most Ontarians access the majority of their healthcare services through primary care.

Primary care reform in Ontario began with the introduction of alternative funding models for physician payment. Prior to 2001, the principal model of funding physician services in primary care was fee-for-service. Currently, there are three predominant funding models for the delivery of primary care services in Ontario: salaried, capitation, and fee-for-service. (Glazier, Klein-Geltink, Kopp, & Sibley, 2009). In a salaried model, primary care providers are employees of an organization and they receive an annual salary which is not dependent on the number of patients served or number of services provided. In a capitation model, primary care providers receive a fixed annual sum for each patient registered to a particular primary care practice. Capitation rates are reimbursed through age- and sex-adjusted payments (Dahrouge et al., 2009). In a fee-for-service model,

primary care providers receive payment according to the number of services they provide, such as patient consultations, and the type of services they deliver (Glazier et al., 2009). Fee-for-service models have been criticized for promoting unnecessary medical appointments and discouraging interdisciplinary collaboration (Breton, Lévesque, Pineault, & Hogg, 2011). NPs typically receive payment through a salaried model (Koren, Mian, & Rukholm, 2010), whereas capitation and fee-for-service models are reserved for physicians. Physicians are free to select any of these three payment models. The uptake of capitation models as the primary funding mechanism by physicians currently exceeds the straight fee-for-service model in Ontario (Glazier et al., 2009).

Workforce development.

NPs are advanced practice nurses, educated to perform expanded functions in primary care. According to the Canadian Nurses Association (CNA):

Advanced nursing practice is an umbrella term describing an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, communities, and populations. It involves analyzing and synthesizing knowledge; understanding, interpreting and applying nursing theory and research; and developing and advancing nursing knowledge and the profession as a whole. (CNA, 2008, p. 1)

The Nurse Practitioner Association of Ontario (NPAO) (2012) further defines the role of the NP as:

a registered nurse with advanced university education who provides personalized, quality healthcare to patients. Ontario NPs provide a full range of healthcare services to individuals, families and communities in a variety of settings including hospitals and community based clinics in cities and smaller towns in Ontario. We work in partnership with physicians, nurses and other healthcare professionals such as social workers, midwives, mental health professionals and pharmacists to keep you, your family and your community well. (NPAO, 2012)

The introduction of new NP roles can respond to the increasing healthcare demands of Canadians and must be based on solid evidence of those needs (CNA, 2008). Healthcare needs have been the most important driver for the introduction of NP roles (De Geest et al., 2008).

The College of Nurses of Ontario (CNO) maintains a database of members entitled to practice that is updated monthly. According to its most recent reports, 2,085 NPs are eligible to practice in Ontario as of September 2012. A recent survey of 594 NPs indicated that 82% of them were working full-time in primary care settings, such as Family Health Teams (FHTs) (15%), Community Health Centres (32%), physician offices (23%), and Nurse Practitioner-Led Clinics (3%) (Koren et al., 2010). According to the College of Nurses of Ontario, NPs also report working in hospitals and other facilities, such as long-term care facilities (2012).

Physicians, and the role they play in Ontario's healthcare system, are recognized broadly. The American Academy of Family Physicians (AAFP) offers this widely adopted definition of the family physician.

Family physicians, through education and residency training, possess distinct attitudes, skills, and knowledge which qualify them to provide continuing and comprehensive medical care, health maintenance and preventive services to each member of the family regardless of sex, age, or type of problem, be it biological, behavioral, or social. These specialists, because of their background and interactions with the family, are best qualified to serve as each patient's advocate in all health-related matters, including the appropriate use of consultants, health services, and community resources. (AAFP, 2009)

The World Organization of Family Doctors (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians [WONCA]) defines the "family doctor" similarly as,

the physician who is primarily responsible for providing comprehensive health care to every individual seeking medical care, arranging for other health personnel to provide services when necessary. The family physician functions as a generalist who accepts everyone seeking care, whereas other health providers limit access to their services on the basis of age, gender, or diagnosis. (Bentzen et al., 1991, p. 1)

In 2011 there were 11,902 family physicians practicing in Ontario, almost half of the total 25,480 physicians in all specialties. According to the Ontario Physician Human Resources Data Centre, in Ontario 51 family physicians left active practice in 2011 and 621 started or returned to active practice in 2011. As of April 2012, 2,397 physicians were practicing in FHTs in Ontario (P. Graham, personal communication, May 28, 2012).

Process.

Process refers to how care is provided and can include appropriateness, acceptability, completeness, and competency (Donabedian, 1966; 2005). Access, continuity of care, coordination of care, and comprehensiveness of care are key components of primary care (Kringos et al., 2010). There is no single best model for the delivery of primary care (Hutchison et al., 2011). However, team-based models have been introduced as one of the dominant primary care reform strategies in Ontario. Two team-based healthcare models for the delivery of primary care, FHTs and Nurse Practitioner-Led Clinics, are described in detail below.

In September 2000, the provincial premiers met to develop a shared action plan for renewing healthcare services in Canada. They agreed to the establishment of team-based healthcare delivery models that would focus on health promotion, disease prevention, and chronic disease management. In 2004 they reaffirmed this commitment and set a goal that half of Canadians would have access to team-based healthcare delivery models by 2011. Primary healthcare teams can expedite access to primary care and improve the quality of

these services (Pollara Research, 2007; Rosser, Colwill, Kasperski, & Wilson, 2011; Russell et al., 2009). The introduction and implementation of these delivery models can also be used as a lever for improvements in healthcare system performance (Breton et al., 2011).

Most team-based healthcare delivery models in Ontario are FHTs. There are now over 170 FHTs in Ontario, serving approximately 2 million patients (Rosser et al., 2011). FHTs are seen as the most promising model for primary care reform in Canada at this time (Glazier & Redelmeier, 2010). FHTs bring together different healthcare providers to co-ordinate high quality primary care through a team approach that allows physicians to focus on complex medical problems, and enhances patient access to a variety of healthcare providers according to their individual needs. FHTs are designed to give physicians support from other complementary healthcare providers, including nurses, NPs, pharmacists, dieticians, and social workers (MoHLTC, 2008b). Physicians usually take the lead positions in FHTs and make the decisions regarding the types of providers that will be included in their teams based on a community assessment which is completed as part of the application for funding process. Physicians usually play a key role in making decisions concerning the types of primary care programs offered to their patients. Physicians may or may not decide to include NPs as members of their FHT. A disadvantage to being employed by a physician-owned FHT for NPs and other interdisciplinary healthcare providers is that the physician-owner may decide at any time that the employee's services are no longer required.

Nurse Practitioner-Led Clinics are different from other primary care team models. The majority of the primary care provided at Nurse Practitioner-Led Clinics is delivered by NPs; physicians support NPs and other healthcare providers to deliver primary care through a team approach (MoHLTC, 2008a). This is in contrast to the traditional FHT model in which NPs and other healthcare providers work to support the physician. Nurse Practitioner-Led Clinics position and champion the NP role at leadership levels within the healthcare team (Registered Nurses' Association of Ontario [RNAO], 2008b). NPs make the key decisions regarding the types of providers that will be included in the teams, and the types of primary care programs offered to patients. The main difference between most FHTs and Nurse Practitioner-Led Clinics is that in Nurse Practitioner-Led Clinics, an NP acts as the most responsible primary care provider and acts as the point of entry to the healthcare system for the patient (PRA Inc., 2009).

Table 1 provides a description of the key features of Nurse Practitioner-Led Clinics, CHCs (the original model introduced in the 1970s), and FHTs. These features were developed from an analysis and synthesis of the literature describing team based healthcare delivery models in Ontario (Glazier et al., 2012; Heale & Butcher, 2010; Health Force Ontario, 2012; McPherson, Kothari, & Sibbald, 2010; MoHLTC, 2012b, 2012c, 2012d; Tazim, 2012; Tetley & Brooks, 2010).

Table 1
Key Features of Team-based Healthcare Delivery Models in Ontario.

Key Feature	Community Health Centres (CHCs)	Family Health Teams (FHTs)	Nurse Practitioner-Led Clinics (NPLCs)
Governance	Community elected board of directors	Mixed provider/Community-based board of directors	51% NP/Community board of directors
Date of Introduction	1970s	2004	2007
Administrative Structure	Executive Director	Executive Director Physician Lead	NP Lead Administrative Lead
Purpose (MoHLTC, 2012b,c,d)	<i>Provide primary health and health promotion programs for individuals, families, and communities</i>	<i>Ensure that people receive the care they need in their communities; focus on chronic disease management, disease prevention and health promotion; work with other healthcare organizations.</i>	<i>...service populations who do not have access to a primary care provider... improve the quality of care through enhanced health promotion, disease prevention, and chronic disease management and improve care co-ordination and navigation of the healthcare system at the local level</i>
Team Composition	Multi-disciplinary team	Multi-disciplinary team	Multi-disciplinary team
Most Responsible Provider	Physicians or NPs	Physicians	NPs
Funding Source	MoHLTC (administered through the Local Health Integration Network (LHIN))	MoHLTC (administered through the Local Health Integration Network (LHIN))	MoHLTC (administered through the Nursing Secretariat)
Payment Model for Providers	Salary-based	Physicians: 60% capitation and 40% from other fees and bonuses. Other providers: salaried	Salary-based
Current Status	73 CHCs: 110 communities 357,000 patients	150 FHTs: 720 physicians 1 million patients	25 NPLCs Patient population: currently n/a
Patient Population Size	3% of the population	16% of the population	800 patients/NP employed

Outcomes.

This section will focus on outcome evidence related to team-based healthcare delivery models (FHTs and CHCs) in the context of Canada and Ontario's healthcare system, nurse practitioner-led care in international contexts, and two studies which specifically examined the outcomes of Nurse Practitioner-Led Clinics in Ontario. Outcomes refer to the end points of care received by patients (Donabedian, 1966, 2005). Primary care outcomes have been examined in terms of quality, effectiveness, and equity (Kringos et al., 2010). Several studies have examined primary care outcomes (Dahrouge et al., 2009; Dahrouge et al., 2010; Dufour & Lucy, 2010; Glazier et al., 2012; Khan, McIntosh, Sanmartin, Watson, & Leeb, 2008) and inter-professional team-based interactions of primary care reform in Ontario (Goldman, Meuser, Rogers, Lawrie, & Reeves, 2010; Pottie et al., 2008; Riva et al., 2010).

For example, a Canadian study conducted by Khan et al. (2008) examined the quality and effectiveness of primary healthcare teams. They used data from a 2008 random telephone survey (the *Canadian Survey of Experiences with Primary Health Care* [CSE-PHC]) which was designed to assess the degree to which Canadians had access to primary healthcare teams and the effect that these teams were having on patient care processes and outcomes in comparison to non-team-based models, for example, solo physician practices (Statistics Canada, 2009). Primary healthcare team was defined as a nurse or other healthcare professional, or both, accessible at the patient's medical doctor's office or regular place of care (Statistics Canada, 2009).

Khan et al. analyzed data collected from this survey between the months of April and June of that year (2008). They found that almost 40% of Canadians had access to a primary healthcare team. They also reported several positive outcomes associated with access to these teams. For example, individuals with two or more chronic diseases were more likely to report being in better health and more likely to report receiving health promotion education and disease prevention measures as a component of their care when they received primary care services from a team-based healthcare delivery model (Khan et al., 2008). Individuals with chronic disease who have access to a primary health team were also more likely to experience whole-patient care and higher levels of service coordination. Overall, patients were more likely to report higher quality of healthcare services from primary healthcare teams, decreased ER use, and fewer hospitalizations. The research team concluded that primary healthcare teams had a positive effect on the perception Canadians have of the overall quality of their healthcare system and the confidence in which they hold it. However, the results also suggest that having access to a team can have a negative effect on confidence if the patient's experience with team-based care does not result in improvements in care processes. This study also suggests that access to same-day, next-day, and after-hours care continues to be an issue and policy reform to address this challenge should be the focus of ongoing healthcare system reform in Ontario.

There is little evidence to support the idea that the formation of primary healthcare teams has improved access to primary care significantly for patients

who need it the most, that is, those patients without a primary care provider. In 2007–2008, the MoHLTC (2008c) reported that only 10% of physicians practicing in primary healthcare teams were accepting new patients. Among those physicians who accepted new patients, on average only 49 new patients were accepted per physician.

The evidence on Nurse Practitioner-Led care is predominantly limited to other contexts and refers to Nurse Practitioner-Led centres or “nurse managed centres,” a model in which NPs provide the main proportion of primary care (Clendon, 2004; Gilmartin, 2004; Mason, Freemantle, Gibson, & New, 2005). Most of these studies have been completed in the United Kingdom where “nurse-led clinics” have also been introduced as part of primary healthcare reform. The NP role was first introduced in the UK in 1982 (Phillips, 2007). None of these studies are Canadian (Thille & Rowan, 2008). Positive outcomes associated with nurse-led clinics include: improved patient satisfaction (Hill, 1997; Sheppard, Warner, & Kelley, 2003; Sullivan, Burnett, & Juszczak, 2006); decreased hospital visits (Clendon, 2004); improvements in patient outcomes (Burnett, Juszczak, & Sullivan, 2004; Corner, Plant, A'Hern, & Bailey, 1996; Pagels, Wang, & Wenstrom, 2008), for example decreased average cholesterol and blood sugar results in patients with diabetes (Harris & Cracknell, 2005; New et al., 2003); and excellent value for money (Mason et al., 2005).

Thille & Rowan (2008) examined the evidence on Nurse Practitioner-Led care. They reviewed 5 observational studies (Benkert et al., 2002; Birkholz & Viens, 2001; Edwards, Kaplan, Barnett, & Logan, 1998; Edwards, Oppewal, &

Logan, 2003; Neff, Kinion, & Cardina, 2007), 4 randomized controlled trials (Lenz, Mundinger, Hopkins, Lin, & Smolowitz, 2002; Lenz, Mundinger, Kane, Hopkins, & Lin, 2004; Mundinger, 2001; Mundinger et al., 2000), and 2 qualitative studies (Krothe & Clendon, 2006; Pohl, Barkauskas, Benkert, Breer, & Bostrom, 2007). They concluded that nurse practitioner-led care resulted in high levels of patient satisfaction and high quality of care. The randomized controlled trials they reviewed compared NP practices to those of physicians and showed equivalence in terms of patient satisfaction, self-reported health status, physiologic outcomes in patients with chronic disease, processes of care, and health system utilization. Participants in the qualitative studies articulated an appreciation for nurse practitioner-led care from a patient perspective, noting a strong orientation towards the community and respectful approaches to caring for previously marginalized populations (Thille & Rowan, 2008).

The Sudbury Nurse Practitioner-Led Clinic was the subject of one of two studies that have examined Nurse Practitioner-Led Clinics in Ontario (PRA Inc, 2009; Thibeault, 2011). The *Evaluation of the Sudbury District Nurse Practitioner Clinics* examined barriers and facilitators to implementation, access to primary care services, patient satisfaction, the integration of NPs, and collaboration with family physicians and other providers (PRA Inc., 2009, p. 6). The PRA evaluation was developed in consultation with MoHLTC. The evaluation team used document review, key informant interviews, focus groups, and surveys with patients to answer 13 important questions. The conclusions support the use of the clinic to address current patient needs in terms of access.

The clinic was established in Sudbury due to the shortage of physicians in the area and the resulting high number of patients with no primary healthcare provider. There were NPs living in Sudbury who were not employed and who lobbied for the clinic, which led to its establishment. The clinic provides a setting where NPs can function to their full scope of practice, providing primary healthcare for patients who did not previously have a health care provider. (PRA Inc., 2009, p. 31)

The other study of Nurse Practitioner-Led Clinics in Ontario was completed in partial fulfilment of the requirements of a Doctor of Nursing Practice degree. The purpose of the study, *A Nurse Practitioner-Led Clinic in Thunder Bay*, was to develop, implement, and evaluate a Nurse Practitioner-Led Clinic (Thibeault, 2011). The Thunder Bay study (Thibeault, 2011) concluded that the introduction of a Nurse Practitioner-Led Clinic in that community was a success and noted that patients who had not had access to a primary care provider now had access to primary care services. The study also noted that the feedback from public stakeholders was extremely positive and patient satisfaction levels were similar to those found in the PRA Inc. (2009) evaluation.

Neither study provides specific direction regarding activities important to the successful introduction of innovations at the system level, apart from the suggestion that the MoHLTC should provide support by sharing information about best practices and lessons learned with the additional 25 clinics that will roll-out in other Ontario communities (PRA Inc., 2009).

In addition to the outcomes previously reported in the literature, the Ontario government identified specific outcomes for the introduction and implementation of Nurse Practitioner-Led Clinics. Table 2 lists the outcomes that the Ontario government has identified for Nurse Practitioner-Led Clinics (MoHLTC, 2008a).

Table 2
Outcomes for Nurse Practitioner-Led Clinics.

Provide comprehensive primary care services through an interdisciplinary team, which includes NPs, RNs, Family Physicians, and a range of other healthcare providers functioning within their scopes of practice.
Provide navigation of the healthcare system and coordinate care for patients – linking patients with other components of the healthcare system, such as acute care, long-term care, public health, mental health, addictions, and community programs and services.
Emphasize early disease detection and diagnosis, illness prevention, and health promotion.
Serve as a driving force for the development and implementation of chronic disease management and self-care programs.
Provide patient-centred care that acknowledges and encourages the patient to be an active member of the team and to use information to support informed decision-making about their individual self-care needs.
Link with other community healthcare organizations to adapt services to meet the needs of specific communities.
Use information technology to support system integration, linking patient records across healthcare settings to provide timely access of important information to all healthcare providers involved in the individual's care.

The introduction of Nurse Practitioner-Led Clinics as a component of healthcare system reform to improve primary care provides a particularly interesting example of stakeholder participation in the introduction and implementation of NP roles in Ontario.

Summary

No studies have examined stakeholder participation in the introduction of an innovation as a component of primary care reform in Ontario at the policy level. A synthesis and analysis of the stakeholder and system change literature was used to develop the preliminary conceptual framework that guided the development of this study. The conceptual framework presented in this chapter integrates stakeholder perceptions of system problems and their concerns with the introduction of innovations as a component of system change. These perceptions and concerns are based on their individual and collective knowledge, attitudes, and motivations for participation. Stakeholder participation in primary care system change initiatives, such as the current primary care reform in the context of Ontario's healthcare system, is inherently connected to stakeholder characteristics and the barriers and facilitators to participation.

An examination of stakeholder participation in primary care system change as a component of primary care reform is an important addition to the empirical nursing literature. Thus the goal of this study was to examine stakeholder participation in a primary care system change process that led to the introduction of Nurse Practitioner-Led Clinics in Ontario.

Chapter Three: Methods

This chapter describes the methodology of a single case study examining stakeholder participation in a system change process. The discussion will address the case study protocol as described by Merriam (1998), Stake (1995), and Yin (2003), the researcher's role, ethical considerations, procedures, and rigour.

Research Design

The research design selected for this study was a single case study. Quantitative studies have dominated the literature on change management in healthcare (Bellman, 2005), however Iles and Sutherland (2001) conducted an extensive literature review to guide change in the National Health System and found the most useful studies to guide the implementation of change processes were qualitative case studies from single site organizations (Iles & Sutherland, 2001). Qualitative methods rooted in constructivism are based on the premise that truth is relative and dependent on individual perceptions of the truth (Baxter & Jack, 2008). The single case study approach is grounded in the constructivist paradigm (Baxter & Jack, 2008; Stake, 1995; Yin, 2003). Case studies offer the researcher choice in terms of data collection and analysis methods, including qualitative approaches. Case studies provide an intensive, holistic description and analysis of a single entity, phenomenon, or social unit and rely heavily on inductive reasoning through the use of multiple data sources (Merriam, 1998). The product of a single case study design is a rich description of a bounded

system (case) over time, through detailed, in-depth data collection from multiple sources (Dempsey & Dempsey, 2000; Pegram, 1999; Yin, 2003). One advantage of using the qualitative approach is that it allows the researcher to interact with participants while at the same time allowing participants to tell their stories (Crabtree & Miller, 1999; Creswell, 2003). In this case, participants told the story of their involvement during a system change process.

The questions posed in this study included how and why stakeholders participated in the introduction of the first Nurse Practitioner-Led Clinic in Ontario. Stakeholder participation in this case was part of a real-life event, which had context-relevant variables. Case studies are the preferred method when questions of “how” or “why” are being posed, when the researcher has little or no control over the phenomenon of study, and when the focus of the study includes a phenomenon that occurs within a complex real-life context (Yin, 2003). Case studies can enhance the understanding of innovations, such as new healthcare service developments, in ways that quantitative methods cannot (Black, 1996). They provide a method for enabling holistic, meaningful, context-relevant understandings about real-life events (Yin, 2003) and are useful particularly when evaluating new, complex developments (Keen & Packwood, 1995).

Positivist critics have developed arguments against the use of case study as a valid research method citing lack of rigour and generalizability, concerns with bias (Jensen & Rodgers, 2001), time requirements, and creation of massive, unreadable documentation (Yin, 2003). Yin (2003) proposes several responses to these criticisms. Rigour and generalizability concerns can be addressed

through careful consideration of the purpose of case study research (Yin, 2003). The purpose of this case study was not to control real-life contextual influences, but to attribute meaning to them as they related to the case through thoughtful consideration. Concerns regarding lack of rigour can be overcome through careful and appropriate design (Yin, 2003). Several components of the design for this case study were included to enhance the rigour of the study procedures. These design components included careful case selection, the use of multiple sources of evidence, establishment of a chain of evidence, having selected participants review a summary report of the preliminary findings (member checking), and the use of a case study protocol (Yin, 2003). Specific strategies to enhance credibility, transferability, dependability, and confirmability are discussed at the end of this chapter.

Researcher's Role (Situating Self)

Qualitative research is interpretative research (Bredo & Feinberg, 1982; Geertz, 1974; Rabinow & Sullivan, 1979), as the investigator typically is involved in a sustained and in-depth experience with the participants. Qualitative investigators must reflect systematically on who they are and what their role will be in the inquiry (Creswell, 2003). Acknowledgement of biases, values, and interests must be examined introspectively and consideration of how these characteristics will affect the study must be stated explicitly (Creswell, 2003). A statement of these characteristics highlights the honesty and openness of the research by acknowledging that all research is laden with values (Mertens,

2003). A statement of my personal biases, values, and interests is described in the following section.

As a female NP, I bring certain personal and professional biases, values, and interests to this study. I believe that all people in Ontario are entitled to the same access to primary care services. Primary care should be available to people in relatively close proximity to their home, when they need it. I believe that NPs make valuable contributions to the healthcare system at large, and can provide leadership for the system change required to provide high quality, primary care access for all people in Ontario. However, NPs are limited in their ability to realize leadership roles in the healthcare system, given the current healthcare context and empowerment of other healthcare providers, mainly physicians. As a NP, I am interested in advancing the ability of NPs to realize their full scope of practice in a variety of healthcare settings. Of particular interest to me are those settings that empower NPs to make decisions and take action on issues that affect primary care access. NPs are predominantly female and historically a power differential has existed between medicine (previously a predominantly male dominated profession) and nursing. This power differential has persisted and continues to have an effect on the ability of NPs to come together as a professional group to lead system change for the improvement of healthcare services in Canada.

At the time this study was proposed I was the co-lead on a funding proposal to support the implementation of a Nurse Practitioner-Led Clinic in my community of Belleville, Ontario. During the development of the proposal and

prior to initiation of data collection for this study, I encouraged the co-leads on the Belleville Nurse Practitioner-Led Clinic project to initiate contact regarding business related to that proposal with any potential participants for this case. I am now a valued member (Chief Nurse Practitioner/Clinic Director) of the team-based healthcare delivery model known as the Belleville Nurse Practitioner-Led Clinic. There were several benefits to my previous involvement in a process similar to this case. These included: (a) acquiring first-hand knowledge about the development of a Nurse Practitioner-Led Clinic; (b) establishing positive relationships with key stakeholders prior to the development of this study proposal, which helped in gaining access to the site and in recruitment of participants; and (c) possessing insight into the types of research questions needed to examine the introduction of the first Nurse Practitioner-Led Clinic in Ontario.

There were also disadvantages to my in-depth knowledge of the process of introducing a Nurse Practitioner-Led Clinic: potential bias; possible perception during recruitment of coercing individuals with whom I had a previous collegial relationship to participate; and participant discomfort during the data collection process. Several strategies were used to deal with these issues and are discussed in the next section which outlines the ethical research practices for this study.

Ethical Considerations

Ethical approval for this study was submitted to the University of Ottawa Research Ethics Board in June 2009 (Appendix B) in accordance with Tri-Council

Policy Statement Guidelines (Government of Canada, 2010). No other ethical approvals were necessary to conduct this study. A letter of information was sent to all potential participants prior to obtaining consent. The letter of information described my role as researcher, the purpose of the study, requirements for participation in the study, participant rights, and contact information of the primary researcher, the supervisor, and the University of Ottawa Research Ethics Board (Appendix C). For those participating in face-to-face interviews, written consent was obtained at the beginning of the interview. For those participating in telephone interviews, written consents were obtained electronically prior to the interview (Appendix D). Consent included permission to audiotape the interviews and willingness to have verbatim quotations included in future publications of the study results. Participants were given the option to withdraw their consent to participate in the study at any time, for any reason, without fear of any negative consequences. There were no financial incentives provided to participants for their involvement in the study.

Participant confidentiality was protected by the use of appropriate data management; for example, all data was kept in locked cabinets and electronic data was stored on password protected equipment. Data was accessible only to the researcher, supervisor, a professional transcriptionist bound by a confidentiality agreement, a graduate student researcher, and members of the thesis committee. Thesis committee members were clearly identified as having access to the data during the informed consent procedure. All participants were assigned a study code. A master list of study codes and participant information

was kept in a locked cabinet separate from the data. Data from participants was identifiable only by the assigned study code. The master list will be destroyed at the completion of the study.

Participants openly shared information with the researcher about the change process. In order to preserve participant confidentiality, data that could have revealed the identity of a participant was suppressed and every attempt was made to present data in such a way as to reduce the potential for misinterpretation. Decisions were made during the data analysis process to ensure that direct quotations from specific participants, which could directly identify them, were included in the data analysis, but not as exemplar quotes. If participants felt their confidentiality or anonymity was threatened at any time during the study, or upon reading the case study draft report, they were encouraged to discuss this with the researcher, her supervisor, or the ethics board.

Procedures

Case selection and boundaries.

The study took place within the context of the Ontario healthcare system. Case selection is a unique aspect of case study research in the social sciences and human services (Stake, 1994). The single most important characteristic of case study research is setting boundaries for the case under study (Miles & Huberman, 1994; Yin, 2003). The boundaries for this case included place (Sudbury, Ontario), time (January 2006 to January 2008), activity (stakeholder

participation), and process (introduction of an innovation during a primary care system change).

On August 30, 2007, the first Nurse Practitioner-Led Clinic in Canada opened its doors in Sudbury, Ontario. Prior to the opening of the Nurse Practitioner-Led Clinic in Sudbury, the MoHLTC did not fund directly any clinics of this nature. Other innovative models of care have been introduced within the past 10 years but Nurse Practitioner-Led Clinics are the most recent innovation. Prior to the Sudbury case there was no support for this model of care; individual perceptions of stakeholder participation during the introduction of this case are extremely valuable. Two NPs in Sudbury have been recognized for their contributions to the system change that resulted in the approval of funding for this team-based healthcare delivery model. Between February 2006 (initial proposal submission to MoHLTC) and November 2006 (MoHLTC announcement of funding for a new model of care) a primary care system change occurred that supported the introduction of the Sudbury Nurse Practitioner-Led Clinic, regarded as the first of its kind in North America (Heale & Butcher, 2010). This primary care system change allowed and influenced the implementation of an additional 25 Nurse Practitioner-Led Clinics in Ontario. Hence, this case was regarded as a pioneer and an innovation in primary care delivery that warranted further examination. Unique or extreme cases, such as the first Nurse Practitioner-Led Clinic, are one rationale for selection of cases for study (Yin, 2003).

The researcher, in consultation with her Chair and committee advisors, considered several possible time-relevant beginning and end-point boundaries

for the case. It was determined that one month prior to the proposal submission to the MoHLTC (January 2006) to 4 months after the opening of the clinic (January 2008) would be an appropriate time period to support adequate examination of the case. This time boundary would allow for examination of both the activities leading up to and the stakeholder responses after the introduction of the clinic, which could also be considered part of the system change process.

Participants and data sources.

Participants.

To ensure that core patterns of the phenomenon were identified, maximum variation in the selection of participants on multiple dimensions was used (Patton, 1990). A purposive sampling approach was used to identify stakeholders involved in the introduction of the first Nurse Practitioner-Led Clinic in Ontario. Participants identified as key stakeholders were sampled from the clinic, the local community, and the province. Before the study began, potential participants were identified from each of these perspectives. At the clinic level, for example, potential participants included members of the Board of Directors, NP Managers, NPs, and management staff. At the local community level, potential participants included representatives from healthcare agencies, healthcare professionals, and members of parliament. At the provincial level, potential participants included policy makers from the MoHLTC, staff from healthcare professional organizations, and nursing researchers.

All potential participants were identified through media accounts of the events leading up to the introduction of the Sudbury Nurse Practitioner-Led Clinic including, for example, two NPs, the executive directors of professional healthcare organizations, and MoHLTC officials. As other public documents were retrieved and reviewed as part of the data collection process, other participants were identified from these documents. Participants were eligible for inclusion if they were 18 years and older, and able to participate in an English language interview.

Recruitment.

In August 2008, email requests were sent to the Clinical Lead NP and Board Chair for the Sudbury Nurse Practitioner-Led Clinic to request further discussion regarding researcher access to the clinic. The initial response was positive, and telephone follow-up to discuss the details of the proposed research protocol occurred later that same month. A formal request by the researcher was submitted to the Sudbury Nurse Practitioner-Led Clinic Board of Directors and a letter of approval to utilize the clinic for the case study was received in August 2008 (Appendix E).

Once participants were identified, they received a recruitment letter by email requesting their participation (Appendix C). If no response was received within one month, a second message was sent. If no response was received within one month of the second attempt, according to the ethics protocol approved by the University of Ottawa, no further contact was made with the potential participants and it was assumed that they were not interested in

participating in the study. All potential participants were contacted by the researcher.

Upon confirmation of interest, a letter of information and a consent form were emailed to the participants. A time for the interview was confirmed in a subsequent email. Participants reviewed the consent form at the beginning of the interview, signed it, and faxed or emailed the form to the researcher.

Twenty-nine people were invited to participate; 20 agreed, and 9 did not respond. Maximum sample variation and saturation was achieved with 16 participants who were representative of the clinic, local community, and provincial levels of Ontario's healthcare system. Data saturation was achieved and confirmed with the inclusion of 16 participants and it was not necessary to continue with interviewing the additional four participants who had agreed to participate. Therefore, the final sample size was 16 participants. Participants included both those individuals who publicly supported their vision for the Nurse Practitioner-Led Clinic and those who did not.

Site visits.

Two visits were made to the Sudbury Nurse Practitioner-Led Clinic site. The main purpose of the site visits was to meet with participants from the clinic and local community system levels, collect documents, examine the physical space and community, and conduct participant interviews. Both site visits were two days in duration (September 29 & 30, 2009; October 27 & 28, 2009).

Data collection procedures.***Interviews.***

The interview schedule (Appendix F) was designed to elicit information about participant perceptions of the system change process to include: (a) their activities; (b) their motivations; and (c) barriers and facilitators of the change process. Participants were asked a series of open-ended questions about their involvement in the Nurse Practitioner-led initiative, characteristics of the leaders involved in the initiative, previous experience with change processes, current knowledge about Nurse Practitioner-Led Clinics, benefits of the clinic and the importance of continuing to develop this model, factors contributing to its success, barriers challenging its introduction, concerns about sustainability, and current actions to support or challenge the sustainability of the clinic. Probes were used to create an opportunity for expansion and explanation of individual responses. These interviews were tape-recorded and transcribed verbatim by a professional transcriptionist. Interviews were conducted between September 29, 2009 and July 18, 2011. The shortest interview was 20 minutes in duration and the longest was 94 minutes (median=37 minutes). Interviews were conducted with participants at a pre-arranged site and time that was convenient for them, either in person (n=7) or over the telephone (n=9).

Document retrieval and selection.

Documents can serve a variety of purposes. Documents for this study were selected to provide contextual data, supplementary research data and to

complement the interview data (Bowen, 2009). The local newspaper was searched to identify public documents pertaining to the introduction of the clinic. To ensure that no existing documentation was overlooked, participants were asked during the interviews to identify and share public documents relevant to understanding the process. The following section describes the process used for document retrieval, selection, and review.

The document retrieval process began with an electronic search of the *Sudbury Star* newspaper on my first visit to Sudbury on September 30, 2009. The search was limited by search term (“Nurse Practitioner Clinic” and “Nurse Practitioner”) and timeframe. The timeframe for the search was limited to include documents from the date of the initial case boundary (January 2006) to the date the search was conducted (September 2009). The search of the *Sudbury Star* for “Nurse Practitioner Clinic” resulted in 70 documents from January 2006 to September 2009. The search term “Nurse Practitioner” resulted in 109 documents from January 2006 to September 2009. All documents were filed by search term on an external hard drive.

A tracking database was created to include: search source or search term, search date and reason for inclusion, results, and document page numbers. The database was used to record document retrieval and sorting procedures and provides an evidence trail in accordance with case study protocol (Yin, 2003). Documents were sorted further by search term and organized in the database according to identification code, title, type, author, author role, date, public or private status, and size of the document (number of pages).

An additional 188 documents were provided or recommended to the researcher over the course of the study through contact with participants during the interview process. These sources included physicians, professional healthcare organization websites (OMA, RNAO, and Nurse Practitioner Association of Ontario), study participants, and other advanced practice nursing researchers. These documents were printed at the time of receipt and filed. These documents were added to the tracking database if appropriate to the time boundaries of the case.

Document analysis requires data selection as opposed to data collection (Bowen, 2009). Documents were selected for inclusion in the analysis if they were available in the public domain and relevant to participant activities during the time boundaries of the case (January 2006 to January 2008). These documents were used as part of the data triangulation process, in addition to field notes, to confirm and provide additional details of key events included in the timeline and story.

Field notes.

Notes were written during the site visits and before and after interviews to complement data retrieved during the process for review. The field notes were reviewed throughout the data analysis process to provide additional depth and insight to the analysis, to direct additional analysis, and to assist in ascribing meaning to the results.

Data analysis.

Qualitative content analysis was used to analyze the data (Elo & Kyngas, 2007; Hsieh & Shannon, 2005; Miles & Huberman, 1994; Woods, Priest, & Roberts, 2002). It is a flexible (Cavanagh, 1997), content-sensitive way to analyze text data (Krippendorff, 1980). The goal of content analysis used in this case was to provide knowledge and understanding of stakeholder participation in primary care system change. Large volumes of data from the interview transcripts were distilled into fewer content-related concepts (Elo & Kyngas, 2007). Contrary to known critics who consider the method to be too simplistic to benefit quantitative research, and by nature not qualitative (Morgan, 1993), it is much more than a simplistic description of data (Cavanagh, 1997). Content analysis is useful in the identification of critical processes (Lederman, 1991). In this case it supported the description of stakeholder participation in a system change process.

Elo and Kyngas (2007) describe two types of qualitative content analysis, deductive and inductive. Deductive analysis requires a body of knowledge for the area of study and the purpose of the study is to test a theory (Kyngas & Vanhanen, 1999). Inductive analysis moves data from the specific to the general; data is combined to form a larger picture, or general statements, not previously tested (Chinn & Kramer, 1995). The approach used is determined by the study purpose (Elos & Kyngas, 2007) – in this study the examination of stakeholder participation in a primary care system change process, an area of interest with relatively limited knowledge and theoretical basis for testing. Therefore, an

iterative approach using deductive analysis based on the preliminary conceptual framework in Chapter 2 and inductive analysis based on emerging findings from the data not included in the framework were used.

Interviews were prepared for analysis through a series of multiple reviews. The goal of the interview preparation phase was to become immersed in the data. The transcripts were read several times (Burnard, 1991; Polit & Beck, 2004) to gain familiarity with the range and diversity of the data collected during the interview process and subsequent analysis. Notes were taken during the interviews and later re-read with the interview transcripts to assist in the analysis. All transcripts were read through in their entirety at the beginning of the analysis and preliminary notes were made in the margins of the transcripts to describe all aspects of the content. This process of organizing the interviews is known as open coding (Elo & Kyngas, 2007). These notes were collated and organized into a coding scheme using major codes and sub-codes, noting data relevant to the concepts identified in the original framework.

Interview quotations were categorized to identify commonalities and these commonalities became the basis of the initial coding scheme. Sub-codes were used to identify commonalities under major codes, a method used to imply comparison between these data (Cavanagh, 1997). Several decisions regarding major codes and sub-codes were made through the process, in collaboration with the researcher's dissertation Chair, and through consulting the current literature on the emerging themes. Saturation occurred quite early in this process, by interview number ten. Ten interviews have been proposed as a specification for

data saturation in theory-based interview studies (Francis et al., 2010). An additional six interviews were coded and reviewed as part of an ongoing data analysis process to ensure that all themes were represented and no new themes omitted.

Codes were refined through an iterative process of analysis and review, during which cross-checking with the study questions was completed to ensure that the evidence within the data was being used to address these questions. Each code was given a label and defined. To check for confirmability, the thesis supervisor and another graduate student researcher independently analyzed and cross-checked 2 full transcripts each (for a total of 4) by coding interviews based on the preliminary study codes and definitions. After a meeting to review and discuss similarities and variances in coding decisions, further refinements were made based on their feedback. These refinements included the deletion of three major codes, the collapse of several sub-codes and the development of consensus on other codes. After this meeting, the initial coding scheme was approved for use by the thesis supervisor. Interview data was then transferred into NVivo8 to manage the interview data using the refined coding scheme.

The refined coding scheme was then used to analyze selected interviews. To ensure that the perceptions of all stakeholders were represented accurately, the project leader's interviews were not included in the initial review. The project leader's interviews had considerably more depth and breadth than the other participant interviews and were reviewed after saturation occurred. Following analyses of the project leader's interview transcripts, the coding scheme was

refined further in consultation with the thesis supervisor and all interviews were analyzed again; no new codes were identified during this final analysis. Major codes and sub-codes were then further analyzed and collapsed to develop a conceptual framework that provides a general description of stakeholder participation in the system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario. One additional interview was analyzed using the conceptual framework to ensure saturation and trustworthiness. The coding of this interview did not add any new meaning to the study findings.

Member Checking

Member checking is considered an important component of verifying and validating information collected and analyzed by the researcher (Merriam, 1998; Stake, 1995). Information obtained through this process can be used to critique the data and provide additional data for triangulation (Stake, 1995). Thirteen of the 16 participants were sent a 3-page summary report of the preliminary findings for review and comment via email. Three participants were not included as they were no longer reachable by email; for example, one of the participants was no longer in her previous position and no forwarding contact information was available. The material sent to the participants for the purpose of member checking is included in Appendix G. Participants were generally in agreement with the preliminary findings.

Qualitative Rigour

The following section describes the processes used during the development of the case study protocol, data collection, analysis, and reporting phases of this study to enhance the credibility, transferability, dependability, and confirmability of the results. Lincoln and Guba's (1985) framework is used to position the evidence for the trustworthiness of this study. Recommendations from Yin (2003) to address concerns about rigour are also discussed in the context of Lincoln and Guba's framework.

Credibility.

Four techniques were employed during the conduct of this study to achieve credibility: triangulation (Lincoln & Guba, 1985); member checking (Lincoln & Guba, 1985); theoretical verification (Morse & Field, 1995); and careful case selection (Yin, 2003).

Triangulation involves the use of multiple data sources within the same study to enhance the researcher's understanding of the phenomenon (Lincoln & Guba, 1985). Interviews, documents, and field notes were used as multiple sources of evidence, with careful selection of participants who represented a variety of system levels and discipline perspectives. Participants who supported and those who opposed the introduction of a Nurse Practitioner-Led Clinic were included in the study. Documents and interview data were compared to examine consistency between the participant's report of the timeline data for the case, the motivations for their participation, and the key messages used to share their

vision for the introduction of the clinic. In addition, two theoretical perspectives, stakeholder theory and system change theory, were used to examine and interpret the data. This approach is referred to as theory/perspective triangulation (Denzin, 1978; Patton, 1999).

Member checking is used to test the data, interpretations, and conclusions (Yin, 2003). The use of member checking is the most crucial technique for establishing a study's credibility (Lincoln & Guba, 1985). Yin (2003) also proposes having selected participants review a summary report of the preliminary findings as a mechanism for establishing rigour. However, it is controversial and several drawbacks have been noted by Angen (2000), Morse (1994), and Sandelowski (1993). For example, member checking relies on the assumption that a fixed reality can be reported by a researcher and, further, a participant can confirm that interpretation of reality. Confirmability of reality is in direct contrast to the values of constructivism in which reality is co-created and seen differently by each participant. Member checking was used in this study and the results of the process are described later in this report.

Theoretical verification is undertaken by the researcher when the findings of the study are compared to the results of previous studies (Morse & Field, 1995). In Chapter 5 of this dissertation, the findings from this study are explored in the context of healthcare system change and stakeholder literature to position the findings within the current discourse in these areas of study. However, the case for this study was carefully selected to represent a unique event. This case represented a major divergence from the currently funded models for primary

care delivery in Ontario and the direction the MoHLTC was taking in its efforts to reform its primary care system.

Transferability.

Transferability demonstrates an ability to apply the findings to different contexts (Lincoln & Guba, 1985). The technique used to establish transferability is a “thick” description of the context. Thick description of context provides a detailed account of the environment in which the study occurred (Holloway, 1997). The exploration and inclusion of a detailed description of context is crucial to case study research (Yin, 2003). During the development of the case study protocol, data analysis, and reporting phases of this study, the healthcare context in Ontario and in Sudbury was reviewed and described within the study report. The thick description of context for this study includes local community and provincial level primary care elements, and evidence to support the use of team-based models as a component of primary care reform, which could have influenced the development of this case.

Dependability.

Dependability refers to the ability to demonstrate that the results of the study are consistent and could be repeated by another researcher (Lincoln & Guba, 1985). The key technique for demonstration of this criterion for rigour is the use of an external, or inquiry, audit. Key decisions made throughout the research process were noted to form an audit trail.

Confirmability.

Confirmability is the degree to which the findings can be considered to have been shaped by the participants' voices as opposed to the motivations, biases, and interests of the researcher. Yin (2003) describes two processes to support confirmability – a chain of evidence and a case study database. During the process of data collection and analysis, a chain of evidence was created to ensure transparency. Interviews were transcribed verbatim and all interviews and documents were filed electronically. Databases for interviews and document tracking were created to indicate the circumstances under which the data was collected, including, for example, times and dates of interviews. In addition, decisions pertaining to the emerging themes for this study were documented, dated, and filed to demonstrate critical analysis and consideration of alternative explanations coming from the data.

Chapter Four: Results

This chapter describes the results of the case analysis of stakeholder participation during the introduction of the first Nurse Practitioner-Led Clinic in Ontario. The first section of this chapter describes the characteristics of the participants and documents. The second section provides an in-depth description of the local context within which the case is situated. The third section presents the conceptual framework which was developed from the data, organized by the major themes reported by the participants. Finally, the results of the member checking process are presented.

Participant Characteristics

Table 3 presents an overview of the participant characteristics. Sixteen participants were interviewed during this case study, representing a range of disciplines, including nursing, medicine, and business. Participants were sampled to represent three different perspectives – the clinic, the local community, and the province. The participants represented two distinct groups of stakeholders, a project team which included two project leaders, and those who participated in the process but were external to the core group. Members of the project team participated in several activities in the change process, whereas the participation level of the external stakeholders was minimal. Eleven participants supported the introduction of the innovation under investigation and five participants were opposed to it.

Table 3
Participant Characteristics.

Stakeholder Group	Perspective	Gender	Discipline	Role
Project Team: n=7	Clinic: n=3 Local Community: n=1 Province: n=3	Female: n= 7 Male: n=0	Nursing: n=6 Medicine: n=0 Business: n=1	Healthcare Providers: n=2 Healthcare Management: n=1 Health Policy: n=4
External Stakeholders: n=9	Clinic: n=0 Local Community: n=4 Province: n=5	Female: n=5 Male: n=4	Nursing: n=1 Medicine: n=5 Business: n=3	Healthcare Providers: n=4 Healthcare Management: n=2 Health Policy: n=3

Document Characteristics

The document analysis included a total of 20 public documents. Fifteen of these documents were from the local newspaper published between January 2006 and January 2008, found using the search term *Nurse Practitioner-Led Clinic*. In addition, 5 documents retrieved from the Ontario Medical Association and the Registered Nurses' Association of Ontario websites (dated for the same period or without a date) were deemed relevant to the introduction of the clinic and were included in the analysis. These documents included media releases, policy papers, and website information. A summary of all documents included in the analysis is provided in Table 4.

Table 4
Documents Summary.

Date	Title	Author	Source	Type
04/09/06	Local nurse practitioners underused	Healthcare provider (NP)	<i>Sudbury Star</i>	Letter
28/09/06	No doctor? Call a nurse	Journalist	<i>Sudbury Star</i>	News article
04/10/06	Funds needed for practitioners	Public member	<i>Sudbury Star</i>	Letter
26/10/06	Walden wants nurse practitioners	Journalist	<i>Sudbury Star</i>	News article
10/11/06	RNAO applauds new NP primary healthcare clinic – the first in Canada	Professional organization (RNAO)	<i>www.rnao.org</i>	News release
11/11/06	Nurse practitioner clinic to open in Sudbury	Journalist	<i>Sudbury Star</i>	News article
20/11/06	Nurse practitioner clinic is good news	Editor	<i>Sudbury Star</i>	Opinion
13/02/07	Clinics good news for orphan patients	Journalist	<i>Sudbury Star</i>	News article
30/07/07	Clinic expects flood of patients	Journalist	<i>Sudbury Star</i>	News article
03/08/07	New models alone won't solve healthcare problems	Healthcare provider (Physician)	<i>Sudbury Star</i>	Letter
04/08/07	Patient line up for care at new clinic	Journalist	<i>Sudbury Star</i>	News article
10/08/07	New clinics good for Sudbury	Public member	<i>Sudbury Star</i>	Letter
23/08/07	Applications flood clinic	Journalist	<i>Sudbury Star</i>	News article
30/08/07	First Nurse Practitioner-Led Clinic Opens Doors in Sudbury	Professional organization (RNAO)	<i>www.rnao.org</i>	News release
31/08/07	Orphan patients find a home	Journalist	<i>Sudbury Star</i>	News article
07/09/07	New clinic will make a difference	Public member	<i>Sudbury Star</i>	Letter

Date	Title	Author	Source	Type
31/10/07	Ten years on, Nurse Practitioners have improved healthcare in Ontario	Professional organization (RNAO)	www.rnao.org	Media advisory
20/11/07	Council makes a stop in city: NPs want ability to handle prescriptions	Journalist	<i>Sudbury Star</i>	News article
2007	Interprofessional Care	Professional organization (OMA)	Request to OMA	Policy paper
No date	NP-led Clinics Frequently Asked Questions	Professional organization (RNAO)	www.rnao.org	Website posting

Case Context

This section describes the local case context, including the geographical context and the state of primary care in the Sudbury area, at the time of the submission of the original proposal for the clinic. The local case context provides some insight into the healthcare system challenges facing the area and a potential rationale as to why Sudbury was chosen as the location for the first clinic of this kind in Ontario. See Figure 2 for the location of Sudbury in comparison to the more southern, larger centres. In Ontario, Canada, Sudbury is known as “the gateway to the north” (Figure 2).



Figure 2: Map of Ontario: Indicating Location of the City of Sudbury

Geographical case context.

The community of Greater Sudbury spans approximately 46,475.5 km² and in 2006 was home to approximately 192,391 people. Similar to other Canadian cities, the population of Sudbury is aging. There was an 11% increase in the local population of individuals aged 45 and older between 2001 and 2006. In Sudbury, individuals aged 45-64 make up 29% of the population and individuals over the age of 65 make up 15% of the population (Statistics Canada, 2007). Individuals in these age groups have considerably more primary care needs than those in the younger population (Glazier et al., 2012).

In February 2006, when the initial proposal was submitted for the first Nurse Practitioner-Led Clinic in Ontario, it was estimated that as many as 30% of Sudbury's population did not have access to a regular primary care provider (Participant 101). Between the time the participants became interested in putting forth a proposal for a new model of care and 2006, nine family physicians had closed their practices and none of those physicians had been replaced. An additional three family physicians closed their Sudbury practices in August 2006, a few months prior to the announcement for the Sudbury Nurse Practitioner-Led Clinic (Butcher et al., 2006). In response to these primary care demands, Sudbury, an underserved community, had been engaged in several physician recruitment activities. These activities included the development of websites, the introduction of the highly publicized Northern School of Medicine, which opened its doors in 2005 (Tamburri, 2005), and offers of financial incentives to physicians who would be willing to relocate to the area. However, these activities had limited success, and the challenges of providing primary care to an aging population continued.

The Sudbury Nurse Practitioner-Led Clinic opened in 2007 to provide primary care to patients in the Sudbury area. It is located in a small plaza at 359 Riverside Drive. It is difficult to find the clinic because there is no indication of the location noted on the outside signage. See Figure 3 for a photograph of the external signage (2009).



Figure 3: External Signage for Sudbury District Nurse Practitioner Clinics

At the entry to the plaza there is internal signage to identify the clinic to patients and visitors. This signage clearly indicates the name of the Nurse Practitioner-Led Clinic: *Sudbury District Nurse Practitioner Clinics*. See Figure 4 for a photograph of this signage (2009).

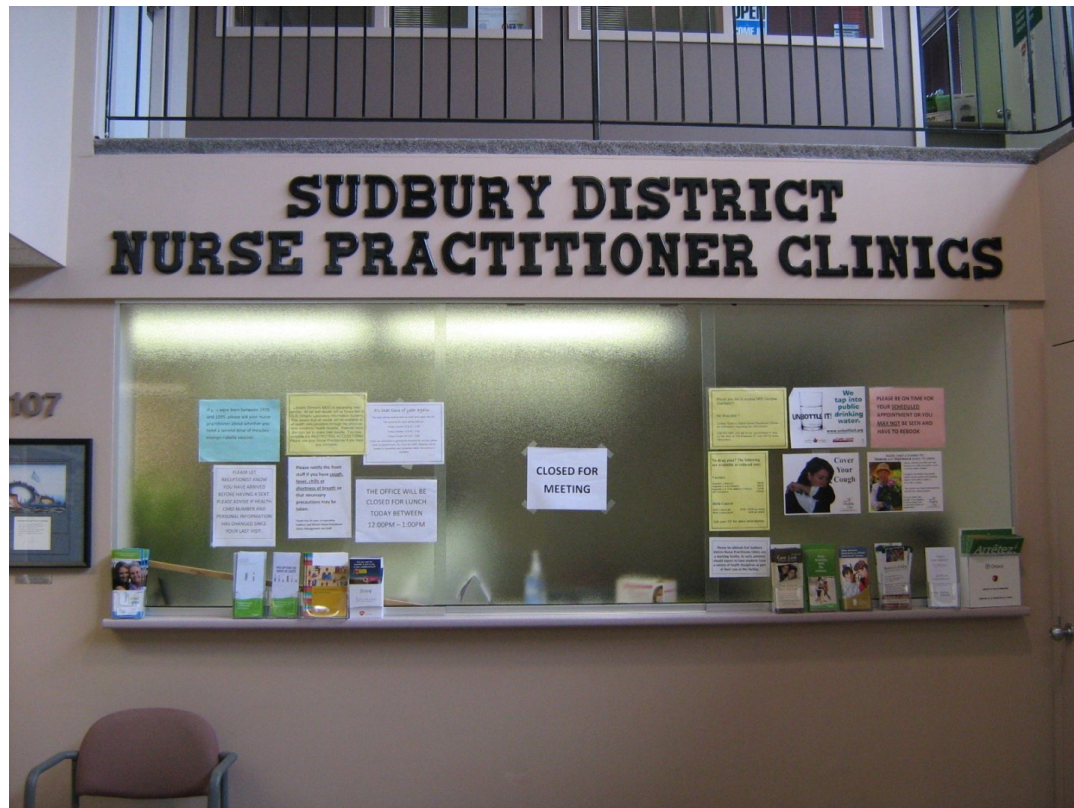


Figure 4: Internal Signage for Sudbury District Nurse Practitioner Clinics

During the period of study, the Sudbury District Nurse Practitioner-Led Clinics, occupying 3,400 square feet (316 m²), included six examination rooms and six offices. The clinic also had a small storage area, a waiting room in the mall common area, a reception area for two medical secretaries, and staff and client washrooms. Most of the rooms lacked windows. Previously occupied by three physicians, the clinic was now (2008) occupied by three NPs, one Registered Nurse (RN), a social worker, a dietician, three part-time physicians, a Clinic Director, and an Administrative Lead.

The clinic's mission is to provide "comprehensive primary healthcare through an interdisciplinary approach" (Sudbury District Nurse Practitioner

Clinics, 2010). NPs provide the majority of healthcare services to patients who are registered with the clinic. The physicians and other interdisciplinary healthcare providers support the delivery of primary care services from their own disciplinary perspectives. The clinic now has an informative website at www.sdnpc.ca.

The following section describes stakeholder activities leading up to the announcement in November 2006 of funding for the Sudbury Nurse Practitioner-Led Clinic. Subsequently, the Liberal government announced in October 2007 that it would fund an additional 25 clinics across the province.

Stakeholder activities during the introduction of the first Nurse Practitioner-Led Clinic.

A summary of significant events that occurred between January 2006 and January 2008 can be found in Table 5. The timeline for the examination of stakeholder activities during this case began with the project leader's proposal submission for the first Nurse Practitioner-Led Clinic in February 2006; however, their *vision* for a Nurse Practitioner-Led Clinic had been in the making for some time. As one participant commented, "Well I think probably my interest in Nurse Practitioner-Led Clinics goes back historically long before that....it was probably 2000" (Participant 100). The proposal for the first Nurse Practitioner-Led Clinic in Ontario was submitted to the MoHLTC in February 2006 by the project leaders in response to a request for proposals for FHTs, not in response to a request for proposals for Nurse Practitioner-Led Clinics. Presumably, the MoHLTC was not expecting an application for a Nurse Practitioner-Led Clinic model at this time. No

response was received until April 2006 when the project leaders received a response from the MoHLTC stating their proposal had not been approved for funding. The project leaders were discouraged, but not interested in quitting.

Through conversations with another NP after the proposal rejection in April 2006, the project leaders were encouraged to engage the media. The direction they received from the other NP was recalled during a participant interview, “Well you didn’t get funding, why don’t you go to the media, why don’t you kick up a storm about it? There’s a group of family doctors who didn’t get their Family Health Team and that’s what they did” (Participant 100). One of the project leaders was unsure if she had the energy to do it, since she had already been involved in political action to influence NP practice for 12 years by this point. So for about a month, the project leaders did nothing (April – May 2006). Then, as one of the project leaders noted about the other, “She started emailing me and saying one more time, we’re going to push this forward, one more time and see if it works. And then I have to stop, my husband told me I have to stop” (Participant 101). They decided in the spring of 2006 (May) to once again start the lobbying process for the first Nurse Practitioner-Led Clinic in Ontario. The project leaders wrote one more letter to the MoHLTC with a copy to other stakeholders, including the executive director of the RNAO, about the urgent

Table 5
Summary of Timeline for Activities 2006-2007.

Date	Event	Data Sources
January 2006	Original proposal for Sudbury Nurse Practitioner-Led Clinic written.	Participant 100
February 2006	Announcement for the first round of funding for FHTs. Sudbury Nurse Practitioner-Led Clinic proposal submitted to MoHLTC under Request for Proposals for FHTs.	Participant 100 Participant 101 Document 183
April 2006	Response from MoHTLC that proposal was not successful.	Participant 100
August 2006	Three more family physicians in the Sudbury area close their practices.	Document 148
1 st week of October 2006	Project leaders address Greater Sudbury Council with their <i>vision</i> for a Nurse Practitioner-Led Clinic.	Participant 100
October 6, 2006	Project leaders receive call from MoHLTC with an offer to fund a FHT. Response required within three days.	Participant 100
October 10, 2006	Project leaders respond to MoHLTC and decline offer for FHT.	Participant 100
~ October 24, 2006	MoHLTC offers a Nurse Practitioner-Led clinic with six Nurse Practitioner positions.	Participant 100
~ November 7, 2006	Project leaders receive letter outlining the details of their funding.	Participant 100, 101, 111
November 10, 2006	Funding announcement for Sudbury Nurse Practitioner-Led Clinic at the NPAO conference by the Minister of Health.	Participant 100 Document 153
January/February 2007	Project leaders receive initial Developmental Grant Funding (start up funds to develop business plan and legalize Board for non-profit corporation).	Participant 100
May 2007	Rental of real-estate space for clinic operations.	Participant 100
August 3, 2007	Clinic opens its doors to start patient registration. Clinic receives 500 applications for patient registration that day.	Participant 115 Document 155, 157, 183
August 30, 2007	Grand opening of clinic with attendance by the Minister of Health.	Document 157, 161, 165
October 10, 2007	Announcement by Minister of Health to fund 25 additional Nurse Practitioner-Led Clinics in the 2008 campaign for the provincial election.	Document 167, 183

healthcare needs of their community and the concurrent number of eight unemployed NPs in Sudbury (Document 148).

Shortly after the project leaders sent the letter, they received a call from an influential provincial stakeholder requesting additional information about the needs and number of unemployed NPs in Sudbury. As one project leader recalled, the response from the stakeholder was, “Well we need to do something about this and I’m going to bring this forth to the Minister’s office” (Participant 102). This brief interaction and verbalized support from a provincial level stakeholder re-energized the project leaders who thought, “Well maybe if there’s somebody out there willing to help us maybe we can move this forward” (Participant 100).

The project leaders initiated several activities during the summer of 2006 aimed at supporting their efforts to gain funding for a Nurse Practitioner-Led Clinic, including presentations to city council, media interviews, and letters to the editor. The project leaders engaged other NPs in these activities. Several NPs attended the council presentations and a group of 14 NPs from Sudbury and the surrounding area wrote letters to the media and local politicians. The project leaders encouraged these NPs to share their stories about the 30,000 unattached patients in the Sudbury area who had no access to a primary care provider while NPs were leaving the area in search of employment. These NPs, if funded by the MoHLTC, could provide primary care to the 30,000 unattached patients in Sudbury (Document 153).

Provincial and community activities to improve access to primary care in Sudbury to this point had focused on recruiting physicians, yet these recruitment efforts were unsuccessful and three additional physicians left their practices during the summer of 2006. During this same period of time, other stakeholders (healthcare professionals, executive director of the RNAO, and representatives from local community healthcare organizations) who supported the idea of a Nurse Practitioner-Led Clinic engaged in networking activities with key decision-makers from the MoHLTC.

Then, one of the project leaders received a telephone call from the MoHLTC at 3:00 p.m. on the Friday afternoon just prior to the Thanksgiving holiday weekend (October 6, 2006). The MoHLTC representatives proposed funding for a FHT, not the Nurse Practitioner-Led Clinic model proposed by the project leaders the previous April. The project leaders contemplated the funding offer over the weekend and rejected it the following Tuesday, October 10, 2006. The two project leaders engaged in intense discussions with key stakeholders over the next few weeks. The last week of October they received an offer to fund their original proposal. The second week of November they received formal approval in writing and on November 11, 2006, at the Nurse Practitioners' Association of Ontario Annual Nurse Practitioner Conference, the Minister of Health announced the first Nurse Practitioner-Led Clinic in Ontario (MoHLTC, 2006). The coming year, 2007, was an election year so the project leaders were determined to open the Sudbury Nurse Practitioner-Led Clinic, hopeful that additional clinics might be funded in other communities. In August 2007, the

project leaders opened the doors to the Sudbury Nurse Practitioner-Led Clinic. On October 10, 2007, less than one year after the introduction of the Sudbury clinic, the MoHLTC announced that an additional 25 Nurse Practitioner-Led Clinics would be funded for operations to provide care for the province's unattached patient population.

Several stakeholders were involved in the introduction of the first Nurse Practitioner-Led Clinic in Ontario. Their activities, motivations for engaging in these activities, and the processes used to affect their vision for change in Ontario's healthcare system, form the basis of the new conceptual framework presented in the next section.

Visions for Change: Stakeholder Participation during the Introduction of the First Nurse Practitioner-Led Clinic in Ontario

The new conceptual framework presented in Figure 5 is a diagrammatic representation of the key study findings and has been used to organize the major themes that emerged from the data. The new conceptual framework includes six key themes: *felt need*; two *visions for change* (one for a Nurse Practitioner-Led Clinic, and one for a FHT); processes related to the *visions* (*shaping, sharing, and protecting the visions*); and *stakeholder activities* related to the *vision* processes which led to *sustaining and spreading their vision* within the context of Ontario's healthcare system. Data from the documents informed three of the major themes: *felt need, visions, and sharing the vision*. Data from the interviews informed all elements of the conceptual framework. Stakeholder participation in this system change

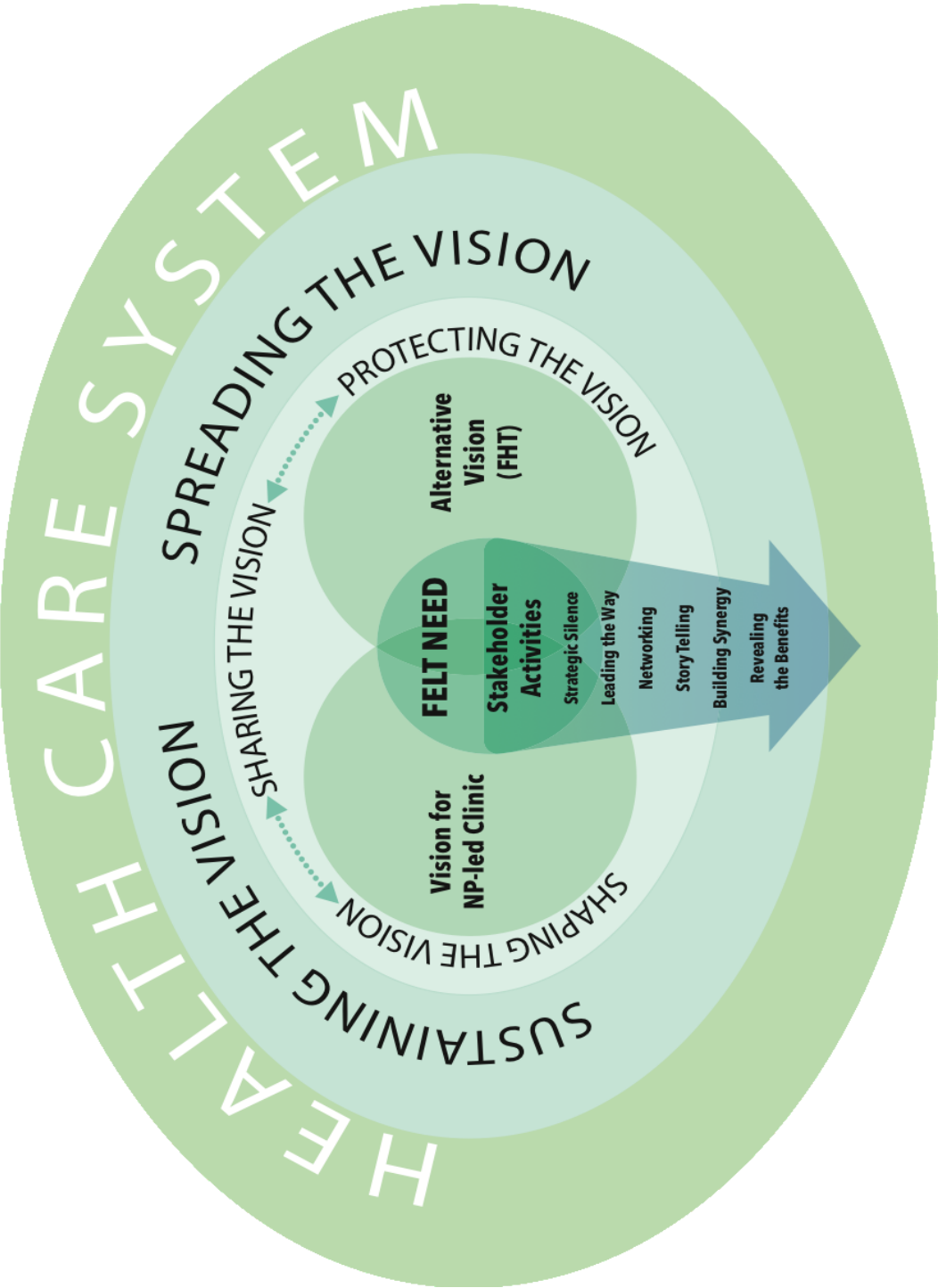


Figure 5: *Visions for Change: Stakeholder Participation during the Introduction of the First Nurse Practitioner-Led Clinic*

was a complex and non-linear process with several individuals involved at various stages. The framework was developed from the perspective of both participants who supported and those who opposed the introduction of the first Nurse Practitioner-Led Clinic in Ontario. The themes were consistently reported by both those who supported and opposed the introduction of the Sudbury clinic and were representative of all stakeholder perspectives at the clinic, the local community, and the provincial level. Each of the themes is defined in Table G1, and was included as part of the member checking documents in Appendix G. Exemplar quotes from participants are identified by numeric code and their position relative to the introduction of the NP-led clinics (supported or opposed), when appropriate.

Felt need.

The core of the framework is the *felt need*, a theme which all participants indicated as the motivator for their participation in the activities related to the primary care system change process. Participants identified an association between an unfilled requirement (goal for change) in the primary care system and their ability to participate in the process to bring about change. The needs identified by the participants included access to primary care, human resource challenges, or inequities existing in healthcare between southern communities and northern communities, such as Sudbury. For example, approximately 30,000 people in the Sudbury area had no access to primary care due to a lack of physicians, while at the same time eight NPs living in the area were unemployed (Documents 148, 153). These unemployed NPs could be providing primary care

access to those in need, but there was a lack of funding in the North to accommodate that. Participants shared personal experiences of their connection with the *felt need*. One participant described the current situation relative to starting practice as a NP in the local community.

You do all this training...it's very frustrating to be in a city where there was a lack of nurse practitioner positions. I did all my placements as a student in this community and saw so many people didn't have a primary healthcare provider...it was very frustrating that these people weren't able to get access to primary healthcare. They were using the walk-in clinics as their main source, or the Emergency room, as their source of healthcare. (Participant 109; Supported)

Participants described a realization of the *felt needs* in the system with passion and in a voice that conveyed their personal experience or an emotional connection with the need. One participant described the issues she was having with getting access to primary care for herself, her daughter, and her mother after their long-time physician died.

My mother was in her 80s and her doctor died, our doctor died; I had the same doctor...my daughters, myself, my mom, so all these women had this doctor and he died. So my mother, who at the time was in her 80s, very frail and in a wheelchair most of the time, blind, but had all her wits about her. She also had a serious heart condition but no doctor would take her. I tried with several physicians in the city and the shortage was nowhere near where what it's at now. Nobody would take her and so you know, I was toddling her around whenever she needed anything, she had a lot of medications, [so taking her to] walk in clinics and Emerg; I mean it was crazy. (Participant 108; Supported)

Not all participants were supportive of the introduction of a Nurse Practitioner-Led Clinic in Ontario. Some were strongly opposed to the idea of a Nurse Practitioner-Led Clinic and were committed to other potential solutions for

the unfilled needs in the system. However, these participants also commented on similar *felt needs*. These participants recognized the importance of addressing the *felt need* in healthcare and for this reason decided not to react negatively to the proposed change. These participants explained their motivation for participation or lack of participation in relation to the *felt need*.

We're trying not to stand in the face of progress of something that might actually help, because we do know that there's a huge shortage of doctors in the province and we know that primary care services are very important, so we don't want to stand in the way. (Participant 114; Opposed)

The documents also revealed the presence of a *felt need*. For example, the following quotation appeared in a RNAO news release, "Nurses all over the province see what their patients need to live full, healthy lives. When they call out for change, the results mean improvements for communities all across Ontario," (RNAO, August 30, 2007).

Participants spoke passionately about how they could influence the *felt need* in the system through participation in the system change process. Their *vision* for a Nurse Practitioner-Led Clinic and the *vision* for a Family Health Team were developed at different times in response to *felt needs* within Ontario's primary care system. Stakeholders engaged in several activities related to the processes to make these visions a reality as motivated by their personal connection to the *felt needs*. The outcome of these activities was the sustainability and spread of their *vision* within Ontario's healthcare system.

The visions.

Both participants who supported their *vision* for a Nurse Practitioner-Led Clinic and those who supported an *alternative vision* for a different type of team-based healthcare delivery model identified an emotional connection to the *felt need* which motivated them to participate in the change process. The *vision* born during the case under examination was their *vision* for a Nurse Practitioner-Led Clinic. The *alternative vision* that had already been realized within Ontario's healthcare system was the *vision* for FHTs. In this study a *vision* is defined as a mental picture of how to address a *felt need* within a system. One participant described *vision* from a business perspective.

....it's all about the burning platform or what's the reason for the change? What's the *vision*?in general concepts it's having the *vision* of what do you need to change. (Participant 110; Supported)

There was an overlap between the *visions*. Both *visions* included the development of a team-based healthcare delivery model to address the *felt needs* of the system. Three themes (*shaping*, *sharing*, and *protecting*) evolved as processes to support the realization of the *vision* for change. The following sections describe these processes.

Vision processes.

Three major themes were identified in relation to the realization of the participants' *visions* for change: *shaping the vision*, *sharing the vision*, and *protecting the vision*. The arrows between the processes in the model represent the interplay among them. *Shaping the vision* was described by participants as

an iterative process of identification and development of specific details of their mental picture for the system change. *Sharing the vision* was the process of communicating the emerging *vision* for change to gain support for their *vision*. *Protecting the vision* was described by participants as the process of identifying opposition to their *vision* and using strategies to address opposing views to ensure their *vision* stayed intact.

Shaping the vision.

Participants described the process of *shaping the vision* in relation to the activities aimed at the development of their *vision* for change.

Well there were many activities...when you're setting up a new model. We felt that we were in a unique position to set up the defining factors of an NP led clinic and if we didn't do it somebody else was going to do it...we knew that we had what it took to do it and that if we didn't do it, the Ministry or somebody else might do it. So we set out to define what a NP clinic was. (Participant 100; Supported)

Participants who were supportive of an alternative model for the delivery of primary care services, FHTs, also described how the *vision* for a model had been shaped.

The Provincial Coordinating Committee on Community and Academic Health Science Center Relations (PCCAR) basket of services definitely suggested that the model from a solo practice or even a small group practice is probably not going to be sustainable over time if we were to truly be able to deliver the complete basket of PCCAR services. So the model that we were developing was a respectful model for family physicians...to continue to develop a very positive relationship with their patients over time but it was also a model of family physicians becoming better organized...(Participant 103; Opposed)

Participants felt that, in addition to having a *vision*, part of *shaping the vision* was to ensure there was a plan for moving their *vision* forward. One participant commented on the project leaders' ability to *shape the vision*, and the success of the system change process, by stating the *vision* had to be specific.

They (the project leaders) had a plan...a business plan, an operational plan; it's all on paper. This was their plan and they were sticking to it...And that's a big part of their success, they weren't floating around, they didn't have a fluffy idea, it was very specific. (Participant 108; Supported)

Once the *vision* had been shaped in the minds of the participants, they expressed *sharing the vision* with others as the next step in the process.

Sharing the vision.

The process of *sharing the vision* included communication of the emerging *vision*. The main purpose of *sharing the vision* was to influence perceptions of stakeholders, such as the public and key decision makers, regarding their *vision* for change in a positive way, to promote an understanding of the reason for change, and to gain support for their *vision*. Project leaders, the project team, and stakeholders representing organizations of healthcare professionals external to the core group of stakeholders all expressed involvement in *sharing a vision*. This *vision* was either for the Nurse Practitioner-Led Clinic or for FHTs. *Sharing the vision* for the clinic included a multi-faceted communication plan.

Well there's not enough ways...It's a multi-faceted communication strategy kind of thing...unless the perceived reason to change is greater than staying the same, then they're not going to do anything...It's all about your perception of the change. And that goes back to the communication. That goes back to the *vision*. (Participant 110; Supported)

Each step of the way we ensured that the Board members would understand the model of the clinic and be supportive of the general philosophies. (Participant 101; Supported)

That was the focus, to work with all parties so they can understand the *vision* and the why behind the *vision* and the evidence. (Participant 102; Supported)

Once stakeholders had an understanding of their *vision*, a consensus developed between the project leaders and project team about what key messages would be shared with other stakeholders. They described common messaging as a key strategy in the process of *sharing the vision*.

...It's critical to keep our voice together. We can set ourselves [apart].... but if we have our acts together, [the nursing community], in terms of the evidence behind the change we want to see and a common strategy and message, and we stay on course, we can get there. (Participant 102; Supported)

So we came up with a basic style of press release...Press releases have certain elements and that's the way they're done, and ours was very patient focused. We released press releases at particular times that matched something real and they always got picked up, they always got published and it was great. (Participant 108; Supported)

I think one of the other lessons for me is the real value of creating that handful of very clear, very consistent messages that carry the key points...the sound bites, because there absolutely is a marketing aspect to this...getting everybody on page with the sound bites so that people are singing from the same book. (Participant 115; Supported)

In addition to participant interviews, the documents provided insight and confirmation of key messages developed as part of *sharing the vision* process by professional organizations, the RNAO, and the OMA. Key messages from these professional organizations were shared with the public through media releases, *Sudbury Star* publications, and position papers. These messages included:

1. Felt needs
2. Current lack of access to primary care (RNAO/OMA/*Sudbury Star*)
3. Number of unemployed NPs and scope of practice issues (RNAO/*Sudbury Star*)
4. Role and responsibilities of NPs in primary care (RNAO)
5. Political activities, for example, proposal submission and lobbying (RNAO/*Sudbury Star*)
6. Provincial and local support for both visions (RNAO/OMA/*Sudbury Star*)
7. Innovation: the clinic was the first of its kind (RNAO/*Sudbury Star*)

These key messages were shared with various audiences which the project team chose strategically. The team knew the importance of determining the appropriate audience for the message – audiences that were powerful and committed enough to make their *vision* a reality. For example, they targeted the president of a large professional healthcare organization and the Minister of Health and Long Term Care, individuals empowered to drive the change forward.

You can stand on a street corner and yell forever; you have to have your message given to the right person and it only really takes one person, if they're able to listen and have the power to make the change. (Participant 101; Supported)

Protecting the vision.

The project leaders and project team took on the task of *protecting the vision* in the face of opposition. Once their *vision* was shared with other stakeholders, initiatives to suppress their *vision* for change began. For example,

the presence of an *alternative vision* (FHTs) was already well established in the system and the MoHLTC had developed funding mechanisms to support applications for FHTs in communities such as Sudbury. The project leaders discussed the *alternative vision* as the predominant model of choice for NPs before the introduction of a Nurse Practitioner-Led Clinic. All participants were aware of FHTs and several were supportive of this model of care. Participants felt that because there was an alternative model in place with the potential to fill the *felt needs* within primary care there was no support for their new *vision* for change.

Family health teams were the vehicle of choice for nurse practitioners and all [that] that entailed. That was the status quo. And there was no support for the *vision* that we had. There was no support anywhere...there were some disgruntled people because the city is involved with a Family Health Team, they were one of the stakeholders, and there was some, a little bit of concern about that. (Participant 100; Supported)

In this study, medical dominance was revealed as a cultural element in Ontario's healthcare system; the OMA was identified by all participants as the biggest barrier to the potential for practice change. The OMA made it very clear in their policy paper, *Interprofessional Care* (Hanna, 2007), that models of care supporting continued physician leadership of primary care teams and consideration of physician compensation should be at the forefront of any discussion related to changing the current structure of interdisciplinary teams, such as FHTs. For example,

The OMA believes that the physician, having a greater breadth of training and larger scope of practice, should be the clinical lead in interprofessional teams. Physicians should be compensated for their

leadership and the indirect services they provide in interprofessional team settings. (Hanna, 2007, p. 4)

Protecting the vision included identifying potential and actual opportunities to suppress their *vision* and developing and using strategies to address opposing views. Despite pressures to alter the model, the project leaders persevered to ensure their *vision* stayed intact. Two members of the project team discussed *protecting the vision*.

Well it's kind of reinforced some of my core beliefs...just because somebody says something isn't possible, doesn't mean you shouldn't try to achieve it and don't take no for an answer. If you truly believe something is attainable and is good, then go for it... (Participant 100; Supported)

...There were people there [*the MoHLTC*] who tried to change the description of it [*the Nurse Practitioner-Led Clinic*] so it would be six physicians and two nurse practitioners instead of six nurse practitioners and two physicians. And we stuck to our guns... We have a model that's actually meeting a need, it's way too important to just back away from. And now we have to really push, we have to push, push, push, with all of our strength to make sure that we continue with this because it makes a huge difference... There were many pivotal points where we were being coerced both subtly and overtly to follow a different path [related to] ...the *vision*. The *vision* for the nurse practitioner clinic... We stuck to the *vision*... It was an outright decision; we will not deviate from our *vision*. (Participant 101; Supported)

Stakeholders who were supportive of the *alternative vision* (FHTs) became concerned about the increasing support for a Nurse Practitioner-Led Clinic and engaged in activities to protect the *vision*. All participants identified the OMA as a strong supporter of FHTs and study participants spoke about the immediate and continued backlash to the idea of introducing a new model of care in which NPs would be the most responsible provider.

Every OMA president since the announcement has bashed the model in the press...There was a letter that went to every mayor and councillor in the province of Ontario. I mean I could list all the things that they have done...We've come under heavy criticism by the OMA and it's daunting because they're the most powerful organization in the province...so it's a challenge. (Participant 100; Supported)

...There was a lot of backlash and at the same time there was a lot of excitement because most people tended to disregard the opinion of some of those negative responses ... we had a huge amount of pressure to open as quickly as possible. (Participant 101; Supported)

Participants described how stakeholders opposed to the Nurse Practitioner-Led Clinic model were given assurances by the MoHLTC that if the NP model did not end up conforming to the current primary care model, the FHT, it would be cancelled. It was a surprise to physicians that there was support for the Nurse Practitioner-Led Clinic model from a provincial perspective, including the MoHLTC. Stakeholders who supported FHTs communicated their concerns to the MoHLTC, however there was no move to cancel the model. Instead, an additional 25 clinics were announced (October 2007) shortly after the original Sudbury clinic was opened (August 2007). One of the participants described the events in the following way,

And so it was at that point that we [physicians] became a little bit more vocal from a political perspective ...We [physicians] were certainly very surprised by support for that model [NP led clinic], when the agreements were always around an inter-professional Family Health Team model...We certainly talked with them at the Ministry about, you know, how the model was evolving and had great reassurance that it was just the development of the community led Family Health Team and that the nurses would be expected to end up looking exactly like a FHT within a year. And if they couldn't do that, the model would be cancelled. (Participant 103; Opposed)

It was at this point that stakeholders opposed to the *vision* for a Nurse Practitioner-Led Clinic model began to develop and share additional key messages within their organization and with the public through the media. One local physician, a member of the Sudbury District Medical Society, expressed concerns in a letter to the editor of the *Sudbury Star* (August 8, 2007), related to the perception that NPs would be practicing without physicians.

Nurse practitioners play a vital role in the delivery of health care in Ontario. When they work in an integrated and collaborative setting with doctors, patient access to care can be enhanced. While doctors appreciate the fact that nurse practitioner clinics are attempting to address care needs in the community, they are moving us farther away from what is most beneficial for patients – an integrated system that provides seamless healthcare.

Stakeholders opposed to the introduction of the Sudbury Nurse Practitioner-Led Clinic, which opened its doors in August 2007, were concerned that the MoHLTC announced that it would support an additional 25 clinics across the province just two months after the Sudbury clinic opened. The MoHLTC announced that it would seek additional applications for Nurse Practitioner-Led Clinics from various locations to include the more desirable practice areas of the province, in Southern Ontario. In essence, this announcement demonstrated a commitment to sustaining and spreading the *vision* for Nurse Practitioner-Led Clinics.

Stakeholder activities.

Stakeholders used a variety of activities throughout the *vision* processes aimed at sustaining and spreading the *visions* for change in primary care for

Ontario. These activities are represented in Figure 5 by a large arrow which originates from the *felt need* and the *visions* for change. The activities work their way through the *vision* processes in the outer circle and include *strategic silence*, *leading the way*, *networking*, *storytelling*, *building synergy*, and *revealing the benefits*. The participants talked openly about the activities they and others used during the introduction of the first Nurse Practitioner-Led Clinic in Ontario. Each of these activities will be defined and described.

Strategic silence.

At times, participants found that the use of silence was a necessary and important strategy to support the system change process. The use of *strategic silence* was a deliberate decision by key participants to avoid public communication in response to criticisms of their *vision* for change. It was thought that a response during the process to critics of the change might have delayed progress towards making their *vision* a reality. At the same time, participants who supported the *alternative vision* (FHTs), also used silence to escape public criticism for potentially delaying the change. Several participants referred to the use of *strategic silence* as “taking the high road.” One participant recalled the use of *strategic silence* as a conscious decision to protect their *vision*, one that emphasized the importance of the relationship between patient and physician.

...We've made a very, very conscious decision that we would always take the high road, that we would emphasize the importance of a patient/physician relationship to family medicine and to the public that we served, that we would be very, very supportive of any moves towards the Family Health Team or to any other model because, Family Health Teams

require the family physicians to change the way that they were paid.
(Participant 103; Opposed)

Another participant described the difficulties experienced in influencing members of the team to stay quiet. Not all stakeholders were prepared to use *strategic silence*; they did not see the value it had in the process of *protecting the vision*.

...We've all agreed not to respond in the paper, that there's no benefit in doing that. Convincing members not to do that is very difficult. They all want to go run with a flag somewhere. They don't appreciate that doing that creates more problems than it's worth. (Participant 111; Supported)

For one participant the use of *strategic silence* was a deliberate attempt to forego any judgment and was related to being seen as a resistor to change.

No-one that I know of is sort of going public on this...I do not want to be labelled as someone who stands in the face of change and someone who refuses to accept change. And especially I don't want to be accused of protecting my turf. None of those things are true. Well I guess at the moment that's all we are doing, we're keeping an eye on the situation, and maybe I'll be wrong, maybe it will work really well and the concerns I'm raising will turn out to be not valid. But I'm certainly keeping my eyes open and following the whole thing. (Participant 114; Opposed)

Leading the way.

Activities related to *leading the way* played an important role in supporting the *vision* for the Sudbury Nurse Practitioner-Led Clinic. Activities associated with *leading the way* were defined by the participants as actions to influence others to do what needs to be done as a collective to ensure their *vision* becomes a reality.

Well I think there has to be a *vision*; there has to be strong leadership. It's very important to establish credibility, get buy-in from stakeholders, and

keep stakeholders engaged, give them a voice. (Participant 104; Opposed)

The project leaders spent many hours of their own personal, unpaid time to ensure their *vision* for the clinic would become a reality.

...The whole brainstorming for the model, the whole set-up of the clinic, everything to do and the political action associated with that came from a laptop in my basement and a laptop from [one of the project leader's] basement. We had no organizational or infrastructural support, nothing...It was just done, volunteered time, it certainly took a lot of time and effort on our part but there was no structure, there was no supporting structure for us. (Participant 100; Supported)

A component of *leading the way* described by the participants was demonstrating perseverance to continue, even in the face of opposition. As one of the project leaders explained,

...To put your neck out there...What have we got to lose? ... If we put some effort in, we might get something great... It's going to be better than what we have now...If it was just letter writing, if that was what would make the success we would have been successful in 1999. So it took until 2006. Perhaps the other piece is that we persevered, kept doing it...A lot of people would have given up. (Participant 101; Supported)

Participants also commented on the growing need for healthcare leaders who are willing to do what needs to be done. For example, one participant stated,

...In healthcare we don't have time today anymore for leaders who don't have the guts...They must step aside and let someone else go in there who will be brave and will do what needs to be done...(Participant 108; Supported)

Both participants who supported and those who opposed the *vision* for the Nurse Practitioner-Led Clinic in Ontario identified *leading the way* as an

instrumental activity to support the change process. Participants discussed the characteristics of the identified project leaders in this case and their ability to communicate effectively as components of *leading the way*. The communication skills of these leaders were integral to forming a collective team aimed at ensuring that their *vision* for the Nurse Practitioner-Led Clinic in Ontario became a reality.

She's a tremendous advocate for nursing...You can't make change happen without really strong dedicated leaders who are able to communicate well...When I look at some of the most difficult to implement changes that have happened over time they had a commonality in terms of trustworthy, respectable, values driven individuals who were trying to make the change happen. They [the leaders] were smart enough to be able to connect with the nay-sayers. (Participant 103; Opposed)

Networking.

Networking was noted as an important stakeholder activity. *Networking* involved the establishment or use of formal or informal relationships to influence other stakeholders and to optimize the communication of their *vision* for change at various system levels. Participants described *networking* with different stakeholders, including the public, decision-makers, other healthcare professionals, and representatives from other professions. *Networking* occurred in a variety of venues, both through personal, one-on-one interactions, and large group interactions. The main purpose of *networking* was to create an awareness of their *vision* to build support that would lead to more energy to move the proposed change forward. *Networking* was acknowledged as a strategy both to support their *vision* for the Nurse Practitioner-Led Clinic, and to oppose the

alternative vision. For example, one of the project leaders described *networking* with the city councillors she knew personally.

...We went to the city council. We went to some members of council that we knew. It's not a big city. I know a lot of people on council personally. And so, I pitched this idea forward. And there was some interest but without funding from the Ministry, there wasn't a real buy-in. Then we went to the media. (Participant 100; Supported)

Another participant identified the importance of not only the project leaders using these relationships and *networking* to their advantage, but the efforts of the entire team in working strategically to use every opportunity possible to network.

...The biggest thing is making sure those relationships were there and making sure that we all spend time pushing from the right direction and that it wasn't just one person banging at the door but several providing their impact. Because if somebody... whoever needs to make the final approval for the change knows, that it's more than one person looking to make this happen. And it gives more substance to the request. (Participant 105; Supported)

Another participant, one of the project team members, identified the purpose of *networking* with several groups as a mechanism to gain and share power to support the change.

...collaborate with others, right, outside of nursing. And we have, collaborated with seniors, with environmentalists, with people of high risk communities...to share; power shared, power gained. But the power becomes a collective good as well... (Participant 102; Supported)

As previously mentioned, *networking* occurred within the project team and with external stakeholders to include members of various provincial political parties. One of the stakeholders who was opposed to their *vision* for the Nurse Practitioner-Led Clinic, but supportive of the *vision* for FHTs, described the

relationships the participant's group had developed over the years and how these relationships were important in the work towards change. This participant talked about the importance of developing relationships with all political parties and a variety of government Ministries which had the potential to influence healthcare through their power and activities.

We've worked well with both political parties and the NDPs to some degree, but mostly with the PCs and the Liberals. And we've had positive relationships with each of the Ministers... with the Premier and his political staff...because family medicine touches so many areas of public life...We've worked well with the Ministry of Children and Youth, with the Ministry of the Environment, Community and Social Services, with the educational sector and so on...Throughout government we've developed very strong and very positive relationships, both within the political arm of government and definitely within the bureaucracy as well. (Participant 103; Opposed)

Another participant who was also opposed to the *vision* for the Nurse Practitioner-Led Clinic talked extensively about the importance of building and using relationships to move change forward.

The other thing people don't understand is that one group is interdependent on the other, so health, education, standards, and E-Health are all tremendously influenced by the fifth group, finance...It's a very slow process. And I was very fortunate to have the Premier and the Conservative Party and to some extent the NDP Minister of Health...I've worked with all of them in terms of political and always with the same administrators. So you have to continue to develop a respectful relationship with all those people in order to get people to move in a general direction, but it's slow, you know, it's really slow – years. (Participant 113; Opposed)

Storytelling.

During the course of these networking activities, participants shared personal experiences relevant to the need for change, or potential outcomes of

the proposed *vision* for change. Five participants commented on the use and importance of *storytelling* as an effective way to support system change initiatives. *Storytelling* was used to convince others about the importance of the change and the potential to fill a need in the system. Stories were viewed by participants as an effective way to create awareness and to encourage an understanding of the *felt need* and their *vision*. The story shared most frequently was the current need for improvements to primary care access. Participants shared personal stories about patients' inability to access primary care. These participants stressed the importance of the stories being relevant, timely, and familiar to specific audiences.

The stories are not only effective and important, but the stories have to be about the patients. The stories have to be real. They have to be about the patients... The community does not care about any of the nurse practitioner's political problems or human resource problems or issues with the Ministry... They don't care about any of that. They care about getting care and they care about seeing that other people are getting care; it's all about that... (Participant 108; Supported)

Another important story shared by the participants was that there were several unemployed NPs in the community of Sudbury who could be providing access to primary care services. The participants emphasized that the unemployed NPs were faced with the choice of moving away from Sudbury to seek employment elsewhere.

We had a number of the other unemployed nurse practitioners write a little blurb. This is my story, and we sent it to everybody... These are people in your community that could be providing you a service but they can't, and there are 30,000 of you who don't access primary care... These people are going to the United States or they're going to southern Ontario... that was the premise of the political action locally. (Participant 100; Supported)

Participants also identified which stories should be shared in the future and how these stories will be important to link to other models. One participant discussed how decision-makers can learn from these stories.

Sharing the success stories, both through academic systems and research and getting the stories published. And I think the next phase of that will be around promoting more cost analysis, economic analysis of the role to influence system change... I think on a go forward level more conversations with key decision-makers in the Ministry, [who can] learn from the stories of our members and say, where are the themes? What's working well, what isn't working well? What are your challenges? And being able to link that with what we know is going on elsewhere, like in the Community Health Centres and the Family Health Teams. (Participant 111; Supported)

Building synergy.

Building synergy was described by participants as those activities that stakeholders engaged in during the change process that used their concurrent involvement in other healthcare system change initiatives to support their *vision* for change. Participants spoke about their involvement in activities to support change in other areas of the healthcare system. The most commonly cited concurrent system change was related to Bill 179, an effort to significantly expand the scope of practice for NPs in the province, which was in the process of being implemented during the case study timeframe.

There are issues around NP barriers to practice...[that] Bill 179 [could] really address... And I've been very involved in writing submissions for that. We brought the Health Professions Regulatory Advisory Committee here for a tour...of the clinic (Sudbury Nurse Practitioner-Led Clinic) and [we] talked to them about what we (Nurse Practitioners) could do. So I mean certainly we've been involved at a system level...The whole Bill 179

impacts on NP led clinics, probably more so than for a nurse practitioner working with five other physicians. (Participant 100; Supported)

Other participants talked about the introduction of the Sudbury Nurse Practitioner-Led Clinic as a component of a larger healthcare system transformation that was occurring at the time of the introduction of the clinic. As change is initiated in one system, e.g., healthcare, or component of a system, e.g., primary care, other changes are easier to achieve to support the goal of equalization of the power base in healthcare.

And that's why I am pushing NPs and the Nurse Practitioner Association of Ontario to open clinics. It's a great achievement, but the bigger, the equally big prize, if not bigger, is the issue of admission, treatment and discharge [for NPs], which is a structural change for in-patient units. And the transformation of Medical Advisory Committees into Inter-Professional Advisory Committees ... Those are huge structural changes that will enable an equalization of power base and full participation of nursing and other health professionals. (Participant 102; Supported)

One participant spoke about *building synergy* in terms of seizing the opportunity. They described *building synergy* as an activity that would produce structural changes to have an effect on the overall goals for system change. The participant explained the importance of making connections between system issues and system change that may not be obvious to all stakeholders.

We were walking up the big circle around Queen's Park and the Minister of Labour happened to be walking down... At the same time there's also a labour mobility legislation on the table... And we said, "Minister, nice to see you, we're all these people, you know us, right." ... "We're on our way to the public hearings on 179," and he said, "Oh yes, important stuff for NPs." And I said, "Minister it's important for you too, it's all about labour mobility; we're the only province that doesn't have open prescribing." A light bulb went on in his head... And we did not believe that we would have open prescribing at that time. So the history of this organization, this practice is right place, right time. (Participant 111; Supported)

Revealing the benefits.

Revealing the benefits was another activity that participants described as important to *protecting the vision* for change. Activities related to *revealing the benefits* included stakeholder identification and use of evidence to justify their *vision* for change. Participants commented on the benefits of Nurse Practitioner-Led Clinics and the potential of the new model to meet the needs of patients. Participants verbalized their interpretation of evidence in support of the model's ability to fill system needs, particularly, the *felt need* to improve access to primary care services for Ontarians and to address the scope of practice issues for NPs.

...One of the obvious benefits...We're actually taking on those unattached patients that nobody else will, so we're actually addressing the unattached issue. We are making the best use of everybody's skill set so physicians aren't doing nurse practitioner work; nurse practitioners are working to their full scope...The taxpayer is getting better bang for their buck in terms of who's doing what...The patient benefits because it's a team-based approach to care and they see the provider that they need to see.
(Participant 100; Supported)

One of the project leaders discussed a confidential client satisfaction survey developed by the Board of Directors for the clinic in 2008. The survey results provided encouraging feedback to the project leaders and project team and confirmed the anecdotal evidence put forth by the healthcare professionals who worked at the Sudbury NP led clinic.

I see the model works so well...people here are getting care; they'll tell you. The Board put forward a client satisfaction survey and it wasn't just a, are you happy/are you not happy? it was based on a client satisfaction survey portion of a survey that was done with the Women's Wellness clinic project...The feedback we received was wonderful, people truly love being

a patient at the nurse practitioner clinic. They want more of it. They say they don't wait as long for appointments, they have extremely thorough care... Nurse practitioners really make a difference in their care...that justified what we all felt. (Participant 101; Supported)

Another participant talked about the idea of Nurse Practitioner-Led Clinics being founded on evidence. *Revealing the benefits* was used as a component of *protecting the vision*.

Not just an idea but it's an idea that is well founded on evidence and articulated in a clear way... Identifying factors that will contribute to the success and factors that could put a dam to the whole thing are equally important. So the key factor to the success of the clinic was that the clinical practice would have to be absolutely stellar...And the volume of patients that they will provide care to is also important... they [Sudbury Nurse Practitioner-Led Clinic] have delivered beyond the expectations, so that has been very important and helpful. (Participant 102; Supported)

Sustaining the vision.

The *vision* processes and stakeholder activities in this study contributed to *sustaining* and *spreading* the *vision* within the Ontario healthcare system. The sustainability and spread of the *vision* is represented by one of the circles within the outer circle that represents Ontario's healthcare system (Figure 5).

Sustaining the vision was described by the participants as a progression towards structural change, identifiable to stakeholders as the persistence of the *visions* for change which contributed to the *vision* becoming part of the fabric of the system. It could be argued that sustainability of Nurse Practitioner-Led Clinics is not guaranteed, however, participants in this study stated that they had few concerns about that. The most commonly cited evidence from the participants to support their lack of concern regarding sustainability of the *vision* for the NP-led

clinic was the Ontario government's commitment to support an additional 25 clinics. The government's commitment was viewed as a consequence of both its recognition of the potential for quality patient outcomes and simultaneous system-wide structural changes, such as Bill 179 (Government of Ontario, 2009), as recommended by the Health Professions Regulatory Advisory Committee (HPRAC).

Well I think the current government is quite supportive... The plan of Premier McGuinty to roll out [an additional] 25 [new clinics] is evidence that there's a lot of support. (Participant 100; Supported)

Well the Ministry so far has been true to its commitment...with its scheduled rollout. Again, against all odds and against the backlash from physicians...The budgetary constraints... I think that's huge for them to continue to do that...a sustainable thing because the more we open, the more [that] are up and running the better chance we have of maintaining, holding our ground and actually growing...I think a lot [of] the work being done to make changes to HPRAC [the Health Professions Regulatory Advisory Committee] could be seen as peripherally supporting nurse practitioner sustainability because if we can get those changes in place then we can make a difference with respect to... [breaking down the] barriers to all nurse practitioner practice and therefore in turn, helping NP led clinics. (Participant 101; Supported)

I don't have any immediate concerns [about sustainability], I think a change in government might cause me to have some concern...My gut tells me the ones that are established are probably pretty secure because they produce good results.... (Participant 115; Supported)

Funding was the only issue described by participants as having the potential to challenge the sustainability of their *vision* for a Nurse Practitioner-Led Clinic. Funding was viewed by the participants as having the potential to challenge the sustainability of any system change.

My concern is around the economy, is it going to set them [Nurse Practitioner-Led Clinics] up...to fail? ...We've had government support so

I'm not worried about that [sustainability], I mean the problem with the economy may cause the model to get tweaked in ways that we would not like it to be tweaked. We'll have to wait and see... The next two years will really tell the tale. I think it would be difficult for the Ministry to back off now. (Participant 111; Supported)

So the problem is sustainability and the cost of healthcare... Although we've always talked about it not being sustainable, I'm starting to think that we're getting very close to the edge. And the government is going to stand up and say, excuse me we got a big problem here, we've run out of money for healthcare. Who's the first person that wants to admit that we're right and help us? That's a big political conundrum. (Participant 113; Opposed)

Spreading the vision.

Spreading the vision was identified as a common theme by half of the participants. This concept was described as a replication of the model in other settings and was seen as confirmation of the government's commitment to introduce the model in other communities. One of the participants analyzed the spread of the clinic to other communities as something so good that it bubbled to the top.

And then something kind of a little bit good starts, and everybody wants that so bad that it bubbles to the top, and it gets support because it's so good. And that's to some extent a little bit of what's happening here I think. I'm anxious to see how all the others [Nurse Practitioner-Led Clinics] roll out and what model they're going to work under. Are they really going to stay NP led, that's a biggy! (Participant 108; Supported)

Member Checking

Four participants, representing all perspectives (clinic, local community, and provincial), reviewed a summary of the preliminary study findings in August, 2012. These participants generally were in agreement with the framework and reported that the findings reflected their experience of participation during the

introduction of an innovation as part of a primary care system change process in Ontario. Some specific suggestions were adopted, such as minor changes to the conceptual framework illustration, Figure 5 (e.g., show *vision* for Nurse Practitioner-Led Clinic and *alternate vision* for FHT at the same level in the diagram). Other suggestions, such as adding structural elements (legislation and legalities), were considered and subsequently rejected since the suggested changes were beyond the focus of the study. The study purpose was to examine the “how” and “why” of stakeholder participation as opposed to the structural elements of the system within which these activities occurred.

Chapter Five: Discussion

This single case study examination provides an in-depth understanding of stakeholders' participation in change processes to introduce a substantive healthcare system innovation. These findings are positioned within the stakeholder and healthcare system change literature. The discussion will address the preliminary and new conceptual frameworks developed from knowledge synthesis and data analysis of this study. The findings address the “why” and “how” questions of stakeholder participation initially proposed by the researcher.

1. How did stakeholders participate in the system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario?
2. Why did stakeholders participate in the system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario?
3. How did stakeholders identify and respond to barriers and facilitators during the system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario?

Between January 2006 and January 2008, several healthcare stakeholders engaged in a variety of activities to influence the introduction of the first Nurse Practitioner-Led Clinic in Ontario. These activities were primarily motivated by their personal connection to perceived felt needs within Ontario's primary care system and their desire to fill those needs. Participants shared information about two visions for team-based healthcare delivery models in Ontario's primary care system and in this case they committed to *shaping*,

sharing, and protecting these *visions*. As a result of their activities (*strategic silence, leading the way, networking, storytelling, building synergy, and revealing the benefits*), two *visions* for change were *sustained* and *spread* throughout Ontario's healthcare system.

The results of this study provide important insights into stakeholder participation that may be relevant to other primary care system change processes. First, the findings from this study contribute new information on the importance of stakeholder participation and the role stakeholder characteristics (knowledge, attitudes, and motivations) play during the introduction of an innovation aimed at changing the structure of primary care delivery in Ontario. Second, the findings are relevant to the perspectives of stakeholders who supported or opposed the introduction of the innovation. These findings have the potential to address some of the questions regarding engagement in healthcare system change that are currently lacking in the literature. Third, the findings suggest that participants played both leadership and supportive roles as components of their participation in vision processes. Fourth, participant activities during their involvement in this system change process demonstrated the importance of building a shared *vision* for change and the power that stakeholder determination to protect that *vision* can play during the change process. Finally, the use of *silence* was discussed by the participants as a valuable strategy to *protect and sustain a vision* for change.

Healthcare Stakeholders: Important Contributors

The findings from this study demonstrate that healthcare providers, policy advisors, and policy makers are capable of making significant contributions during the introduction of innovations in today's challenging primary care environments. Furthermore, even in the face of strong opposition these stakeholders have the potential to make change happen if motivated to do so. Two groups of stakeholders were identified and included in this study, those stakeholders who supported the introduction of the innovation and those who opposed it. Both groups engaged in a variety of activities (*strategic silence, leading the way, networking, storytelling, building synergy, and revealing the benefits*) during their participation to introduce a new model of team-based healthcare delivery to Ontario's primary care system. Their activities provide the basis for concrete recommendations and direction to stakeholders who make the decision to participate in change processes that may lead to the introduction of innovations in healthcare systems. A discussion of facilitators and barriers to change as they relate to stakeholder participation, with a focus on stakeholder activities, and stakeholder roles, particularly the role of resisters and the effect they have on the change process follows.

The key facilitators for the change process in this case were the stakeholder activities (*leading the way, networking, storytelling, building synergy, and revealing the benefits*). These activities have been reported previously in the literature as levers for change. Edwards et al. (2011) analyzed the NP literature through a socio-political lens as a case exemplar of whole system change. They

described the system change process used to introduce NPs into Canada's healthcare system. Facilitators for the change process were stakeholder activities. These activities included: lobbying, advocacy, partnership, leadership, knowledge production and dissemination (Edwards et al., 2011).

In this study, the characteristics and activities of those participants who opposed the change were the same as those who supported it. The findings from this study make a valuable contribution to knowledge through the addition of perspectives from stakeholders who were opposed to the introduction of an innovation. Previously, the change literature in healthcare has focussed on stakeholder roles aimed at supporting change, such as the role of champions (Edwards & Grinspun, 2011; Kirchner et al., 2010) and leaders (Caldwell, Chatman, O'Reilly, Ormiston, & Lapid, 2008; Carter et al., 2011; Chreim, Williams, Janz, & Dastmalchian, 2010; Gifford, 2011) during the process to bring about change. More specifically, the focus of the literature related to facilitators and barriers to the introduction and implementation of NP roles in Canada and Ontario was on individuals who were supportive of this innovation (DiCenso et al., 2010; Edwards et al., 2011; Kaasalainen et al., 2010; Sangster-Gormley et al., 2011).

However, there is little published research that examines the activities of stakeholders who oppose the introduction of an innovation during the change process (Ford & Ford, 2010) with the exception of identifying that they may represent a barrier to the change and recommendations for how to engage these resistors (Naylor et al., 2009; Plamping, 1998; Saint et al., 2009). These

stakeholders are described as “resistors to change” who erect blockages to the proposed change (Ford & Ford, 2010; Lawrence, 1969; Plamping, 1998).

Blockages to system change are created intentionally by stakeholders to perpetuate the status quo in power relationships (Edwards et al., 2011). In the case of the introduction of NPs in Canada, the power relationships involved medicine and nursing. Physicians have been identified as a major barrier to the implementation of NP roles in several countries (Bourgeault & Mulvale, 2006; DiCenso et al., 2010; Pong & Russell, 2003). The status quo is the perpetuation of medical dominance within the healthcare system (Bourgeault & Mulvale, 2006). The results of this study confirm these findings.

Participants who were opposed to the clinic revealed that they were not resistant to change in the primary care system, however, they did not agree with the *vision* for change that was being proposed by the other group. Each group of stakeholders protected their *vision* for change. In this study participants who were opposed to the introduction of a Nurse Practitioner-Led Clinic often “took the high road” and engaged in the use of *strategic silence* to avoid being labelled as a resistor to change in the primary care system. *Strategic silence* is discussed later in this chapter. The use of resistance has been noted by authority figures, such as managers in organizations, as a mechanism to refute a proposed change or to criticize the introduction of change, however, there is no agreed upon definition of resistance (Ford & Ford, 2010). However, resistance can be viewed as feedback and it may be useful for improving the design of the innovation or the process being used to introduce the innovation. Resistance has

the potential to deepen the discussion about the change, thus contributing to an increased awareness of the change, which can keep the change alive (Ford & Ford, 2010).

Stakeholders who erect blockages should not necessarily be labelled as resistors to change; these stakeholders require additional attention (Naylor & Naylor, 2012). Individuals leading change initiatives in primary care should identify those opposed to the change, hear their concerns, allow them an opportunity to share their *vision* for change, and assess their characteristics (knowledge, attitudes, and motivation). Participant characteristics were a key factor leading participants to contribute as healthcare stakeholders in this study. These characteristics are highlighted in the following section.

Stakeholder Characteristics

The preliminary conceptual framework (Figure 1) described three broad categories of stakeholder characteristics (knowledge, attitudes, and motivations) which influenced their participation (Anderson et al., 2006; Andrews et al., 2003; Gillespie et al., 2004; Greenhalgh et al., 2006; Rogers, 2003). The participants in this study confirmed that these characteristics influenced their participation. For example, knowledge emerged as knowledge of a *felt need* in the system and the solution to fill the perceived need. Participants in this study were motivated by their knowledge and personal connection to a *felt need* (problem) and commitment to their *vision* for change.

Participants identified problems in the current primary care system and sought knowledge of these problems and possible solutions to bring about

change. This finding is in keeping with the system change literature. For example, a summary and synthesis of 60 planned change theories was included in Graham et al.'s (2006) sentinel work. The authors agreed on eight common activities that stakeholders undertake as components of their participation in system change processes. Problem identification is the first activity in the action cycle of the knowledge to action framework. In this case, the problems (*felt needs*) identified were access to primary care, human resource challenges, and inequities in the healthcare system between northern and southern Ontario. Participants acquired knowledge of these problems through two mechanisms, (a) their professional roles in the system, and (b) personal experience with the problems. Passive and active awareness of problems that contribute to stakeholder participation in system change are described by Rogers (2003) as key activities undertaken by stakeholders.

When participants who were opposed to the introduction of the Nurse Practitioner-Led Clinic became aware of the increasing support for this model, they felt they had to protect the *alternative vision* for change. They were uncertain about the effect of this new model. Previous empirical research has examined the importance of reducing uncertainty and clarifying the vision of change (Bordia et al., 2004; Fairhurst, 1993) and stakeholder uncertainty concerns have the potential to influence both initial and continued stakeholder participation (Gallivan, 2001; Lewis, 2007). The preliminary conceptual framework (Figure 1) described the presence of stakeholder concerns as a barrier and their absence as a facilitator to initial stakeholder participation. In the

preliminary conceptual framework, stakeholders' motivation, commitment, knowledge, and moral responsibility (perception of their duty to attempt to achieve change which would improve patient care) were described as facilitators to continued participation while a top-down approach to change was described as a barrier. However, stakeholder concerns and motivations regarding current innovations in primary care and reform initiatives that are being introduced in Ontario's healthcare system are relatively unknown. This study provides some insight into these concerns and motivations. Knowledge of these stakeholder characteristics will be useful to engage stakeholders in change processes to introduce innovation in primary care in other contexts in Ontario and Canada.

In this study, a personal connection to the *felt need* was strongly indicative of each participant's level of participation. For example, two participants (project leaders) felt a strong connection to the human resource challenge, namely, a lack of jobs for NPs in the system. Other participants (members of the project team) felt a strong personal connection to the problem of access to primary care. Personal connection to a *felt need* has been discussed previously in relation to a stakeholder's identifiable reward for participation in system change (Lewis, 2007). Stakeholder theory assumes that most individuals participate in initiatives in response to a deep emotional commitment (Jensen, 2002) and was proposed in the preliminary conceptual framework (Figure 1) as a motivation for stakeholder participation.

Study participants were committed to filling the *felt need* and had confidence in their ability to influence the change. In Greenhalgh et al.'s

Conceptual Model for Considering the Determinants of Diffusion, Dissemination, and Implementation of Innovations in Health Service Delivery and Organization, Based on a Systematic Review of Empirical Research Studies (2004, p. 595), *felt needs* are described as “tension for change”. “Tension for change” is related to a stakeholder’s perception of the current state of the system. If a stakeholder perceives a situation as intolerable, the potential for successful introduction of the innovation increases (Gustafson et al., 2003). The findings from this study suggest that *visions for change* emerge from these *felt needs* and participants described a mental picture of what they thought would address the access, human resource, and scope of practice needs in Ontario’s primary care system.

Visions for Change

Participants identified and discussed two *visions* for change, a *vision* for a Nurse Practitioner-Led Clinic and a *vision* for a FHT. Both *visions* were significant contributors to the initiation of, and continued stakeholder participation in, the system change process to introduce an innovation. Both models emerged from mental pictures that stakeholders thought would address a particular *felt need* within Ontario’s primary care system. *Vision* has been noted as an important concept in the literature on leadership (Gifford, 2011; Kouzes & Posner, 1995), management (Bowles, 1997), and practice development in nursing (Boomer, Collin, & McCormack, 2008). Vision, as defined by the International Council of Nurses (1999), is “a compelling image of the preferred future that sets out a group’s or organization’s highest aspiration in clear and powerful language.”

The *visions* for change discussed by the participants in this study mediated between stakeholder motivations to initiate participation in a system change process and the activities they engaged in to realize their *vision*. When a vision is taken seriously, it is an inspirational force in people's lives and acts as a self-fulfilling prophecy (International Council of Nurses, 1999). The participants' belief in their *vision* and their commitment to change encouraged continued participation in response to their *felt needs*. The concept of *vision* was not reflected in the preliminary conceptual model (Figure 1) as it was not revealed in the literature to be a contributor to a stakeholder's decision to participate in a system change process, however, the findings revealed that the *vision* was a critical component. The opportunity to promote a *vision* can be an important motivator for stakeholder participation in primary care system change.

There is a broad consensus among multiple healthcare stakeholders that the primary care system needs major reform as part of the larger national healthcare reform agenda (Aggarwal & Hutchison, 2012; Council of the Federation, 2012). Stakeholder participation in this reform is crucial to its success (Aggarwal & Hutchison, 2012). However, very little is known about what motivates stakeholders to participate in primary care reform in Ontario. The results of this study show that although stakeholders have different *visions* of how the current needs within our system can and should be filled, they are motivated by similar factors to participate in system change processes.

Vision processes.

Participants described three vision processes: *shaping the vision*, *sharing the vision*, and *protecting the vision*. *Shaping the vision* emerged as the first component of the visioning process and has been described as a key component of practice development in nursing (Manley & McCormack, 2003). Practice development refers to the activities designed to achieve quality patient care, such as nurturing innovation in practice settings (Knight, 1994; Manley, 1997). This study provides an example of practice development on a larger scale, that of the Ontario healthcare system. Large-scale practice development provides an opportunity for healthcare providers to critically evaluate their current practices and to identify areas for improvement (McCormack et al., 2009). In this study, the innovation being introduced to address the identified area of improvement (primary care) was the use of NPs as the most responsible provider and leader within a team-based healthcare delivery model. Practice development has the potential to expose deeply rooted cultural elements in healthcare systems. These cultural elements may inhibit the realization of transformation to support patient-centred care (McCormack et al., 2009).

Shaping, sharing, and protecting the vision are noted in the system change literature but there is limited information about how stakeholders define and participate in these processes to support change (Boomer et al., 2008). It has been recognized that vision processes usually occur from the top-down (Bowles, 1997). In the preliminary framework (Figure 1) derived from the existing literature, a top-down approach was identified as a potential barrier to

stakeholder participation. However, healthcare improvements have previously been influenced through a 'top down' approach (Bate, Robert, & Bevan, 2004). The findings from this study suggest that vision processes can occur from the ground up (grass roots approach) and that this approach can facilitate stakeholder participation. In this study the *visions* were shaped in response to *felt needs* identified by participants who deliver primary care in their local community and not by administrators and policy makers. In 1978, the Alma Ata declaration recognized that solutions for health care needs within a community should be identified by the community and led by community members. Problems or *felt needs* cannot be solved by distant policy makers (Askew, 1991).

The second vision process described by participants, *sharing the vision*, supports the findings of a study conducted by Cummings & McLennan (2005) which used a case example to examine the process of effecting change. They examined the use of an advisory committee to implement an advanced practice nursing role in an oncology centre, traditionally a medically oriented model of care (Cummings & McLennan, 2005). In accordance with previous recommendations (Cummings, Fraser, & Tarlier, 2003), an advisory committee shaped and shared a *vision* for change. The committee then included its *vision* for change in documents and presentations that were disseminated widely to a variety of key organizational stakeholders. Their case examination led them to several conclusions: understanding several stakeholder perspectives is important to the success of the change, aligning the change to be meaningful to stakeholders is crucial to the success of the change, and individuals who are

able to describe and clarify their *vision* for change must be available to support this *vision* (Cummings & McLennan, 2005).

Participants in this study discussed the importance of the project leaders' and project team's ability to network both with stakeholders who were in support of their *vision* and those who were opposed. The findings from this study suggest that a detailed communication plan with a mechanism to provide feedback to all stakeholders (Naylor & Naylor, 2012), especially key decision-makers and physicians, and including those stakeholders from the initial planning stages (Sangster-Gormley et al., 2011), should guide system change initiatives in primary care reform.

The importance of aligning the change to the perceived *felt need* is critical in healthcare system change initiatives and the need for change must be greater than the perceived benefit of the status quo (Gustafson et al., 2003). In this study, all participants, both those who supported and those who opposed the innovation, communicated a deep personal connection to the need for change. Participants (project leaders and the project team) were committed to shaping their *vision* for change (first vision process) and they shared their *vision* (second vision process) with select audiences to ensure their *vision* became a reality. The project leaders in this study developed and followed a written plan to clarify their *vision* and they used key messages to ensure that stakeholders had a clear understanding of this *vision*. This study demonstrates the importance of planning healthcare system change. The plan must include a clear articulation of the

vision for the proposed change and the message must be consistent throughout the change process.

The third vision process, *protecting the vision*, has been cited in the literature as a response to barriers to change. Davies, Tremblay, & Edwards (2010) coined the phrase “barriers management,” and recommend that for change, such as the implementation of evidence-based practice, to be sustainable strategies should go beyond the management of barriers. Marchionni & Richer (2007) attribute stagnation partly to a barriers-oriented approach to change. This stagnation is evident particularly when there are long-standing system issues (Davies et al., 2010), such as the medical dominance of Ontario’s primary care system. In this study, in spite of significant resistance from one of the most powerful lobby groups in Canada, the OMA (DiCenso et al., 2010; OMA, 2013), and the deeply rooted power of physicians as the most responsible providers and leaders in primary care (OMA, 2013), study participants (project leaders and project team) developed a positive, or “yes, we can,” attitude. The project leaders expressed the attitude they would not accept anything less than what they had proposed in their original submission and they were prepared to protect this *vision* against all odds. This attitude contributed to their ability to persevere even in the face of strong opposition to the proposed change.

Strategic silence

The stakeholder and system change literature contain little on the *strategic use of silence* by stakeholders. Silence is viewed as the act of remaining passive (Morrison & Milliken, 2000) and documented as a sign of weakness (Jick & Mitz,

1985; Snow-Turek, Norris, & Tan, 1996). The use of silence identifies the individual as giving up control to form a dependent relationship with an individual or group in power (Bryant, 2003). However, Bryant (2003) proposed that one of the most constructive responses to change can be silence and suggested that the use of voice could be used as a strategy to express discontent with organizational change. She interviewed 22 participants from several industries (power, paper production, water, healthcare, and education) in south-east Australia to gain an understanding of their experiences with organizational change. She concluded that the act of silence is more complicated than previously suggested. Several reasons for using silence are likely to exist and it may be used as a strategic career move or as a deliberate act of sabotage or resistance to change (Bryant, 2003). Therefore, as suggested by the participants in this study, silence can be used by stakeholders as a calculated response to change and project teams leading change initiatives must recognize that silence does not always equate with agreement. Further assessment of individuals who are silent on the change should be initiated to identify and respond to presumed stakeholder concerns.

Implications for Nursing Practice, Education, and Further Research

Several opportunities exist for NPs to play a key role in healthcare system transformation. NPs represent a growing proportion of the nursing population in Ontario and they are well prepared to provide primary care, including health promotion and disease prevention. With approximately 1,500 primary healthcare NPs currently practicing in Ontario, there is significant potential for a subset of

these NPs to lead the transformation of primary care. However, it is only recently that NPs have been recognized as leaders in primary care through their expanded roles in team-based healthcare models (Heale & Butcher, 2010).

NPs can use their collective voice to educate decision-makers, healthcare providers, and the public about the evidence of the benefits of NP-led innovations (Desborough, Forrest, & Parker, 2011; PRA, 2009; Thibeault, 2011; Thille & Rowan, 2008). Their participation as important stakeholders in primary care reform has the potential to support further integration and expansion of their role in Ontario's healthcare system to address human resource issues and primary care access gaps across the province (CNA, 2012). The following section describes potential implications of the study findings for nursing practice, education, and further research.

Nursing practice.

Three important considerations for nursing practice are comprehensive stakeholder assessment, using *silence strategically* to respond to opposition, and *protecting the vision* as a mechanism to persevere.

First, comprehensive stakeholder assessment must include both stakeholders who support and oppose the *vision* for change being proposed. This assessment should occur at the beginning of the process and the results of this assessment can be used to support strategies to engage stakeholders in further dialogue. This dialogue is particularly important with those stakeholders who have concerns about the innovation and proposed *vision* for change. Physicians, known to have challenged the introduction and implementation of NP

roles, should be engaged during the initial stage of any process to introduce new team-based healthcare delivery models.

Second, there was significant resistance from the OMA to the introduction of the first Nurse Practitioner-Led Clinic (DiCenso et al., 2010; OMA, 2009). The OMA publicly criticized the model as evidenced by the participants' voices and key messages in some of the documents reviewed for this study. Participants who supported the introduction of the clinic intentionally used silence to respond to public criticism from the OMA of the new model for primary care. At times it was difficult for the participants to keep silent. Participants who employed this strategy recognized its effectiveness in terms of value and outcomes, that is, in deferring public criticism, during the introduction of this innovation. One participant spoke about the challenges of keeping silent and persuading others to stay silent. It is essential that NPs recognize the importance of making a conscious effort to use *silence as a strategy* to avoid criticism from other stakeholders. It is a powerful tool to support the introduction of innovations in primary care. Project teams should evaluate the use of *silence as a strategy* to respond to criticism as opposed to always speaking up.

Finally, NPs can utilize the processes (*shaping the vision, sharing the vision, and protecting the vision*) described by the participants in this study, particularly perseverance in protecting a *vision* for change to advance change in primary care systems. This study provides evidence that healthcare providers can have success during the introduction of an innovation if they are committed to *protecting their vision* for change.

Nursing education.

Implications for nursing education stem from the growing need to ensure adequate preparation at the graduate level to support the evolving role of nurses as important stakeholders and leaders in primary care system reform. Graduate education in nursing can influence a nurse's thinking and contribute to his or her appreciation for responding to policy issues through action (Sundquist, 2009). However, it has been questioned whether this education adequately prepares nurses for advanced roles in primary care (Desborough et al., 2012). In some countries, such as Australia, nursing education has been criticized for failing to keep up with policy reforms to support expanded roles for nurses in primary care (Keleher, Parker, & Francis, 2010).

The NPs and project team protected their vision for a Nurse Practitioner-Led Clinic that resulted in the introduction of the first clinic of its kind in North America. Participants identified key leaders involved in the project and spoke about the need for leaders to take the initiative and responsibility to get things done in healthcare. These leadership roles will require adequate preparation. However, in spite of growing recognition of the need to increase NP educational preparation to a Master's degree in all specialties (Mitchell, Pinelli, Patterson, & Southwell, 2001) until recently all NP programs in the province were post-diploma certificate programs with a focus on direct patient care and included courses such as pathophysiology, health assessment, pharmacology, and therapeutics (Ontario Primary Health Care Nurse Practitioner Program, 2013). The development of educational content to parallel the increasing need for NPs

to be nursing leaders in primary care and other settings is a requirement to be fulfilled as healthcare providers, the public, and policy makers move forward with system change in Ontario.

For example, specific processes, such as *protecting the vision*, and activities, such as *strategic silence*, could be included in graduate course content to support advanced nurses' participation in healthcare system change initiatives. Graduate students should also have the opportunity to participate in the change process through initiatives that include a practice development approach. The course projects could include an assignment which requires the student to engage colleagues at the clinical site in a system change process.

Further research.

The benefits of integrating NPs into the fabric of Ontario's primary care system are well known and the barriers and facilitators to the integration of NPs in Ontario have been well documented (CHSRF, 2010). However, research related to stakeholder participation to support the integration of NPs as key members and leaders of interdisciplinary healthcare teams is missing from the literature. Additional studies aimed at describing stakeholder characteristics, activities, and outcomes related to the integration of NPs and other providers in innovative models of team-based healthcare delivery in primary care are needed. These studies have the potential to benefit provincial initiatives in other areas of Canada as they move forward with their plans to increase the number of NPs practicing in interdisciplinary team settings.

Another area of interest is the inclusion of patients as stakeholders in primary care system change. Although patients were not identified as key stakeholders for inclusion as participants in this study, they do have a role to play in health care system change (Bate & Robert, 2006; Pickles & Hide, 2007). Future studies in the area of primary care system change should focus on mechanisms to incorporate patients' perspectives on their experiences with health care services and how their *vision* can be addressed.

Recommendations for further research include the following four questions aimed at providing a comprehensive understanding of the themes identified in this study. What are the *felt needs* of the general population as they relate to high quality access to primary care services? What are the *visions* for the future of healthcare from the perspective of health care professionals and end-users (patients)? How do *visions* identified by nursing and medicine differ and how are they similar? In the area of sustainability and spread of emerging *visions* for the introduction of system innovations, did other newly emerging clinics operationalize the vision for a Nurse Practitioner-Led Clinic as it was shaped and protected by the project leaders and project team in the initial case? Finally, is *protecting the vision* a component of other healthcare system change initiatives?

Strengths and Limitations

The results of this case study, although not meant to be generalizable, provide useful and transferable knowledge in the area of stakeholder participation. This section discusses the strengths and limitations inherent in this case study. The strengths included the data collection and analysis procedures,

case selection, and purposive sampling. The limitations included the sample characteristics, potential researcher biases, and procedure for member checking.

The following data collection and analysis procedures were used and demonstrate rigour as strengths of this study. Those procedures included: establishment of a chain of evidence, having participants review the draft case study report (member checks), and the use of a case study protocol (Yin, 2003), and careful case selection. Thoughtful consideration of the context in this case allowed an in-depth description of stakeholder participation. This case was unique in that it represented a major divergence from the status quo in team-based delivery of primary care in Ontario. The placement of the clinic in an area that had inequitable access to primary care, in spite of the availability of practitioners with the skills to provide that care, highlighted an opportunity for the province to fund a new model of primary care that would respond to the needs of a specific community.

It is recognized broadly in the literature that case study research is limited by its nature to the examination of a small sample of participants in relation to an event occurring within a specific context. Limitations of the conduct this study are noted to be the sample selection and potential researcher bias. Stakeholders holding three different perspectives (the clinic, the local community, and the province) on Ontario's healthcare system were purposively selected during the data collection and efforts were made to match the methods with the aims of the study. However, the type of participants selected for inclusion could also be a limitation. The participants were a highly motivated group of stakeholders with

exceptional skills in change management. The results of this study should therefore be viewed through this lens as opposed to having meaning for all stakeholders, particularly those who may or may not be motivated by a *felt need* to participate in system change processes.

Given the researcher's position in the healthcare system as a currently practicing NP with a vested interest in the success of Nurse Practitioner-Led Clinics, the results of this study could be viewed as biased. However, in an effort to offset the potential expressed biases, a physician participated as a member of the thesis committee. The sample included both participants who supported and those who opposed the introduction of the innovation presented in this case. Detailed notes were made to reflect on the decisions made throughout the conduct of this study in collaboration with the thesis supervisor (who is not an NP), and engaged participants in member checking of a summary of the preliminary findings. The delay between data collection and member checking could have limited the number of responses received and the participants' ability to recall their experience and to comment on the findings.

Conclusions

This case study is one the few examinations of stakeholder participation efforts to reform Ontario's primary care system through the introduction of an innovative team-based healthcare delivery model. Primary care reform is at a critical stage in Ontario and has the potential to improve patient access to high quality care in ways that were not originally predicted and are not yet measurable due to their complex nature. The benefits of including a variety of stakeholders in

this reform process cannot be overestimated. The Sudbury Nurse Practitioner-Led Clinic was the first Nurse Practitioner-Led Clinic in Ontario, representing a significant deviation from the traditional structure and process for the delivery of primary care. This change process was led by NPs.

In Nurse Practitioner-Led Clinics, NPs are the most responsible providers and leaders in a team-based healthcare delivery model, previously a role in primary care that was predominantly held by physicians. This change occurred in the face of strong opposition from one of the most powerful lobby groups in the province, the OMA. Stakeholders who are committed and motivated by *felt needs* and a *vision* have the potential to make great strides in system change.

Stakeholders undertake a variety of activities as they engage in *shaping, sharing, and protecting a vision* for change. An understanding of these activities, in addition to stakeholder characteristics, including their motivations to participate in the introduction of a new *vision* for primary care in Ontario, has the potential to inform future initiatives to introduce similar innovations in healthcare systems.

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Appendix A: Literature Search Procedure

A literature search on stakeholder participation, system change, and the introduction of nurse-led innovations, such as Nurse Practitioner, was completed. A broad search was done originally using the search terms “stakeholder,” “participation,” and “healthcare” from 1998 to 2008 in three databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Ovid Medline (R), and Proquest. Limits included articles published in the English language and peer reviewed articles. The combination of these terms in both CINAHL and Ovid Medline (R) yielded no articles. The search terms were then broadened to the combination of “stakeholder” and “participation” and/or “engagement”. This search resulted in potentially relevant citations (Table A1).

Table A1

Stakeholder Participation in Healthcare Search Results.

Search Terms	CINAHL	Ovid Medline (R)	Proquest
Stakeholder (title)	102	218	3067
Stakeholder (title) + healthcare (any field)	2	10	93
Stakeholder (title) + participation (any field)	9	37	747
Stakeholder (title) + engagement (any field)	2	8	265
Stakeholder (title) + healthcare (any field) + participation (any field)	0	0	30
Stakeholder (title) + healthcare (any field) + engagement (any field)	0	0	15

Abstracts of articles obtained from the searches with the combination of stakeholder and any other term, a total of 1218, were reviewed for duplication. Those thought to be most relevant to the present study were retrieved and reviewed.

Another search of the same databases using a combination of the terms “system,” “change,” and “healthcare” was completed. Limits were set to include all journals, articles written in the English language, and articles that were peer reviewed. This search resulted in potentially relevant citations (Table A2).

Table A2
Healthcare System Change Search Results.

Search Terms	CINAHL	Ovid Medline (R)	Proquest
System change (title)	108	538	3699
System change (title) and health care (any field)	8	96	78

The abstracts for the articles related to healthcare and system change, a total of 182, were reviewed for duplication and those thought to be most relevant to the present study were retrieved and reviewed.

Another search of the same databases using a combination of the terms “Nurse Practitioner,” “system change,” “implementation,” and “introduction” was completed. Limits were set to include all journals, articles written in the English language, and articles that were peer reviewed. The combined search yielded a number of citations (Table A3).

Table A3
Introduction and Implementation Search Results.

Search Terms	CINAHL	Ovid Medline (R)	Proquest
Nurse Practitioner (title)	15535	1915	1694
Nurse Practitioner (title) + system (any field) + change (any field)	59	12	374
Nurse Practitioner (title) + implementation (any field)	25	92	232
Nurse Practitioner (title) + introduction (any field)	20	43	273

Abstracts of the articles containing the search term “Nurse Practitioner” in combination with the other terms, a total of 1130, were reviewed for duplication. Those thought to be most relevant to the present study were retrieved and reviewed.

Websites Searched

Registered Nurses Association of Ontario

Ontario Medical Association

Nurse Practitioner Association of Ontario

Advanced Practice Nursing Chair

Health Quality Ontario

Canadian Nurses Association

Ministry of Health and Long Term Care

Canadian Health Services Research Foundation

Canadian Institutes for Health Research

Appendix B: University of Ottawa Ethics Certificate

File Number: 16-09-11

Date (mm/dd/yyyy): 06/25/2011



Université d'Ottawa
Bureau d'Éthique et d'Intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-Investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Title</u>
Kathryn	Hugnet	Health Sciences / Nursing	Supervisor
Dakota	Davies	Health Sciences / Nursing	Co-Supervisor
Dawn	Stacey	Health Sciences / Nursing	Co-Supervisor
Tammy	Armstrong	Health Sciences / Nursing	Student Researcher

File Number: H06-09-11

Type of Project: PhD Thesis

Title: Stakeholder Participation in Primary Care System Changes: A Case Study Examination of the Introduction and Sustainability of a NP-led Clinic in Ontario

<u>Renewal Date (mm/dd/yyyy)</u>	<u>Expiry Date (mm/dd/yyyy)</u>	<u>Approval Type</u>
02/13/2012	08/12/2011	1a

(1a: Approval, 1b: Approval for initial stage only)

Special Conditions / Comments:

N/A

File Number: H06-09-11

Date (mm/dd/yyyy): 01/25/2011



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at

Signature:

[Signature box]

Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Sciences and Health Sciences REB

2

550, rue Cumberland Ottawa (Ontario) K1N 6N5 Canada
550 Cumberland Street Ottawa, Ontario K1N 6N5 Canada
(613) 562-5841 • Téléc./Fax (613) 562-5338
<http://www.research.uottawa.ca/ethics/index.html>
<http://www.recherche.uottawa.ca/deontologie/index.html>

Appendix C: Participant Letter of Information



Université d'Ottawa
Faculté des sciences
de la santé
École des sciences
infirmières
University of Ottawa
Faculty of Health
Sciences
School of Nursing

Stakeholder participation in primary care system change: A case study examination of the introduction and sustainability of a NP-led clinic

Dear: (insert participant's name)

I am a doctoral student at the University of Ottawa conducting a research study called *Stakeholder participation in primary care system change: A case study examination of the introduction and sustainability of a NP-led clinic in Ontario*. You have been identified as someone who has had an interest in the introduction and/or sustainability of NP-led clinics in Ontario. This study is part of the requirements for a doctoral degree in Nursing at the University of Ottawa. My supervisor is Dr. Kathryn Higuchi, Associate Professor with the School of Nursing, University of Ottawa.

Purpose: This case study will examine stakeholder participation during the introduction and sustainability of a NP-led clinic in Ontario. The results of this study may be used to inform stakeholder participation in other primary care system change initiatives.

Procedure: This interview will take approximately 45-90 minutes. The purpose of the interview is to ask your perspective on and involvement in the process to introduce and/or sustain NP-led clinics in Ontario. I am interested in learning why you became involved in the process, what you did as part of your involvement in the process and how you influenced the process. With your permission, I will record the interview to make sure that I capture all the important details. You may choose to stop the interview at any time for a break, to indicate that interview is over, or to withdraw from the study. I will check with you intermittently to ensure your continued consent to participate in the study.

Once I have finished collecting information for the study, I will write a report. I will provide you with a draft summary of the case study report and ask you to review the report to verify that I have understood and clearly articulated your perspective while maintaining your anonymity.

☎ 613 557-5475
☎ 613 557-5443

45: Smyth
Ottawa ON K1H 6N5 Canada

Participant Rights: Although there are no direct benefits to you or your organization for participating in this study, the results should provide a better understanding of how and why people become involved in a primary care system change. This information will be important to the development of other health care change initiatives, and may be an indirect benefit to you as a participant. There is no direct risk of harm from participating in this study.

You are under no obligation to agree to participate in this study and if you choose to withdraw from the study, you may do so without any penalty or consequence. You may also select not to answer specific questions that come up during the interview at your discretion. Participation will require approximately 45 to 90 minutes of your time. I realize that this may potentially be inconvenient. The interview will be scheduled at a time and location that is convenient for you in an effort to avoid disruption to your regular work or personal time commitments.

Confidentiality: Your name will not be recorded with any of the information that is collected during the interview. A numerical code will be assigned to all information that is collected. A master list of codes with identifiable participant information will be kept in a locked cabinet in Dr. Kathryn Higuchi's office in the Nursing Best Practice Research Unit at the University of Ottawa to be destroyed with other electronic files and documents 15 years after the end of the study. All transcripts of recorded interviews will be kept in a locked cabinet in Dr. Kathryn Higuchi's research office separate from the master list of codes. Electronic document files will be stored on password protected equipment. Only myself and members of my thesis supervisory committee will have access to the data.

If you have any questions or require further information regarding this research study, please contact me at [redacted]. You may also feel free to contact my supervisor, Dr. Kathryn Higuchi [redacted]. If you have any questions about your rights as a participant, you may contact the officer for Ethics in Research, Office of the Vice-Rector, University of Ottawa at (613)-562-5841 or email ethics@uottawa.ca.

Tammy Armstrong, Ph.D. student researcher, School of Nursing, University of Ottawa

Appendix D: Participant Consent Form

Stakeholder participation in primary care system change: A case study examination of the introduction and sustainability of a NP-led clinic

Consent for Study – Participant

I have read the letter of information, had the purpose of the study explained to me, and I agree to participate. I understand that participation will require no more than 2 hours of my time and I will be contacted two times throughout the study, once for the Initial Interview and again to review the draft case study report. I have had all my questions answered and understand who I can contact if I have any additional questions.

Participant Name: (Please print): _____

Signature: _____

Date: _____

Person Obtaining the Informed Consent: _____

Signature: _____

Date: _____

There is a copy of this consent with the letter of information. You can keep that copy.

Appendix E: Site Approval for Access



July 7, 2009
University of Ottawa
Faculty of Health Sciences
School of Nursing

Dear Tommy,

Thank you for the letter outlining your interest in reviewing the critical system change leading to the introduction of NP Clinics. We understand that you intend to use the Sudbury District Nurse Practitioner Clinics as a case study and will conduct interviews with key stakeholders in the development of the clinic as well as review any public documents related to same. This research will be used to fulfil the requirements of your doctoral thesis.

The Board of Directors of SDNPC has considered your request and is happy to provide you with our authorization for the project.

The dates and times of the onsite visit must be negotiated with Marilyn Butcher, Clinic Director and me to ensure their availability and that there is as little interference with the ongoing operations of the clinic as possible.

Sincerely,

6/2/09

Appendix F: Interview Schedule

Date of interview: _____ Start time: _____ End time: _____

Length: _____ Participant code #: _____

Stakeholder participation in primary care system change: A case study examination of the introduction and sustainability of a Nurse Practitioner-Led Clinic

Introduction: As you know I am a PhD student at the University of Ottawa and this interview is a component of my doctoral research. As a key stakeholder, you have been identified as having a vested interest in the introduction and sustainability of Nurse Practitioner-Led Clinics in Ontario. I would like to ask you several questions about your involvement in the process to introduce and/or sustain the Nurse Practitioner-Led Clinic in Sudbury. I will be recording this interview, please feel free to tell me at any time if you would like me to turn off the tape recorder during the interview. This interview should take no longer than 90 minutes and there are 12 questions. (pause)

Do you have any questions regarding your participation at this point? (pause)

Please feel free to stop the interview at any time and/or ask questions during the interview.

Please state your name and current position.

Probes: How long have you been in this position?

Can you please describe how your position relates, if at all, to primary care and/or system change?

1. Can you tell me about your involvement in the Nurse Practitioner-Led Clinic initiative?

Probes: When did you first get involved in the Nurse Practitioner-Led Clinic initiative?

What did you do when you first became involved? Can you give me some examples of this?

Why did you decide to get involved with the Nurse Practitioner-Led Clinic

initiative in Ontario?

Are you still involved in the Nurse Practitioner-Led Clinic initiative?

If **yes**, why have you continued to be involved?

If **no**, when did you stop being involved and why?

What activities have been engaged in as part of your involvement?

Alternate wording: What you been doing as part of your involvement?

What was the outcome of these activities?

How did you make sure that your opinion about Nurse Practitioner-Led Clinics was heard?

What people and organizations did you need to influence to insure that your opinion was heard?

How do you feel you have benefitted from your involvement with this initiative?

2. Can you tell me who has taken a leadership role in the efforts to influence the introduction and sustainability of Nurse Practitioner-Led Clinics? And how?

Probes: What did they do to provide support?

I would like to talk about the change process now and what knowledge and experience you have with the change process.

3. Thinking about the change process in general, can you describe your previous experience with activities to create and/or sustain system change? (learning from other experiences and learning from this experience)

Probes: How did you learn about the strategies that you used to influence the NP led clinic initiative?

Alternate wording: How did you learn about what might work to influence the Nurse Practitioner-Led Clinic?

Were there any resources that were helpful?

What resources did you find more helpful?

What other system change initiatives have you been involved in?

What have you learned from your experience with these change initiatives?

Alternate wording: What have you learned from your experience in trying to bring about change?

Can you provide any examples?

What have you learned from your experience of participating in this project?

Nurse Practitioner-Led Clinics are a new way of delivering primary care. The next few questions are directly related to your knowledge and perceptions of Nurse Practitioner-Led Clinics.

- 4. Do you have any previous experience in working with NP led clinics?**
- 5. If not, how did you learn first about Nurse Practitioner-Led Clinics? then what did you do to learn more?**
- 6. Do you see any benefits to Nurse Practitioner-Led Clinics? Can you explain?**

Probes: Are they cost effective?

Do they increase primary care access for the patients?

Do patients get high quality primary care?

- 7. In your opinion is it important to continue to develop Nurse Practitioner-Led Clinics? Why?**
- 8. During the process of introducing the Nurse Practitioner-Led Clinic, did you identify any factors that were contributing to the success of the Nurse Practitioner-Led Clinic initiative?**

Probes:

If stakeholder has positively influenced the initiative: Ask how they were able to use these factors to enhance the introduction of the clinic?

If stakeholder has negatively influenced the initiative: Ask how they worked to counteract these factors to facilitate their agenda (activities)?

- 9. Did you identify any barriers that challenged the introduction of this Nurse Practitioner-Led Clinic?**

Probes:

How did you identify this as a barrier?

Depending on how the stakeholder influenced the initiative:

Ask how these barriers were addressed?

OR

Ask how these barriers were used to facilitate their agenda
(activities)?

10. Do you have any concerns about the sustainability of Nurse Practitioner-Led Clinics? Can you explain?

Probes: What factors do you see as influencing the sustainability of Nurse Practitioner-Led Clinics?

Will continued funding be an issue?

If a new political party was to come into office in the next election, would this influence the funding that has been promised for this Nurse Practitioner-Led Clinics and others like it?

11. Do you know of any current actions aimed at supporting the sustainability of the Nurse Practitioner-Led Clinic?

Explain further

Probes: Are you involved and how?

12. Are you aware of any current actions that challenge the sustainability of the Nurse Practitioner-Led Clinic?

Explain further

Probes: Are you involved and how?

I would like to look at public documents that may have been used by yourself or others as part of your involvement in the Nurse Practitioner-Led Clinic initiative to get a better understanding of the how the process occurred.

Do you know of any documents that might be useful? If so, how and where would I access those documents?

Thank-you for taking the time to answer my questions. Are there any other comments you think would be pertinent to this study and contribute to my understanding of stakeholder participation in this initiative?

Interview ends

Appendix G: Member Checking Documents

Email to participants:

Dear Participant;

During the interview I conducted as part of my doctoral study, Stakeholder participation in primary care system change: A case study examination of the introduction of the first Nurse Practitioner-Led Clinic in Ontario. you indicated an interest in commenting on the emerging results. In the attached document I have provided a summary of the preliminary findings, an illustration of the conceptual framework and definitions of key themes.

I am sensitive to your time demands in providing feedback on the preliminary findings. Therefore, I have developed two specific questions for your consideration in relation to the preliminary results.

1. Do these preliminary findings reflect your experience in participating in the primary care system change that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario?

Yes No Comments

2.Are the themes defined in such a manner as to have meaning for multiple stakeholders from various professions; nursing, medicine and business?

Yes No Comments

It would be appreciated if you could send a response to these questions and any comments you have in addition to your response to these questions to me by August 15th. I am meeting with my committee the following week and would like to include your feedback in my discussions with them as I move forward with the next draft of my thesis. If you are not able to make this deadline I would still appreciate your response and comments. Thank-you again for your time and participation in my doctoral study; it is greatly appreciated.

Thanks,

Tammy

Tammy Armstrong, RN(EC), PhD(c)
University of Ottawa

Attached File: Summary of preliminary study findings

Objective: To examine stakeholder participation in the system change process that led to the introduction of the first Nurse Practitioner-Led Clinic in Ontario as an innovative model of primary care delivery.

Design: Qualitative case study using semi-structured interviews, document review and field notes.

Setting: Sudbury District Nurse Practitioner Clinics, Sudbury, Ontario, Canada.

Participants: Purposeful sample of 16 participants, including stakeholders from nursing, medicine, and business at the clinic, community, and provincial system levels.

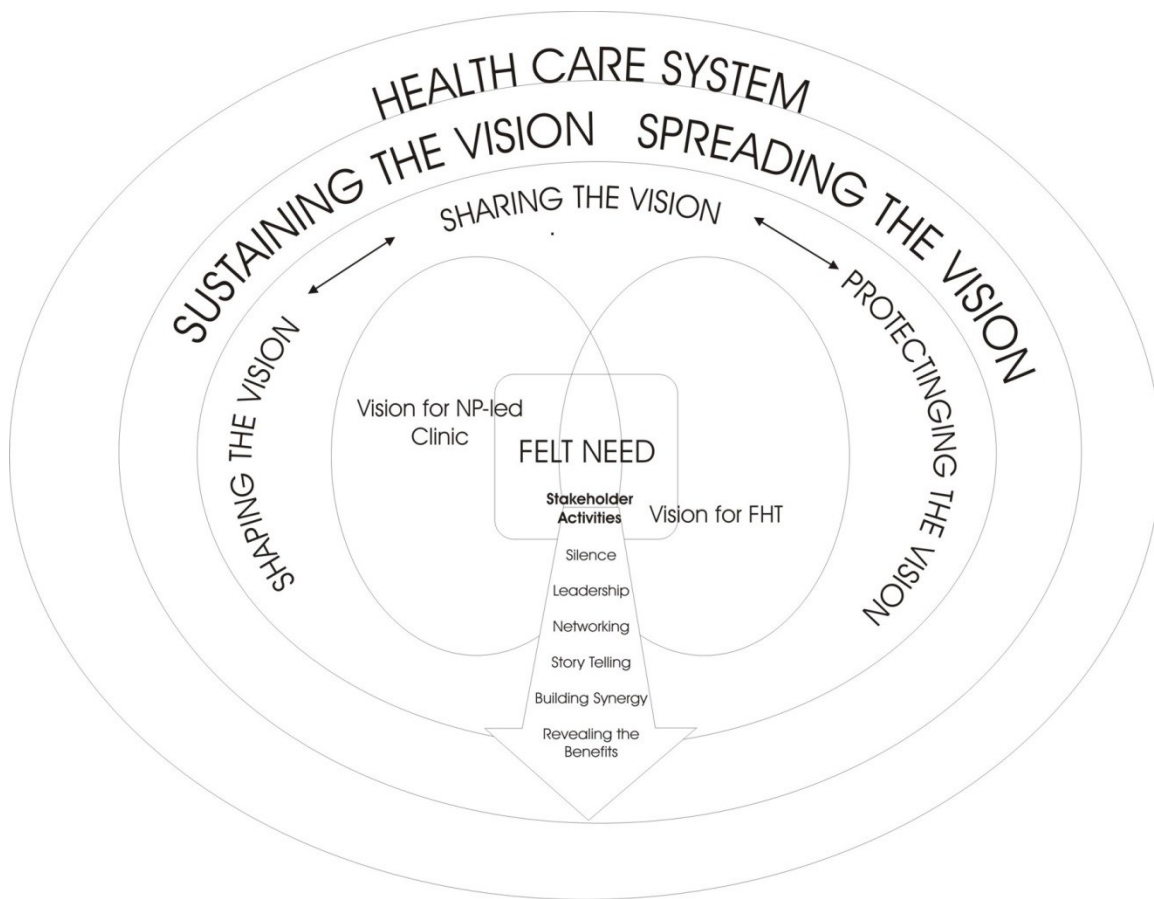
Methods: Data included semi-structured interviews, public documents (n=15) and field notes. Interviews were audio-taped and transcribed verbatim. All data were subjected to content data analysis.

Main Findings: Stakeholder participation in this system change was a complex and non-linear process with several individuals involved at various stages. Six main themes are reported: the *felt need*, *two visions for change* (one for a Nurse Practitioner-Led Clinic and one for Family Health Teams), *vision processes* related to ensuring the vision became or continued to be a reality in Ontario's health care system (*shaping, sharing and protecting the vision*), stakeholder activities, and *sustaining* and *spreading* the vision.

The core of the framework is the *felt need*, a theme which all participants expressed as the motivation for their participation in the activities related to the primary care system change process. The *visions* for a Nurse Practitioner-Led Clinic and a Family Health Team were developed in response to the *felt need*. Stakeholders engaged in several activities related to the processes to make these visions a reality. The outcome of these activities was the sustainability and spread of the *vision* within the Ontario Health Care System.

A conceptual framework is used to organize and present the key themes and their relationships as identified and defined through the content analysis of the interviews, document review and field note supplementation. The framework was developed from an analysis of the interview and document data that included stakeholders who supported and who were opposed to the introduction of the first Nurse Practitioner-Led Clinic in Ontario. A table with definitions of the key concepts is also attached (Table G1).

A vision for change: Stakeholder participation during the introduction of the first Nurse Practitioner-Led Clinic



The following table provides definitions for each of the key themes identified in the second conceptual framework.

Table G1
Key Theme Definitions.

Key Theme	Definition
Felt need	An unfilled requirement (goal for change) in the primary care system.
Vision	A mental picture of how to address a felt need within a system.
Vision Processes	Methods used to ensure a vision for system change becomes or continues to be a reality.
1. Shaping the vision	The iterative process of identification and development of specific details of the mental picture for system change.
2. Sharing the vision	The process of communicating the emerging vision for change to gain support for the vision.
3. Protecting the vision	The process of identifying opposition to the proposed vision and using strategies to address opposing views to ensure the initial vision stayed intact.
Stakeholder Activities	Individual behaviours that occur as a result of a stakeholder's desire to engage in vision processes.
1. Strategic silence	Deliberate decision by stakeholders to avoid public communication in response to criticisms of the vision for change which was used as a strategy to support the system change process.
2. Leadership	Activities initiated to influence others to do what needs to be done as a collective to ensure the vision becomes a reality.
3. Networking	The establishment or use of formal or informal relationships to influence other stakeholders and to optimize the communication of the vision for change at various system levels.
4. Storytelling	Sharing personal experiences relevant to the need for change or potential outcomes of the proposed vision for change to convince others of the importance for the change and the potential to fill a need in the system.
5. Building synergy	Activities related to the use of a stakeholder's concurrent involvement in a simultaneous health care system change initiative to support the current vision for change.
6. Revealing the benefits	Identification and use of evidence to justify the vision for change.
Sustaining the vision	Progression towards structural system change identifiable to stakeholders as the ability of the change to persist as part of the fabric of a system.
Spreading the vision	Replication of the model in other settings within the system.