Received: 13 February 2020 | Accepted: 25 February 2020

DOI: 10.1002/nop2.477

RESEARCH ARTICLE

NursingOpen Open Access WILEY

A qualitative study exploring the influence of clinic funding on the integration of family practice nurses in Newfoundland and Labrador

Maria Mathews[1] | Dana Ryan[2] | Richard Buote[3] | Sandra Parsons[4] | Julia Lukewich[2]

[1]Department of Family Medicine, Schulich School of Medicine & Dentistry, Western University, London, ON, Canada

[2]Faculty of Nursing, Memorial University, St. John's, NL, Canada

[3]Division of Community Health and Humanities, Memorial University, St. John's, NL, Canada

[4]Department of Health, Government of Newfoundland and Labrador, St. John's, NL, Canada

Correspondence
Julia Lukewich, Faculty of Nursing, Memorial University, Health Sciences Centre, 300 Prince Philip Dr, St. John's, NL A1B 3V6, Canada.
Email: jlukewich@mun.ca

Funding information
This study was funded by grants from Memorial University Faculty of Nursing, and the College of Registered Nurses of Newfoundland and Labrador (CRNNL).

Abstract

Aim: This study explores the contributions of family practice nurses in primary care across Newfoundland and Labrador funded by fee-for-service and alternate payment plans to examine the influence of funding arrangements on nursing roles/activities.

Design: A qualitative descriptive design was employed.

Methods: Semi-structured telephone interviews were conducted between March-July 2018 with physicians and Registered Nurses working in primary care settings in Newfoundland and Labrador. Interviews were transcribed verbatim, and a content analysis approach was used to identify recurring themes.

Results: Clinic funding was instrumental in the integration of family practice nurses into primary care settings and influenced roles/activities. In fee-for-service practices, nurses work with physicians and focus on one-on-one patient care in office-based settings, whereas nurses in alternate payment plans practices work more independently, in a wider range of settings and with emphasis on both individual and group-based encounters. Compared with alternate payment plans practices, fee-for-service practices tend to be more restrictive due to physician billing requirements.

KEYWORDS
family practice, fee-for-service, funding, primary care, qualitative research, registered nurse

1 | INTRODUCTION

Family practice nurses (FPN) are Registered Nurses (RNs) who work in primary care settings and are able to deliver a broad range of health services, including preventative screening, health education, management of chronic diseases, paediatric and women's care and care coordination (Canadian Family Practice Nurses Association, 2017; Canadian Nurses Association, 2011, 2013; Norful, Martsolf, & Poghosyan, 2017). The integration of RNs into primary care workforce has been associated with improved access, reduced costs and higher quality of care and could offer solutions to health complexities facing healthcare systems internationally (Horrocks, Anderson, & Salisbury, 2002; Laurant et al., 2005; Todd, Howlett, MacKay, & Lawson, 2007).

2 | BACKGROUND

Despite the advantages associated with this role, many provinces such as Newfoundland and Labrador (NL), New Brunswick and British Columbia have integrated FPN at a slower pace than other jurisdictions across Canada where reforms have included funding

strategies to facilitate the introduction of FPN. For example, in Ontario, RNs are the most predominant non-physician workforce in primary care settings, including Community Health Centres and Family Health Teams. The introduction of the Community Health Centre and Family Health Team dates back to 1979 and 2005, respectively, and both focus on the inter-professional team to deliver a broad range of healthcare services (Glazier, Zagorski, & Ryaner, 2012; Hutchison, Levesque, Strumpf, & Coyle, 2011; Lukewich, Williamson, Edge, VanDenKerkhof, & Tranmer, 2018). In Nova Scotia, the formal integration of FPN into primary care occurred over a decade ago and there are now more than 35 inter-professional primary care teams that include FPN established across the province (Nova Scotia Health Authority, 2017; Todd et al., 2007), Howlett, MacKay, & Lawson, 2007).

While there is a general commitment to develop the role of FPN, to date, NL has not introduced system-wide reforms to facilitate the integration of FPN into primary care practices. Rather, in NL the introduction of FPN has been highly organic and driven by response to localized need. While the number of FPN remains small, NL provides an ideal setting to conduct pilot research on the influence of funding on FPN work since funding models are straightforward and there have been few reforms to complicate the health policy context (i.e. we can directly connect funding models to FPN roles).

2.1 | Research question

What influence does clinic funding have on FPN roles and activities in primary care settings in NL? This pilot study used semi-structured qualitative interviews with primary care physicians and FPN to describe, compare and contrast the roles of FPN in primary care settings funded by fee-for-service (FFS) and alternate payment plans (APP; i.e. global funding). Understanding this relationship is vital for developing a plan to further integrate FPN across Canada. A broader and more defined understanding of FPN roles in these settings can help achieve optimal contribution of this workforce to patient care. In Canada, provincial public health insurance programs (e.g. Medical Care Plan in NL) cover the costs of all medically necessary care for residents, including primary care services. In NL, physicians are paid either by fee-for-service (a set fee for each service) or by salary (an annual amount) by the provincial health insurance program. Physicians paid by fee-for-service are self-employed and manage their own practices. Salaried physicians are employees of the regional health authority and work in authority-owned practices.

3 | THE STUDY

3.1 | Design

A qualitative descriptive design was employed. This pilot study used semi-structured qualitative interviews with primary care physicians and FPN to describe, compare and contrast the roles of FPN in primary care settings funded by fee-for-service (FFS) and alternate payment plans (APP; i.e. global funding).

3.2 | Methods

To be included in the study, participants had to be physicians or RNs working in a FFS or APP primary care setting in NL. We excluded Licensed Practical Nurses, Nurse Practitioners and RNs working alongside specialist physicians.

Since there is no database or registry of primary care practices that include both family physicians and FPN, we used several sampling strategies to reach the target population (Berg, 1995; Creswell, 2014). First, study authors and individuals in their professional networks identified the names/contacts of any known family physicians who worked with FPN in a primary care setting. The NL Medical Association (NLMA) sent three emails to its members, requesting physicians and nurses to self-identify to a research assistant. In addition, the College of Registered Nurses of NL (CRNNL) provided contact information for RNs who, at annual registration, consented to have this information shared for research purposes and indicated primary care as their place of employment. Lastly, we asked participants to identify and invite other family physicians and FPN to the study.

A research assistant sent study invitations to a total of 12 physicians (9 were identified through professional networks and invited directly; 3 responded to the email invitation from the NLMA) and 26 nurses (10 were identified through professional networks; 16 were identified through the CRNNL). The invitations described the study and asked willing participants to contact the research assistant to arrange a time for an interview and provide written consent. The original target sample for the study was 20 participants, however, the pool of eligible participants was smaller than initially expected and, given that this population has not been heavily studied in NL, it was difficult to ascertain the number of potential participants prior to screening. Recruitment continued until we exhausted the pool of eligible participants (i.e. we sent invitations until we could not identify any additional FPN, physician who worked with FPN, or practice where a FPN was known to work). Compensation was available to physicians ($100/hour) through the Family Practice Renewal Program (FPRP), an initiative tasked with primary healthcare system transformation in NL led by the provincial medical association.

Research assistants conducted semi-structured telephone interviews between March - July 2018 using an interview guide from Oelke, Wilhelm, Jackson, Suter, and Carter (2012), with input from the study team and the FPRP, CRNNL and Government of NL, and tailored to the NL context. Separate interview guides were developed for FPN and for family physicians. FPN were asked about their experience working in primary care practices (e.g. length of time in position, any training/education received prior to beginning position), current roles/activities in the practice and barriers/facilitators to maximizing their scope of practice in this setting. Family

physicians were asked about their experience working with FPN, funding models used to support FPN and barriers/facilitators to optimal use of the FPN role in their practice. Each participant was interviewed seperately. Throughout the interview, research assistants confirmed descriptions of experiences of participants to ensure that responses were being accurately captured and understood (member checking) (Berg, 1995; Creswell, 2004).

3.3 | Analysis

Interviews were recorded and transcribed verbatim. Using content analysis, we identified reoccurring patterns/themes in the data. Every member of the research team (a nursing researcher, applied health services researcher, graduate student, and research assistants) independently reviewed two interview transcripts (one physician and one FPN) to identifying themes and sub-categories. We then met as a team to review the transcripts line by line, discussing codes, definitions and resolving disagreements until we reached consensus. The research assistant applied the template to additional interviews and identified additional themes, which were reviewed and agreed upon by the research team. A final coding template was applied to all the transcripts (Berg, 1995; Creswell, 2004). NVIVO software was used to assist in the organization and management of qualitative data.

We used the constant comparative method to enhance the credibility and trustworthiness of the analysis (Strudsholm, Meadows, Robinson, Thurston, & Henderson, 2016), by comparing and contrasting themes and quotations from FFS and APP clinic transcripts. Through the development of the coding template, we moved from more descriptive to more analytic codes, developing broader conceptual themes that capture variations in experiences. An audit trail (transcripts and audiotapes, drafts of the coding template, coding disagreements and their resolutions) documented the analysis. We also use thick description and present illustrative quotes to support each identified theme (Berg, 1995; Creswell, 2014; Glaser & Strauss, 1967; Guest & MacQueen, 2012; Rowan & Huston, 1997).

3.4 | Ethics

This study was approved by the NL Health Research Ethics Board and the four regional health authorities in NL. Given the small number of physicians and FPN in the study, we have taken several measures to protect confidentiality and limit the likelihood that individuals are identified. We have assigned each participant with a unique study ID number and edited quotations (as noted by square brackets) to obscure identifying information without changing the meaning of the quotation. We have also limited demographic description of study participants.

4 | RESULTS

The interviews consisted of family physician-FPN teams who worked together in the same primary care practice and one lone FPN whose physician counterpart did not participate in the study. Three family physicians and five FPN, who together had an average of 22 years experience in healthcare, participated in interviews that lasted 19–36 minutes (average 31 minutes). Four of the participants were employed in a FFS-funded setting (2 physicians; 2 FPNs), whereas the remaining 4 were employed in an APP-based setting (1 physician; 3 FPNs). Two participants were male, and six were female. All but one participant worked full-time.

Participants in the study worked in clinics that were either funded through FFS or an APP (specifically a global clinic budget with clinicians remunerated through salary). Clinic funding played an instrumental role in the origins of the FPN position, team functioning and the focus of FPN roles (Table 1).

4.1 | Origins of the FPN positions

Fee-for-service and APP clinics had very different reasons for bringing FPN into the practice. In FFS clinics, the decision was made by the physician to improve access to care and ensure sufficient time

TABLE 1 Relationship between clinic funding and FPN roles in NL

	Fee-for-service	Alternate payment plans
Origins of the FPN positions	To improve wait times, health promotion, patient education	Co-location as a means of interdisciplinary collaboration
Focus of FPN care	Maternity care, women's health, chronic disease care, one-on-one patient education	Post-acute care home care, group-based teaching, public health, mental health
Locations of nursing practice	In clinic, home visits	Homes, schools, community, clinic
FPN training/education	Acute care nursing	Community and public health nursing
Nature of team-based care	Coordinated scheduling, care provided in tandem	Independent clinics, ad hoc collaborations
Communication	Patient-related case meetings, charts	Clinic meetings, case management, hallway consultations
Determining nursing roles	Standing orders, medical directives	Scope of practice, organizational policy

to deliver health promotion and education. For example, in a FFS practice, a physician noted that a shortage of physicians in the local community led to lengthy delays in seeing patients for routine appointments: "My practice is two and a half times the size of what it should be… I was behind an hour in the clinic and the waiting room was full and at the time the patients were waiting a month for an appointment and 3 months … for an annual check-up…" (ID 03). The physician was unable to provide health promotion and educate patients with the existing workload:

> *…I had a young girl in front of me who wanted the birth control pill, then the phone rang saying that I got to go right away … and I just wanted to grab [the patient] … and say, "I have some really important things to tell you, I gotta talk really fast so you're going to have to listen." That kind of crystalized it to me…*
>
> *(ID 03)*

Other participants from FFS settings cited similar experiences in relation to the need for an FPN to assist with the demanding workload. In contrast, an APP physician noted that the FPN was part of the vision when the clinic was created. The proposed model embraced the idea of "co-location" as a means of enhanced inter-professional collaborations:

> *Well, I think that the most important initial strategy was housing us together … and that's unusual, you don't find that … Usually the health, community and public health nurses are in their own corners, you know, different places in the city… they actually have their offices in our clinic along with [other health professionals] … that's the main driver, that's one of the main drivers for collaboration is that we have proximity…*
>
> *(ID 04)*

4.2 | Focus of FPN care

In FFS clinics, FPN cared for specific groups in the larger clinic population. A FFS physician described the process of determining where the FPN would fit into the physician's practice: "I had a look at my practice [to see] what areas do I need help in? …And so in my practice, it was diabetes, it was well-woman care, it was pre-natal care, it was well-baby care." (ID 03). Consequently, FPN in FFS clinics were focussed on the needs of this population:

> *Typically the patients range from chronic disease management to prenatal visits, to pap smears, hypertension management. It's pretty well everything across the life span that would encompass any preventative measures and any chronic disease.*
>
> *(ID 02)*

In APP clinics, FPN cared for vulnerable populations, often in practices that focussed on the needs of its surrounding community: "… we work with very vulnerable populations and it's just knowing your clients … a lot of clients now are dealing with mental health and addictions… in a low socioeconomic population…" (ID 05). A nurse who worked in an educational setting described the needs of her patient population:

> *…it can be hygiene issues, like bed bugs, scabies, disease outbreak in residence, that sort of thing, or mental health… I'll help them with their communicable disease guidelines, so all those students, when they go to do practicums … they need their immunizations updated…*
>
> *(ID 08)*

4.3 | Location of nursing practice

In FFS clinics, given that physicians had to see patients to bill for care, the FPN worked alongside physicians in either the medical clinic or patients' homes during home visits. In contrast, APP nurses worked in the community, independently and often with groups or one-on-one with individual patients: "…a lot of her work will be outside our clinic like the breastfeeding classes are down on [street name] and the prenatal classes are not on site…" (ID 04). Concurred an APP nurse: "I try at least once a week to get into the schools… I try to do some extra community work as well besides the work here at the clinic…. I would say, I'm probably like 60% here [in the clinic], 40% out…" (ID 05). Another APP nurse described the types of care she provided in the community, often in home visits:

> *…it's post-op care following surgeries, it could be someone having chemo in the community, it could be someone requiring home IV therapy. Palliative care has been a big part … It could be also diabetic teaching, including diet compliance, teaching them how to do glucometer checks and self-administering insulin. We would also teach people about changing colostomies … suture and staple removal. Wound care … a lot of diabetic ulcers, venous ulcers, peripheral vascular disease ulcers.*
>
> *(ID 06)*

4.4 | FPN training/education

The nature of the FPN's training differed. While nurses with many years of acute care experience were recruited for FFS clinics ("… it's really important to have some acute care setting years behind you before you step out into this environment." [ID 02]), APP clinics looked for nurses with public health or community health training ("I'm also certified in community health…" [ID 05]).

4.5 | Nature of team-based care

The regulations around FFS remunerations dictate the way that patient visits are scheduled. A physician in a FFS practice said:

> *…for me to bill for anything [the FPN] does, I have to see the patient as well… And so for me to bill for what she's seeing, because I'm a fee-for-service physician, I have to do that…. otherwise I would not be able to generate her salary, right? …we can't have her here seeing patients alone.*
>
> *(ID 03)*

As a result, the physician and FPN work in tandem. A FFS physician described a typical visit:

> *…the nurse goes in first, they open up, start a file in the EMR and ask [patients] what they're here for today. [The nurses] do the vital signs, they look at their medication list, … make sure that their medication list is up to date … so that when I go in, I'm going to be renewing medications and those medication checks have already been done….*
>
> *(ID 01)*

In contrast, APP clinic FPN scheduled patients independently and often saw patients on their own ("I run my own clinic with booked appointments for most of the day, every day." (ID 08)), bringing in a physician only when they were needed:

> *If I have a baby that I'm assessing in clinic, I might notice thrush or the need of further assessment for the physician … if the doctors are available I can just call them in and have a quick assess of my own assessment and vice versa. If they have questions for me … they can come and kind of grab me and we can kind of collaborate together with the client.*
>
> *(ID 05)*

4.6 | Communication

Staff in FFS clinics relied on charting to communicate with each other and coordinate what care each professional would provide to the patient. For example, a FPN in a FFS practice said: "We do a lot of communicating through the patient charts, like what [the patients] need done. Like if I come in, I know by looking at their care plan what the goals are for their visit." (ID 07). In contrast, APP clinic staff relied on hallway conversations and collegial consultations. Unlike in FFS practices where charts were shared, nurses in APP clinics maintained their own set of charts for their patients: "…they [the FPN] are not linked in our electronic medical record- the nurses have their own." (ID 04). In both FFS and APP clinics, case management meetings were held to discuss patients. In APP clinics, these meetings would involve a variety of health professionals ("…we have a case conference that, it's all the, all the professionals in the clinic so it's, you know, myself, the physicians, the counselors, psychology, all those." [ID 08]), while in the FFS clinics, the meetings only involved the physician and the FPN.

4.7 | Determining nursing roles

In FFS clinics, nursing roles and activities are supported by standing orders or medical directives: "…there are medical directives here, which we use a lot for everything." (ID 07). The FFS physician described preparing for the FPN:

> *I started writing some stuff down to give to the nurse…, "This is the counseling I do when I start a patient on the birth control pill, this is the counseling I do when I diagnose a patient with hypertension, this is the counselling I do when I diagnose a patient with diabetes, this is the counseling for hyperlipidemia," and so on.*
>
> *(ID 03)*

In APP clinics, the FPN role was determined by existing policies: "…within [regional health authority] policies … I have my own scope [defined by the ARNNL]. I don't go beyond that scope and… everybody knows what their role is in regards to patient care … there's kind of an understanding without saying it." (ID 05). There was no direct involvement from the other clinicians in determining the FPN role: "There was never any formal process…. There's no written guidelines as to what I do and [physicians] do." (ID 06).

5 | DISCUSSION

RNs form the core of interdisciplinary primary care teams (Canadian Nurses Association, 2013, 2014; Lukewich et al., 2018). However, there is still a critical need to generate evidence on this role in primary care to support policy-makers and health administrators in decisions related to investing in this profession (The Lancet, 2019). This pilot study shows that clinic funding has an impact on the integration of FPN into primary care settings in NL; FPN scope of practice is more restricted in FFS practices. In both APP and FFS settings, FPN work as generalists providing a broad range of services. In FFS practices, FPN work in tandem with physicians and focus on one-on-one patient care in primarily office-based settings. In APP practices, FPN work more independently, in both office and community-based settings, with a balanced emphasis on individual and group-based encounters. APP FPN roles are predominantly determined by nursing scope of practice and patient needs in the community, while FFS FPN roles are more restricted due to physician billing requirements and physicians' established need for the FPN role in the first place. Like other studies, our findings highlight how models of primary care enable nurses to contribute their unique skills and expertise

towards patient care delivery (Association of Registered Nurses of Newfoundland & Labrador, 2018; Berkowitz, 2016; Smolowitz et al., 2015).

Family practice nursing falls under the umbrella of "community health nursing," which also includes home care and public health nursing (Canadian Family Practice Nurses Association, 2017; Canadian Nurses Association, 2011; Oandasan et al., 2010). In APP clinics, there was substantial overlap between the role of the FPN and traditional public health and home care nurses. Although the role of FPN is likely to vary from practice to practice, there is a lack of clearly defined role expectations and understanding of the optimal role of FPN. To address this, an expert team developed a national set of family practice nursing competencies (Lukewich et al., 2019). These competencies clarify the FPN role and how it differs from other community health nursing disciplines, support team functioning, maximize FPN scope of practice and provide a framework to evaluate the effectiveness of family practice nursing in Canada's broader healthcare workforce (Lukewich et al., 2019).

The funding of primary healthcare teams is a vital, but largely understudied issue (Wranik & Haydt, 2018; Wranik et al., 2017). While previous studies recognize that team funding and the degree to which non-physician workforce remuneration is derived from physician activity influence team functioning, ours is among the first to describe how funding has a direct impact on the contributions of FPN. The study highlights how FFS funding restricts the scope of practice of FPN nurses. Within the primary care setting as a whole, there is often a lack of clarity regarding FPN role expectations, which could lead to poorly integrated care and underutilization of nursing skills and abilities (Canadian Nurses Association, 2014). Similar findings from a pediatric setting has determined that practice environment plays a role in nursing scope of practice, and that increasing scope of practice leads to greater levels of job satisfaction (Déry, Clarke, D'Amour, & Blais, 2018). Expanding the physician-led model within FFS practices in primary care can lead to improvements in nursing role satisfaction, as well as patient and system-level outcomes. By highlighting seven areas influenced by funding, our findings lay the groundwork for further research on the influence of funding models on FPN responsibilities in provinces where the integration of FPN is more advanced. Understanding how funding models have an impact on the RN role in this setting will aid health administrators and policy decision-makers in developing improved health policies and planning and implementing nursing resources to maximize workforce contributions.

5.1 | Limitations

This is the first known Canadian study to examine the relationship between primary care funding models and the roles of RNs in the team. While we exhausted the pool of eligible participants in the province of NL, we may not have reached saturation in our pilot study. The study findings, based on funding models in NL, may not be transferable to other provinces. Larger, cross-jurisdictional studies in provinces with well-established primary care teams should examine whether these findings are attenuated.

6 | CONCLUSION

The contributions and impact of FPN in NL are heavily influenced by the funding arrangements of the settings where these nurses work. Knowledge of how factors influence nursing contributions can assist in the development of evidence-based recommendations and health policy decisions, especially in jurisdictions with scarce primary care-based nursing resources, such as NL. Understanding the relationship between funding and how FPN function in a team and contribute to patient care will inform the future integration and optimization of FPN across Canada.

CONFLICT OF INTEREST

None to declare.

AUTHOR CONTRIBUTIONS

MM led the conception and design of the study, wrote the final draft of the manuscript and supervised data interpretation and analysis; JL led the conception and design of the study, assisted with the writing and editing of the manuscript, and assisted with interpretation of data and analysis; DR transcribed the interviews, interpreted and coded the data for analysis, and assisted with manuscript writing; RB conducted the interviews and assisted with interpretation of data; and SP conducted the interviews and assisted with interpretation of data. All authors read and approved the final manuscript.

ETHICAL APPROVAL

This study was approved by the NL Health Research Ethics Board (#20181421) and the four regional health authorities in NL.

PATIENT CONSENT

All participants reviewed the approved consent form prior to the interview and consented to participate in the study.

ORCID

Dana Ryan https://orcid.org/0000-0001-7949-8849

REFERENCES

Association of Registered Nurses of Newfoundland and Labrador (2018). *Comprehensive evaluation of the Nurse Practitioner role in Newfoundland & Labrador*. Retrieved from https://www.arnnl.ca/sites/default/files/documents/DD_ComprehensiveEvaluationOfTheNursePractitionerRoleInNL.pdf

Berg, B. (1995). *Qualitative research methods for the social sciences* (2nd ed.). Boston, MA: Allyn and Bacon.

Berkowitz, B. (2016). Registered Nurses in primary care: A value proposition. *Nursing Outlook*, *64*(6), 525–526.

Canadian Family Practice Nurses Association (2017). *Canadian Family Practice Nurses Association – CFPNA*. Retrieved from https://www.cfpna.ca/

Canadian Nurses Association (2011). *CNA's primary care toolkit: Role descriptions for RNs in primary care*. Retrieved from https://www.cna-aiic.ca/en/nursing-practice/tools-for-practice/primary-care-toolkit/role-description

Canadian Nurses Association (2013). *Registered nurses: Stepping up to transform healthcare*. Retrieved from https://www.cna-aiic.ca/~/media/cna/files/en/registered_nurses_stepping_up_to_transform_health_care_e.pdf

Canadian Nurses Association (2014). *Optimizing the role of nurses in primary care in Canada- Final report*. Retrieved from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/optimizing-the-role-of-nurses-in-primary-care-in-canada.pdf?la=en

Creswell, J. (2014). *Research design – Qualitative, quantitative and mixed methods approaches*. Los Angeles, CA: SAGE.

Déry, J., Clarke, S. P., D'Amour, D., & Blais, R. (2018). Scope of nursing practice in a tertiary pediatric setting: Associations with nurse and job characteristics and job satisfaction. *Journal of Nursing Scholarship*, *50*(1), 56–64.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York, NY: Aldine.

Glazier, R. H., Zagorski, B. M., & Ryaner, J. (2012). Comparison of primary care models in Ontario by demographics, case mix and emergency department use, 2008/09 to 2009/10. In: *ICES Investigative Report*. Institute for Clinical Evaluative Sciences. Retrieved from https://www.ices.on.ca/Publications/Atlases-and-Reports/2012/Comparison-of-Primary-Care-Models

Guest, G., & MacQueen, K. M. (2012). *Applied thematic analysis*. Los Angeles, CA: SAGE.

Halcomb, E., Stephens, M., Bryce, J., Foley, E., & Ashley, C. (2016). Nursing competency standards in primary health care: An integrative review. *Journal of Clinical Nursing*, *25*(9–10), 1193–1205.

Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *BMJ*, *324* (7341), 819–823.

Hutchison, B., Levesque, J. F., Strumpf, E., & Coyle, N. (2011). Primary health care in Canada: Systems in motion. *Milbank Quarterly*, *89*(2), 256–288.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2005). Substitution of doctors by nurses in primary care (Review). *The Cochrane Database of Systematic Reviews*, *18*(2), CD001271.

Lukewich, J., Allard, M., Ashley, L., Aubrey-Bassler, K., & Bryant-Lukosius, D., Klassen, T., Wong, S. (2019). *National competencies for registered nurses in primary care*. Report prepared for the Canadian Family Practice Nurses Association (CFPNA). Retrieved from https://www.cfpna.ca/national-core-competencies

Lukewich, J., Williamson, T., Edge, D., VanDenKerkhof, E., & Tranmer, J. (2018). Team composition and chronic disease management within primary healthcare practices in Eastern Ontario: An application of the measuring organizational attributes of primary health care survey. *Primary Health Care Research and Development*, *19*(6), 622–628.

Norful, A., Martsolf, G., de Jacq, K., & Poghosyan, L. (2017). Utilization of Registered Nurses in primary care teams: A systematic review. *International Journal of Nursing Studies*, *26*, 15–23.

Nova Scotia Health Authority (2017). *Community health team communities*. Retrieved from http://www.nshealth.ca/content/community-health-teams

Oandasan, I. F., Hammond, M., Conn, L. G., Callahan, S., Gallinaro, A., & Moaveni, A. (2010). Family practice Registered Nurses: The time has come. *Canadian Family Physician*, *56*(10), e375–e382.

Oelke, N. D., Wilhelm, A., Jackson, K., Suter, E., & Carter, R. (2012). *Optimizing collaborative practice of nurses in primary care settings*. Alberta Health Services, Health Systems and Workforce Research Unit. Retrieved from http://docplayer.net/4872937-Optimizing-collaborative-practice-of-nurses-in-primary-care-settings-nelly-d-oelke-amanda-wilhelm-karen-jackson-esther-suter-rebecca-carter.html

Rowan, M., & Huston, P. (1997). Qualitative research articles: Information for authors and peer reviewers. *Canadian Medical Association Journal*, *157*(10), 1442–1446.

Smolowitz, J., Speakman, E., Wojnar, D., Whelan, E., Ulrich, S., Hayes, C., & Wood, L. (2015). Role of the Registered Nurse in primary health care: Meeting health care needs in 21st century. *Nursing Outlook*, *63*(2), 130–136.

Strudsholm, T., Meadows, L. M., Robinson, A. V., Thurston, W. E., & Henderson, R. (2016). Using mixed methods to facilitate complex, multiphased health research. *Internatiional Journal of Qualitative Methods*, *15*, 1–11.

The Lancet (2019). 2020: Unleashing the full potential of nursing. *Lancet*, *394*(10212), 1879. https://doi.org/10.1016/S0140-6736(19)32794-1

Todd, C., Howlett, M., MacKay, M., & Lawson, B. (2007). Family practice/primary health care nurses in Nova Scotia. *Canadian Nurse*, *103*(6), 23–27.

Wranik, W. D., & Haydt, S. M. (2018). Funding models and medical dominance in interdisciplinary primary care teams: Qualitative evidence from three Canadian provinces. *Human Resources for Health*, *16*(38), 1–9.

Wranik, W. D., Haydt, S. M., Katz, A., Levy, A. R., Korchanga, M., Edwards, J. M., & Bower, I. (2017). Funding and remuneration of interdisciplinary primary care teams in Canada: A conceptual framework. *BMC Health Services Research*, *17*(351), 1–12.

How to cite this article: Mathews M, Ryan D, Buote R, Parsons S, Lukewich J. A qualitative study exploring the influence of clinic funding on the integration of family practice nurses in Newfoundland and Labrador. *Nursing Open*. 2020;7:1067–1073. https://doi.org/10.1002/nop2.477