RNAO

Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Coming Together, Moving Forward: **Building the Next Chapter of**

ONTARIO's RURAL, REMOTE & NORTHERN NURSING WORKFORCE REPORT

TASK FORCE MEMBERSHIP

David McNeil (co-chair)	Health Sciences North
Louise Paquette (co-chair)	North East Local Health Integration Network
Doreen Armstrong-Ross/Darlene Furlong	Dryden Regional Health Centre
Connee Badiuk	Association of Ontario Health Centres - AHAC
Candace Chartier	Ontario Long-Term Care Association
Bernice Downey	Aboriginal Nurses Association of Canada
Darryl Galusha	Ontario Association of Non-Profit Homes and Services for Seniors
Claire Goldie	Health Canada – First Nations and Inuit Health Branch Ontario Region
David Groulx	ANDSOOHA - Public Health Nursing Management/ Ontario Public Health Chief Nursing Officers
Bonny Johnson	Association of Ontario Health Centres - CHC
Charlotte Koso	Ontario Home Care Association
Johanne Labonte	HealthForceOntario Marketing and Recruitment Agency
Pam Mancuso	Ontario Nurses' Association
Dianne Martin /Annette Weeres	Registered Practical Nurses Association of Ontario
Jennifer Michaud	North East Local Health Integration Network
Susan Pilatzke	North West Local Health Integration Network
Karen Poole	Council of Ontario University Programs in Nursing
Julia Scott	Ontario Hospital Association
Michelle Marie Spadoni	Lakehead University
Provincial Chief Nursing Officer (ex-officio)	Ministry of Health and Long-Term Care
Doris Grinspun (ex-officio)	Registered Nurses' Association of Ontario
Heather Woodbeck (ex-officio)	Registered Nurses' Association of Ontario

Staff lead: Tim Lenartowych, Director of Nursing and Health Policy – Registered Nurses' Association of Ontario (tlenartowych@RNAO.ca)

Editor: Marion Zych – RNAO
Designer: Olga Gabrieleva – RNAO

Coming Together, Moving Forward: **Building the Next Chapter of**

ONTARIO'S RURAL, REMOTE & NORTHERN NURSING WORKFORCE REPORT

TABLE OF CONTENTS

Dear Reader:

As fellow northerners and co-chairs of the Registered Nurses' Association of Ontario's (RNAO) Rural, Remote and Northern Area Nursing Task Force, we are pleased to deliver this report titled: *Coming Together, Moving Forward: Building the Next Chapter of Ontario's Rural, Remote and Northern Nursing Workforce.*

The selection of this title was deliberate. We chose 'coming together' to signify the importance of community within rural, remote and northern areas. This report is grounded within the importance of context and the solutions needed to sustain the nursing workforce are dependent upon partnership with: each other, government, and associations. We chose 'moving forward' as a reflection of the resilience of rural, remote and northern communities and the nursing workforce in these areas. While it is easy to dwell on deficiencies and what is not working, we have prepared this report to build on successes and focus on solutions. Lastly, 'building the next chapter' speaks to the important role rural, remote and northern communities have played in the development of the province of Ontario and Canada as a whole. The next chapter for Ontario's rural, remote and northern nursing workforce can be vibrant with the implementation of the proposed recommendations in this report. In doing so, Ontario would be well positioned to become a world leader in responding to the health human resource challenges experienced in rural, remote and northern regions.

We would like to thank RNAO for this opportunity and extend our sincere gratitude to each member of the task force and countless people who participated in consultation activities. This report is dedicated to nurses who represent their profession with leadership, professionalism and dedication as they serve the people living in rural, remote and northern communities.

Respectfully yours,

David McNeil, BScN, MHA, CHE, PhD(c)

Past President of RNAO
Vice President Clinical Programs and
Chief Nursing Officer
Health Sciences North

Louise Paquette, BScL

Chief Executive Officer
North East Local Health
Integration Network

Executive Summary

With a population of 13 million people, the province of Ontario covers a significant geographic distribution of 917,741 square kilometres (Statistics Canada, 2005). Fourteen per cent of the population is categorized as living in a rural, remote or northern area (Statistics Canada, 2011). Within this land mass is a rich diversity of people, systems and institutions that are privileged to call it home - including Francophone persons and First Nations, Inuit and Métis people. There are unique challenges that exist within these communities that affect access to health services: geographic distance, socioeconomic status, availability of health human resources and infrastructure. These factors have an impact on health status, wellness and the ability to offer person-centred health care.

Registered nurses (RN), nurse practitioners (NP) and registered practical nurses (RPN) are important care providers in rural, remote and northern settings. Their roles span the continuum of care and can be found in all areas of the health system. Nursing practice in rural, remote and northern settings is unique in that these nurses are often generalists, with a high degree of competency in a number of clinical domains and specialties (Montour et al, 2008; Baumann et al, 2006). Despite their importance, the retention and recruitment of nurses in these regions is a constant challenge (Pitblado et al, 2013; Hunsberger et al, 2009; Montour et al, 2008; Baumann et al, 2006). A sustainable nursing workforce is needed to promote access to care, better outcomes for people and health system cost-effectiveness. For this to be realized, we need a collective approach by government, health planners/funders, associations, communities, employers and other interest groups. Response to an issue of such significance requires careful consideration of the context and culture of rural, remote and northern communities.

Responding to this need, RNAO engaged a number of stakeholders representative of nursing in rural, remote and northern communities to form a provincial task force. Co-chaired by David McNeil, past-president of RNAO and Vice President of Clinical Programs & Chief Nurse Executive at Health Sciences North and Louise Paquette, Chief Executive Officer of the North East Local Health Integration Network, the mandate of the task force was:

To ensure a stable and sustainable nursing workforce exists in rural, remote and northern areas of Ontario by bringing together policy-makers, professional and labour associations, administrators, researchers, educators and other stakeholders.

The task force reported to the Chief Executive Officer of RNAO and was presented with two objectives:

1. Identify the enablers and barriers impacting the retention and recruitment of RNs, NPs and RPNs in Ontario's rural, remote and northern areas.
2. Propose short, medium and long-term strategies to ensure the retention and recruitment of RNs, NPs and RPNs in Ontario's rural, remote and northern areas.

The task force was launched in April 2014 and developed a work plan that consisted of:

- Scoping review of the literature;
- Reviewing nursing human resource data;
- Environmental scan of current and emerging initiatives;
- Key informant interviews;
- Expert deliberations;
- Consultations and engagement with the field;
- Final report with findings and recommendations.

Through its detailed analysis, the task force identified the following barriers and enablers of retention and recruitment in rural, remote and northern communities. Each of these factors, depending upon the context, availability and/or action, can be seen as an enabler or barrier.

- Targeted government intervention and support;
- Access to nursing as a career;
- RN, RPN and NP nursing education programs;
- Student placement opportunities;
- Continuing education and professional development;
- Culturally and contextually appropriate educational content;
- Orientation to rural, remote and northern practice;
- Language proficiency;
- Full and expanded nursing roles;
- Workload;
- Work environments;
- Employment status;
- Compensation;
- Nursing leadership;
- Marketing employment opportunities;
- Community integration;
- Spousal employment;
- Technology-enabled service delivery, consultation and education;
- Partnerships;
- Research and evidence;
- Engagement in decision-making;
- Funding models; and
- Infrastructure.

Crystal Culp is an RN who works at the nursing station in Mishkeegogamang, north of Sioux Lookout.
PHOTO: Brent Wesley

Jackie Kilgour is an RN in Markdale Hospital's medical/surgical unit.
PHOTO: Tracy Rovers

Recommendations

The recommendations being advanced to improve the retention and recruitment of nurses in rural, remote and northern communities include:

Recommendation #1: Expand and create programs that enable residents of rural, remote and northern communities to access practical nursing, baccalaureate and graduate nursing education locally across the province.

Recommendation #2: Provide sustainable funding for current initiatives that prepare and support First Nations, Inuit and Métis persons to pursue nursing education programs, preferably locally, and expand these programs across the province.

Recommendation #3: Ensure that all entry-level nursing education programs in Ontario incorporate the socio-cultural context of First Nations, Inuit and Métis people in the curriculum.

Recommendation #4: Expand and create new initiatives that prepare and support Francophone persons to pursue nursing education, preferably locally.

Recommendation #5: Develop regional networks that co-ordinate opportunities for rural, remote and northern student placements and establish community partnerships to support travel and accommodation.

Recommendation #6: Continue to highlight in all marketing the unique and rich opportunities that exist within rural, remote and northern communities, while also openly communicating the realities that are experienced in these communities.

Recommendation #7: Invest and support strategies that will enable achievement of 70 per cent full-time employment for all nurses.

Recommendation #8: Fund a rural nursing orientation program to provide any nurse who is newly hired, or returning, to rural, remote and/or northern practice with an opportunity for an extended supernumerary orientation that includes accessing prerequisite certifications, if needed.

Recommendation #9: Leverage capacity to relieve short-term staffing gaps in rural areas through organizational partnerships that facilitate longer-term secondments in place of agency utilization and/or overtime.

Recommendation #10: Collaborate with rural, remote and northern nurses to create dedicated continuing education programs that recognize the unique nature of rural nursing practice.

Recommendation #11: Maintain current government interventions that promote the retention and recruitment of nurses in rural, remote and northern communities and expand them to all health-care settings, minimizing eligibility restrictions and optimizing their administration.

Recommendation #12: Establish a rural nursing education initiative to augment the Nursing Education Initiative to provide reimbursement for tuition and transportation/accommodation costs associated with pursuing education.

Recommendation #13: Enable collaboration between health organizations with capacity to deliver specialty care and rural, remote and northern organizations, to support ongoing education and competency development.

Recommendation #14: Expand access to, and utilization of, the Ontario Telemedicine Network (OTN) and leverage other forms of virtual connectivity to deliver education and consultation in rural, remote and northern areas, augmented with in-person opportunities.

Recommendation #15: Ensure effective standards exist to guide the appropriate use of technology in service delivery models and develop new standards, where needed.

Recommendation #16: Address compensation and benefit inequities for RNs, NPs and RPNs that exist between the community (including primary care) and hospital sectors and ensure that compensation reflects the realities of rural living.

Recommendation #17: Develop a framework, including practice standards and education pathways that support the expanded utilization role of nurses in rural, remote and northern settings, including RN prescribing.

Recommendation #18: Identify ways to develop and support the capacity of rural, remote and northern nurse administrators to effectively respond to clinical and human resource complexities.

Recommendation #19: Bridge research gaps by funding studies that focus on rural, remote and northern nursing practice and issues/interventions affecting recruitment and retention in these areas.

Recommendation #20: Consider the context of rural, remote and northern health-care delivery through meaningful engagement of relevant stakeholders and conducting an impact analysis, when developing new provincial initiatives.

Recommendation #21: Enable local health human resource planning that is inclusive of all sectors, engages the local voice and is informed by evidence and appropriate data.

Recommendation #22: Support evidence-informed funding models that consider population health needs and local context to enable person-centred care.

Recommendation #23: Invest in ongoing infrastructure renewal and growth in rural and remote communities (i.e. telecommunications, hydro, transportation, housing, etc).

Recommendations

Introduction

Ontario is a province that covers a significant geographic distribution of 917,741 square kilometres (Statistics Canada, 2005). Within this land mass is a rich diversity of people, systems and institutions that are privileged to call it home. Ontario has a long and prosperous history, much of which was shaped by First Nations, Inuit and Métis people (Government of Ontario, 2015). Rural, remote and northern communities dominate the physical landscape of Ontario and have played an important role in the postcolonial development of this province through agriculture, natural resources, business and building key transportation networks. Throughout history, people in these regions have dealt with the realities of varying degrees of isolation and have developed an unparalleled sense of self-sufficiency and resilience. Ontario is currently home to nearly 13 million residents and 14 per cent of the population is categorized as living in a rural area (Statistics Canada, 2011). There are unique challenges and opportunities that exist in rural, remote and northern communities. Much of the evolution of health-care systems in these regions has been driven by: "distance between locations, a challenging wilderness geography, limited access to various methods of transportation, harsh weather, and population shifts tied to boom and bust economies" (North East Local Health Integration Network, 2014). Today, rural, remote and northern communities, not unlike other areas of the province, are responding to an increasing prevalence of chronic disease and shifting demographics. The Ministry of Health and Long-Term Care (2011) indicates that life expectancy at birth is lower, all-cause mortality rates increase as remoteness increases and a higher proportion of rural/northern residents report having fair/poor health status. The Ministry further identifies access to quality health care as being a long standing issue in these areas. Browne (2010) reports that access to care in rural and remote settings is influenced by:

- Geographic barriers
- Limited availability of health-care personnel and services
- Impact of health-care reform
- Cultural factors
- Government initiatives

Addressing the health needs of Ontarians in rural, remote and northern communities, and securing the effective delivery of health services demands, at minimum, evidence-informed planning, the availability of appropriate infrastructure, a sustainable health human resource workforce, public engagement, and collective leadership to bring about continuous improvements and optimal health outcomes. Increasingly, care is being delivered by interprofessional teams with a heavy reliance on technology. A sustainable health human resource workforce is critical towards improving access to care and health outcomes. Registered Nurses (RN), Nurse Practitioners (NP) and Registered Practical Nurses (RPN) are vital care providers in rural, remote and northern settings. Their role spans the continuum of care and nurses can be found in all areas of the system. Despite their importance, the recruitment and retention of nurses in rural, remote and northern areas of Ontario is a challenge (Pitblado et al, 2013; Hunsberger et al, 2009; Montour et al, 2008; Baumann et al, 2006). A sustainable nursing workforce is needed to promote access to care, better outcomes for people and health system cost-effectiveness. Although commendable attempts have been made to address the challenges that exist, including government interventions to entice nurses to consider rural practice, efforts have largely been a patchwork approach that has been ineffective towards a broader goal of enabling a sustainable workforce. Baumann and colleagues (2008) have identified that nursing human resource policy interventions have often favoured urban practice areas. This means that rural, remote and northern areas are left struggling to solve staffing challenges that could produce a health human resource crisis if unresolved.

Rewarding opportunities await nurses in rural, remote and northern communities. However, a collective approach is needed to promote the sustainability of the nursing workforce by activating joint efforts of government, health planners/funders, employers, associations, communities, and other interested groups. Response to an issue of such significance requires careful consideration of the context and culture of rural, remote and northern communities. Solutions demand that the voices of all nurses, other health professionals, researchers, educators and community members be heard and thoughtfully considered. The purpose of this report is to present the findings of the Registered Nurses' Association of Ontario's (RNAO) Rural, Remote and Northern Nursing Task Force. The report is a synthesis of the extensive process undertaken. For a full review, the task force's technical details, including records of work undertaken, can be accessed at: www.RNAO.ca/RuralRemote

Nurse practitioner Jennifer Fournier tends to a patient at the Capreol NP-led clinic, outside of Sudbury.
PHOTO: Rob Provencher

Krista Reynolds Miller, RPN, checks on Claudette Beaudry, a resident of Au Chateau long-term care in Sturgeon Falls.
PHOTO: Peter Zwarich

About the Task Force

RNAO is the professional association representing RNs, NPs and nursing students in all roles and sectors in Ontario. The association's mission is to foster knowledge-based nursing practice, promote quality work environments, deliver excellence in professional development, and advance healthy public policy to improve health. RNAO promotes the full participation of present and future RNs, NPs and nursing students in improving health, and shaping and delivering health-care services. It is in its purpose of advancing healthy public policy to best serve Ontarians, that RNAO presents this work with both urgency and hope.

RNAO engaged a number of stakeholders representative of nursing in rural, remote and northern communities to form a provincial task force. An important criterion for participation was experience working in a rural, remote and/or northern area.

The mandate of the task force was:

To ensure a stable and sustainable nursing workforce exists in rural, remote and underserviced areas of Ontario by bringing together policy-makers, professional and labour associations, administrators, researchers, educators and other stakeholders.

The task force reported to the Chief Executive Officer of RNAO and was presented with two objectives:

1. Identify the enablers and barriers impacting the retention and recruitment of RNs, NPs and RPNs in Ontario's rural, remote and northern areas.
2. Propose short, medium and long-term strategies to ensure the retention and recruitment of RNs, NPs and RPNs in Ontario's rural, remote and northern areas.

The task force's mandate included nurses practising in all areas of health and health-care: public health units, primary care, health centres, nursing stations, hospitals, home health-care, support services, corrections, occupational health, mental health, long-term care, rehabilitation and complex continuing care.

The task force commenced in April 2014 and developed a work plan consisting of:

- Scoping review of the literature;
- Nursing human resource data analysis;
- Environmental scan of current and emerging initiatives;
- Key informant interviews;
- Expert deliberations;
- Consultations with the field;
- Drafting a final report with findings and recommendations.

The recommendations within this report were developed by the task force and informed by the processes undertaken. The task force used a draft recommendations framework to consult with the field with the following objectives:

- To determine whether the recommendations were clear
- To assess to what extent the recommendations were grounded in evidence and experience and
- To ascertain whether the recommendations would have an impact towards improving the recruitment and retention of the nursing workforce in rural, remote and northern areas

The consultation process consisted of: a provincial survey with 242 respondents; four in-person consultation sessions/site visits in the northwestern, northeastern, eastern and southern sections of the province; video/tele-conference focus groups; and a webinar.

The task force met eight times with dialogue between meetings.

Buffy Gourley-Sutherland is a nurse practitioner with the Iroquois Falls Family Health Team.
PHOTO: Tammy Desrochers

NP Shannon Cadieux goes through a therapeutic activity with Gert, a resident of Nipissing Manor.
PHOTO: Josh Willard

Defining Rural, Remote and Northern

Attempts to define a rural, remote and northern workforce have been subject to significant debate. This debate has been important because it assists policy-makers in targeting interventions to specific regions, and understanding the unique identity of these regions. Pragmatically, it has created complexities and confusion. The Ministry of Health and Long-Term Care's Rural and Northern Health Care Framework/Plan (2011) offers the following definitions:

"[Rural] communities in Ontario are those with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000."

"Northern Ontario is comprised of 10 territorial districts (145 municipalities): Kenora, Rainy River , Thunder Bay, Cochrane, Algoma, Sudbury, Timiskaming, Nipissing, Manitoulin, and Parry Sound. This area covers over 800,000 square kilometres, representing nearly 90 per cent of Ontario's land area. It extends across two time zones, from the southern boundary of the District of Parry Sound, north to Hudson Bay and James Bay [Coast], and westerly from Quebec to the Manitoba border."

"[Remote] communities are [mostly Aboriginal communities] … without year-round road access, or which rely on a third party (e.g. train, airplane, ferry) for transportation to a larger centre."

Other attempts to define rurality have focused on quantitative measures, including the Rurality Index of Ontario (RIO). The RIO score considers the following: population, population density, travel time to the nearest basic referral centre and travel time to the nearest advanced referral centre (Ontario Medical Association, 2009). This tool is often used by government to determine eligibility criteria for various programs and initiatives (Ministry of Health and Long-Term Care, 2013).

It is not the aim of the task force to further contribute to the complexities associated with defining these regions. Nor, is it the aim of the task force to remedy this confusion. Rather, the task force recognizes the subjectivity that is involved in assigning definitions and that definitions can be limiting when considering the richness of rural, remote and northern regions. Instead, the task force has chosen to focus on attempting to resolve nursing human resource issues that are applicable across rural, remote and northern regions. Often these regions are compared to one another to highlight the differences and distinctions. Context is key and how health human resource issues are experienced will vary depending on the region. For example, the experience of a human resource shortage in a rural southwestern Ontario community located within two hours of a major urban setting will be different from a remote fly-in community. In both instances, the core issue is the same and the solutions may be similar. However, the process of implementing the solutions would be different. The task force has endeavored to provide recommendations that address systemic issues, while recognizing that implementation must consider context and local variation.

Distinctively, rural and northern regions contain a number of communities with smaller population sizes. The Rural Ontario Institute (2013) identifies that there are 393 non-metro census divisions in the province and of these, 52 had fewer than 100 residents and 288 had populations ranging between 1,000-24,999 residents. For example, the Timiskaming region is home to 12 census subdivisions with population sizes between 100-499 (Rural Ontario Institute, 2013). The Kenora region has 20 subdivisons of the same size range and the Hastings region of Eastern Ontario has seven subdivisions with a population under 2,500. These are just a few examples demonstrating the prevalence of smaller communities among the rural, remote and northern landscape.

Rural and northern areas also contain larger communities that are often recognized for their varying degrees of urbanity. While these communities may or may not experience human resource challenges, they maintain vital relationships with more rural and remote settings. These centres are often used as referral hubs and co-ordinate access to care with more isolated communities.

It is well established that health is strongly influenced by a multitude of determinants, including social and environmental factors (World Health Organization, 1978). The challenges associated with residing in a rural, remote and northern community are felt by those who are socially disadvantaged. Population health profiles indicate that there are a higher proportion of people within northern and rural areas who have not completed secondary school when compared with the provincial average (Ministry of Health and Long-Term Care, 2004). There also appears to be a higher dependency ratio in predominantly rural and northern areas (Statistics Canada, 2014a). While unemployment rates generally declined in northern areas between 2009 and 2012, both the North East and North West regions have seen slight growth in unemployment between 2012 and 2013 (Statistics Canada, 2014b). As Industry Canada and FedNor (2010) indicate: "while much progress has been made, Northern Ontario's economy continues to struggle with similar and persistent socio-economic and geographical challenges." Given this context, it may not be surprising that there is a statistically significant proportion of the northern population that considers their health status to be "fair or poor" versus the provincial average (Statistics Canada, 2014c). Therefore, it is imperative for decision makers to understand and recognize the unique socio-economic and geographic context that exists within rural, remote and northern communities.

The task force would like to recognize the uniqueness of remote regions that exist within the northern reaches of the province, given the sheer magnitude of isolation and limited resources that exist, along with the richness of culture and context. While the health human resource limitations that are experienced there may be similar to other rural/northern areas, the implications and magnitude are much more pronounced. Any interventions applied to these regions must carefully consider the culture and context and engage the local voices.

Lastly, it is important to recognize the unique spirit that is present within all rural, remote and northern communities. This spirit is impossible to quantify and is the product of a number of variables, including (but not limited to): the unique historical and cultural experience fostered by Francophone persons, First Nations, Inuit and Métis populations and others; the sense of community and pride; connection to the land and natural resources and the resilience that has been nurtured through centuries of self-sufficiency.

Characteristics of the Rural, Remote and Northern Nursing Workforce

Pitblado, et al (2013) conducted a study of the characteristics of the rural nursing workforce in Canada. Data from 2003-2010 was analyzed from the Canadian Institute for Health Information's Nursing Database. A summary of this study with findings from Ontario was further described by Paterson et al (2014). Their key findings included:

- "In 2010, 7.2% of the regulated nursing workforce in Ontario was located in rural areas of the province where 11.3% of the population lived.
- In urban areas, the nurse-to-population ratio held steady for RNs and increased for RPNs. In rural areas it decreased for RNs, but increased for RPNs.
- The numbers of RNs in rural Ontario achieving baccalaureate degrees increased from 2003 to 2010. The number of rural RNs achieving Master's degrees also increased during this time, however this proportion remained higher in urban than in rural Ontario.
- In 2010, fewer rural than urban RNs worked full-time. Rural RNs held the highest proportion of casual positions.
- Between 2003 and 2010, the number of rural nurses working in primary healthcare settings increased from 17.0% to 22.7%. The greatest increase was in rural NPs (from 61.9% to 86.3%)."

The distribution of the workforce among area of employment is summarized in the figure below:

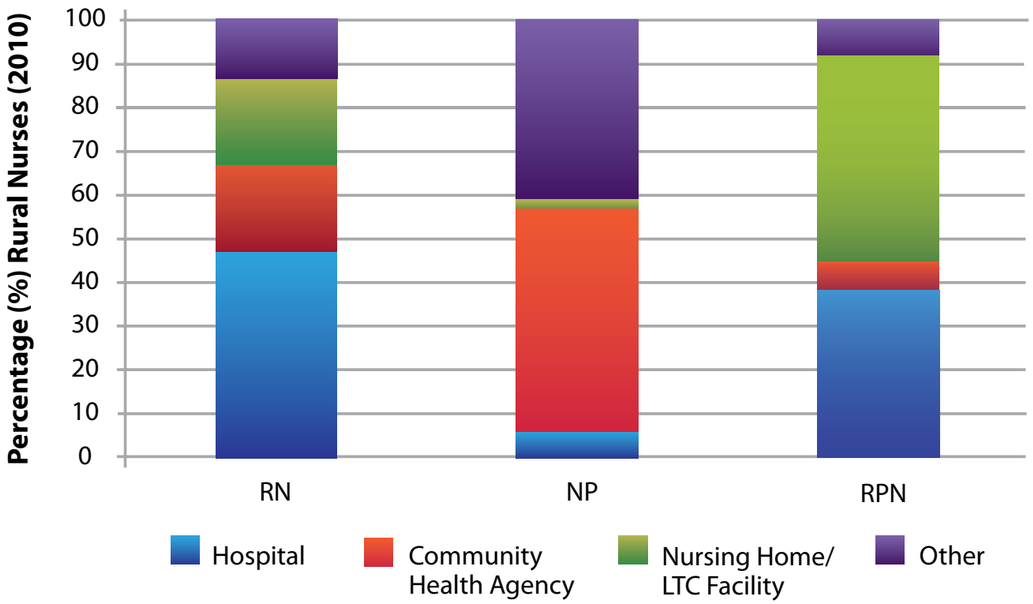


Figure replicated from Paterson et al (2014) *Nursing Practice in Rural and Remote Ontario: An Analysis of CIHI's Nursing Database.* Note that 'Community Health Agency' includes: nursing stations, home care agencies, community health centres and public health units. 'Other' includes: business/industry/ occupational health office, private nursing agency/private duty, self-employed, physician's office/ family practice unit, educational institution, nursing association/government, other.

While it is clear that there are challenges recruiting and retaining nurses in rural, remote and northern communities that often result in vacancies, health human resource planners could benefit from a greater understanding of the supply and distribution of the nursing workforce in parallel to population health needs and service demands. Please see Appendix A for a breakdown of the number of nursing positions and employment status by LHIN.

Nursing care, staffing and scheduling models have a significant impact on patient/client/population outcomes (RNAO, 2007a). It is important for employers in rural, remote and northern areas to match evidence and patient/client/population needs with the competencies and role of the appropriate provider (RNAO, 2007a; RNAO, 2010). Continuity of care and caregiver are central to achieving the best possible outcomes for people. Full-time employment enables continuity of care and caregiver, which has been found to significantly improve quality of care (RNAO, 2014a). A 2005 study led by the Centre for Rural and Northern Health Research found that 68 per cent of RNs and 67 per cent of RPNs working in Ontario's rural hospitals preferred full-time employment versus 58 per cent and 46 per cent, respectively, who were working full-time. Today, 66.6 per cent of Ontario's RNs, 55.9 per cent of RPNs and 82.7 per cent of NPs report working full-time (CNO, 2014b) Hunsberger et al (2009) have identified waiting for full-time work as a source of dissatisfaction for rural nurses. As a result, these nurses often seek multiple employment to make up for full-time hours (Montour et al, 2008). From an employer perspective, Baumann et al (2006) found that employers seek higher proportions of part-time nurses for scheduling and replacement purposes, however, this is complicated by the abundance of multiple employment. A more recent study of the entire nursing workforce in Ontario found that 72 per cent of RNs and 76.8 per cent RPNs prefer full-time employment (College of Nurses of Ontario, 2014b). Although this represents aggregated data at the provincial level, it shows that there is still a higher desire for full-time employment than what nurses have been able to attain. It is clear that matching preferred employment status and scheduling arrangements with actual employment status and scheduling arrangements, is an important enabler of retention and recruitment. This is particularly true in unique settings, such as the most remote areas of the province where there are distinctive working conditions and significant isolation.

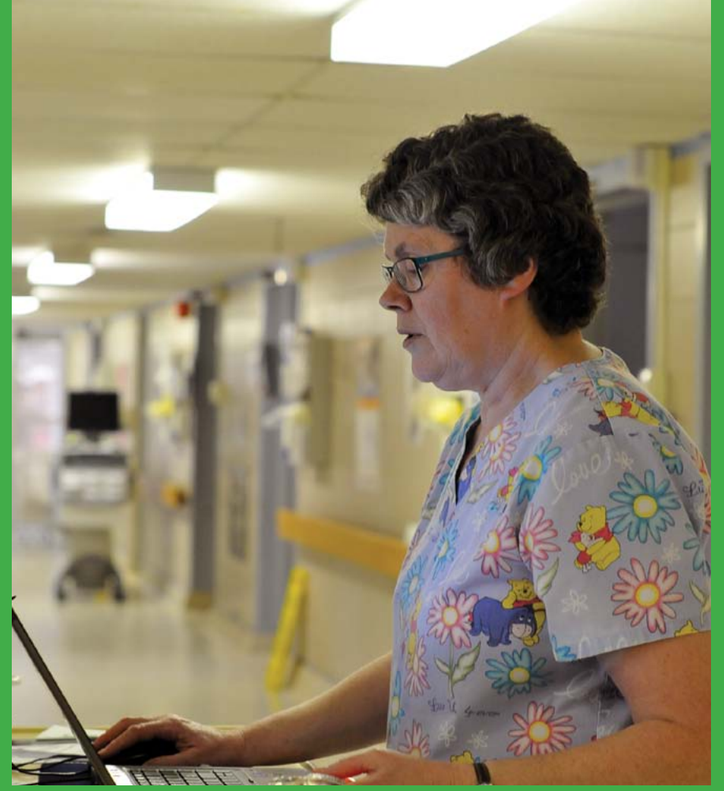
It is encouraging to see that the number of nurses practising in primary care is increasing, with significant gains for NPs, which leads to improved access to primary care. This increase may reflect recent developments with the emergence of Nurse Practitioner-led clinics (NPLCs) and other interprofessional primary care models that have emerged in rural areas. NP-led nursing stations have also emerged across several communities, including remote areas to bring chronic care closer to home and rural regions with high seasonal populations to avoid unnecessary emergency department visits (Gravenhurst Banner, 2013). An ongoing challenge affecting the recruitment and retention of NPs (and others) in primary care is that public-sector compensation restraint has meant that most NPs in primary care have not seen a salary increase for up to nine years. Moreover, inequities with other areas of the system are destabilizing the workforce (Association of Family Health Teams of Ontario et al, 2013). This compensation gap between those working in the community and institutional sector is persistent and will serve as a barrier in attracting NPs into the community to enable the delivery of care closer to home and transformation of Ontario's health system. This challenge is exacerbated in already difficult to recruit rural, remote and northern communities in Ontario. For the past several years, RNAO has urged the government to harmonize upwards NP compensation across sectors (RNAO 2012, RNAO 2013, RNAO 2014b, RNAO 2015a).

When describing the rural, remote and northern nursing workforce it is important to consider the unique role they play. Often these nurses, who are generalists, have a high degree of competency within a number of clinical domains and specialties (Montour et al, 2008; Baumann et al, 2006). Nurses in these areas are required to apply their knowledge and skill without the resources often found in urban settings (Baumann et all, 2006). The nature of rural practice often demands that nurses practise autonomously to their full scope (Canadian Nurses Association, n.d.). This can be both challenging and rewarding as rural nurses react positively when enabled to practise to their full scope (Hunsberger et al, 2009). In many rural, remote and northern communities, nurses may practise beyond their current scopes of practice through delegation (MacLeod and Kulig, 2004).

Another unique facet of rural, northern remote practice is that given the size and location of these communities, it can be challenging to separate personal and professional roles (MacLeod et al, 2004). This means that the nurse is caring for neighbors, friends and families as she/he maintains her/his professional identity throughout the community. It is important for new nurses to feel included within the community culture to minimize feelings of seclusion. With guidance from their employer and colleagues, nurses should actively explore the community, including any unique practices, traditions or events that exist.

As identified, the rural, remote and nursing workforce is filled with both opportunity and challenge. The characteristics are unique and reinforce the importance of considering context and culture when attempting to promote recruitment and retention.

Debbie McIntyre works as an RN with the Leeds, Grenville & Lanark District Health Unit.
PHOTO: Kris Sample



Pat Carefoot is a charge nurse in the medical/surgical unit of Markdale Hospital, part of Grey Bruce Health Services
PHOTO: Tracy Rovers

Dwayne Bishell is an RPN with Saint Elizabeth Health Care in the North Simcoe Muskoka area.

Identifying Barriers and Enablers of Recruitment and Retention

Through its detailed analysis, the task force identified the following barriers and enablers of recruitment and retention of nurses in rural, remote and northern communities. Each of these factors, depending upon the context, availability and/or action, can be seen as an enabler or barrier:

- Targeted government intervention and support;
- Access to nursing as a career;
- RN, RPN and NP nursing education programs;
- Student placement opportunities;
- Continuing education and professional development;
- Culturally and contextually appropriate educational content;
- Orientation to rural, remote and northern practice;
- Language proficiency;
- Full and expanded nursing roles;
- Workload;
- Work environments;
- Employment status;
- Compensation;
- Nursing leadership;
- Marketing employment opportunities;
- Community integration;
- Spousal employment;
- Technology-enabled service delivery, consultation and education;
- Partnerships;
- Research and evidence;
- Engagement in decision-making;
- Funding models; and
- Infrastructure.

Barb van der Meer (L) is a registered nurse with the Leeds, Grenville & Lanark District Health Unit.
PHOTO: Kris Sample

Pam Fellbaum is an RN for CarePartners. In Ontario, 50 per cent of clients receiving home care have wounds.
PHOTO: Greg Fess

RPN Debbie Larabie checks Daelene's height and weight at the Shkagamik-Kwe Aboriginal Health Access Centre.
PHOTO: Peter Zwarich

The task force has strived to develop recommendations that address each of the enablers and barriers it identified to improve recruitment and retention of nurses in rural, remote and northern communities. Each recommendation is accompanied by a focused rationale to explain how it was derived. The task force also proposes who might lead the recommendation, along with relevant stakeholder involvement in implementation. The latter is not an attempt to compose a comprehensive list of all stakeholders, rather an attempt to identify potential partnerships that could be established or maintained.
While the mandate of the task force was to identify short, medium and long-term strategies, many of the recommendations require little new funding and engage a diverse group of leaders, thus work could commence immediately to mount a comprehensive response. The task force recognizes that there will be varying lengths of time for full realization of the desired outcomes for each recommendation, some immediate and others multi-year, however, implementation can start now. The recommendations are organized into three groups: recruitment, retention and system policy and planning. Placement of the recommendations are not exclusive and many are interconnected.

RECRUITMENT

Recommendation #1 Expand and create programs that enable residents of rural, remote and northern communities to access practical nursing, baccalaureate and graduate nursing education locally across the province.

Proposed Leader: Ministry of Training, Colleges and Universities

Stakeholders: Ministry of Health and Long-Term Care, educators, professional associations, Contact North and Ontario Telemedicine Network (OTN)

The literature has consistently identified people who were initially residents of rural and remote areas are most likely to return to practise as a nurse (Dolea et al, 2010; Hunsberger et al, 2009; Roberge, 2009). These individuals are likely to have community connections, social support systems in place and appreciate the realities of living in a rural, remote and/or northern area. It can be challenging for residents of these areas to pursue nursing education due to finances, relationships and other obligations. At present there are nursing programs that offer people the opportunity to learn close to home in rural and northern communities. These programs demonstrate their success and support recruitment to rural, remote and northern communities. However, the task force heard about the need to increase the offering of some of the current programs as health-care organizations could benefit from a steady stream of graduates. In addition, there is opportunity to expand these programs to provide even more students with the opportunity to learn closer to home. To make this happen, the task force has identified the following steps be considered with any new program:

- identify new regional sites to deliver programs,
- ensure contextually appropriate learning is provided,
- ensure the appropriate infrastructure, including reliable technology to support distance learning and,
- create partnerships to offer high quality clinical placements, including supporting local preceptors/ clinical instructors and offering access to specialized placements.

The medical profession has pioneered an innovative model that the nursing profession could learn from and adapt. The Northern Ontario School of Medicine (NOSM) represents a partnership between Lakehead University and Laurentian University. Regarded as a "made-in-the-north solution" the school delivers "… a distinctive model of distributed, community-engaged, and socially accountable, medical education" and is "…a result of many partnerships and collaborations with individuals, communities and organizations including Aboriginal and Francophone, hospitals and health services, physicians and other health professionals, universities and colleges, information communication technology organizations, and other medical schools." The vast majority of students are from Northern Ontario and a significant proportion of graduates have pursued rural/northern practice (Strasser et al, 2013). Lastly, the task force received feedback that access to graduate level education can be difficult in these regions and consideration should be given to ways in which graduate studies can be made more accessible.

Recommendation#2 Provide sustainable funding for current initiatives that prepare and support First Nations, Inuit and Métis persons to pursue nursing education programs, preferably locally, and expand these programs across the province.

Proposed Leaders: Ministry of Training, Colleges and Universities and Ministry of Aboriginal Affairs

Stakeholders: Ministry of Health and Long-Term Care, educators, professional associations, Aboriginal Nurses Association of Canada, Health Canada and Chiefs of Ontario

Many Aboriginal communities are within rural, remote and northern reaches of the province. First Nations, Inuit and Métis persons experience challenges pursuing post-secondary education in Ontario. Although great progress has been made, there are still "…social, cultural, financial and geographic barriers to participation in postsecondary education and training opportunities" (Ministry of Training, Colleges and Universities, 2011). Particularly in remote communities, students are exposed to both federal and provincial education systems, which perpetuate barriers to post secondary education and training. Increasing the number of First Nations, Inuit and Métis persons within Ontario's nursing profession will enrich the diversity of the profession and enable culturally competent care. The Conference Board of Canada (2015) indicates that increasing the number of First Nations, Inuit and Métis nurses is "one of the best ways to improve the quality of care for Northern and Aboriginal communities."

Lakehead University has implemented a *Native Nurses Entry Program*, which is a transition program targeting Aboriginal people who may lack the prerequisites to achieve admission into a baccalaureate nursing program. Through this program, students "…gain the necessary skills and academic preparation required for the successful completion of a [baccalaureate nursing program]" (Lakehead University, n.d.). Data obtained from Lakehead University shows that 172 Aboriginal persons have successfully completed this program and 65 completed the baccalaureate nursing program. Although not all went on to pursue nursing education, many pursued education in related fields and have developed prosperous careers.

Another example is the North East LHIN's support for a first-ever program to locally train personal support workers (PSWs) to provide care to seniors living at home in Hudson and James Bay coastal communities.

Working in partnership with the Red Cross to develop and implement a culturally appropriate PSW training program, 15 students have graduated through training made available in coastal communities and are now providing community-based care for older adults. Moving forward, it is imperative that programs, such as the *Native Nurses Entry Program* have access to sustainable funding to be able to operate and deliver positive outcomes. In addition, the task force has identified an opportunity to expand this type of program to other regions of the province to make it more accessible to First Nations, Inuit and Métis populations.

Recommendation #3 Ensure that all entry-level nursing education programs in Ontario incorporate the socio-cultural context of First Nations, Inuit and Métis people in the curriculum.

Proposed Leader: COUPN and CAATs

Stakeholders: Aboriginal Nurses Association of Canada, Ministry of Training, Colleges and Universities and Ministry of Aboriginal Affairs

RNAO's (2007b) guideline on embracing cultural diversity in health care defines culturally competent care as being: "The ability to provide care with a client-centered orientation, recognizing the significant impact of cultural values and beliefs as well as power and hierarchy often inherent in clinical interactions, particularly between clients from marginalized groups and health." First Nations, Inuit and Métis people can be found across Ontario, although largely prevalent in rural, remote and northern communities, and contribute to the richness and diversity of the province. Their experience of health and healing, along with cultural traditions are unique. Unfortunately, "racism and cultural oppression have been realities for many minority groups living in Canada … with longstanding impacts of poverty, poor health, loss of identity and marginalization" (RNAO, 2007b). It is imperative that all nurses have an understanding of the socio-cultural context of First Nations, Inuit and Métis persons to be able to deliver culturally competent care.

Recommendation #4 Expand and create new initiatives that prepare and support Francophone persons to pursue nursing education, preferably locally.

Proposed Leaders: Ministry of Training, Colleges and Universities and Office of Francophone Affairs

Stakeholders: Ministry of Health and Long-Term Care, educators and professional associations

Francophone persons live in a number of rural and northern regions of the province, particularly in the east and north east. They are a testament to the rich history and cultural diversity of these regions. The task force heard that health-care organizations in these areas have a challenge recruiting Francophone nurses to provide culturally-competent care. At present, there are limited opportunities for Francophone persons to pursue nursing education in the French language (Collège Boréal, University of Ottawa and Laurentian University provide education in French). Therefore, the task force is urging for an increase in the accessibility of nursing education programs delivered in French. It would be of greatest benefit if these programs could be easily accessible in regions with a high proportion of Franchophone persons.

Recommendation #5 Develop regional networks that co-ordinate opportunities for rural, remote and northern student placements and establish community partnerships to support travel and accommodation.

Proposed Leaders: Communities, educators and health-care organizations

Stakeholders: Community service groups and municipal government

Exposure to rural, remote and northern practice through clinical placements can promote recruitment (Dolea et al, 2010). There is wealth of opportunity for clinical experience in these communities. However, students have difficulty pursuing these placements because of travel and accommodation barriers (Lea & Cruickshank, 2005). The task force heard of a number of instances where communities have stepped up to offer billeting programs and travel support to nursing students. Some health-care organizations have on-site residence facilities or access to them. Many communities have established programs to support medical students on placement. These programs are wonderful, however, communities must be engaged to recognize their stake in supporting a sustainable nursing workforce. Although much of the attention has been placed on physician recruitment, if communities do not have a sustainable nursing workforce, they risk losing access to an array of services. One way of supporting this proposal is through the development of regional networks that bring together communities, educational institutions and health-care organizations to co-ordinate opportunities to meet the travel and accommodation needs of nursing students. These networks can maintain an inventory of resources available, connect students with these resources and support ongoing opportunities for expansion. A significant benefit of this system is that it is virtually cost-neutral and relies on partnerships that leverage existing resources and capacity.

Recommendation #6 Continue to highlight in all marketing the unique and rich opportunities that exist within rural, remote and northern communities, while also openly communicating the realities that are experienced in these communities.

Proposed Leaders: Health-care organizations and HealthForceOntario

Stakeholders: Professional associations and career marketing groups

Promoting the opportunities of nursing as a profession to those who live in rural, remote and northern regions is the most effective recruitment and retention practice. Where there is a reliance on external recruits, focus should be directed to those who are prepared to embrace the possibly distinct living conditions from what they are used to. Although a wealth of opportunity exists within rural, remote and northern communities, the living conditions can be different from urban regions. In order to make an informed employment decision, geographic distance, isolation, extreme climate, limited or lack of public transportation, costs of living and other factors need to be considered by nurses when contemplating a career in rural, remote and northern communities. Marketing career opportunities in these regions should include an open discussion about the realities experienced.

Recommendation #7 Invest and support strategies that will enable achievement of 70 per cent full-time employment for all nurses.

Proposed Leaders: Ministry of Health and Long-Term Care, Local Health Integration Networks and employers

Stakeholders: Professional associations and unions

Throughout the task force's consultations, nurses and employers frequently expressed the importance of full-time employment as an enabler of recruitment and retention. Provincially, 72 per cent of RNs and 76.8 per cent RPNs prefer full-time employment vs 66.6 per cent of Ontario's RNs and 55.9 per cent of RPNs who have attained this employment status (College of Nurses of Ontario, 2014b). RNAO, since 2000, has insisted that having 70 per cent of nurses employed full-time is paramount to continuity of care and care-giver, as well as central to maximizing retention and recruitment (Grinspun, 2000, 2001, 2003, 2007; RNAO, 2001, 2003, 2005; 2014a). The 70 percent full-time employment policy was first adopted by the provincial government in 2003 and has remained has the policy target to-date (Liberal Party of Ontario, 2003; Auditor General of Ontario, 2013). While some employers have indicated scheduling flexibility as a barrier towards offering full-time employment, research suggests that precarious employment complicates scheduling as it creates competition for a nurse's availability (Baumann et al, 2006). In rural, remote and northern communities, 70 per cent full-time can be achieved through supportive funding models and through creative nursing human resource planning. For example, the Nursing Health Services Research Unit (2010) identified innovative scheduling, cross-training, collaboration across sectors, partnerships and participation in government initiatives as potential enablers of 70 per cent full-time.

Consideration should be given to remote regions of the province given isolation and unique working conditions, whereby employment arrangements often require nurses to rotate between their employment and home communities. However, as this report has already identified, efforts should be made to support residents of remote communities, predominantly First Nations, Inuit and Métis persons to pursue the nursing profession.

RETENTION

Recommendation #8 Fund a rural nursing orientation program to provide any nurse who is newly hired, or returning, to rural, remote and/or northern practice with an opportunity for an extended supernumerary orientation that includes accessing prerequisite certifications if needed.

Proposed Leader: Ministry of Health and Long-Term Care

Stakeholders: Health-care organizations and unions

Nursing practice in rural, remote and northern communities is a unique, professionally challenging and enriching experience. It requires nurses to apply a broad set of competencies and the capacity and confidence to practise with a high degree of autonomy, often within a context of limited resources available for support. Enabling the effective introduction of new nursing graduates and even experienced nurses who are unfamiliar with this type of practice, requires the availability of comprehensive and high quality orientation experiences as key enablers of retention (Hunsberger et al, 2009; Martin Misener et al, 2008; Baumann et al, 2006; Minore et al, 2005). The Nursing Graduate Guarantee initiative, funded by Ontario's Ministry of Health and Long-Term Care, provides health-care organizations with funds to offer new nursing graduates an extended orientation experience. This program is to be applauded for its success, however, it only applies to nurses within six months of graduation. Recognizing the complexity and uniqueness of nursing practice in rural, remote and northern areas, the task force is calling on government to develop a similar program for any nurse who is new to rural practice or returning after extended absence.

The task force also recognizes that often nurses in rural, remote and northern areas require special certifications given their roles. These certifications can take time, especially if there are limited educational offerings throughout the year. A supernumerary orientation program could enable nurses to initiate clinical experience by beginning employment, while simultaneously pursuing the necessary certifications.

Recommendation #9 Leverage capacity to relieve short-term staffing gaps in rural areas through organizational partnerships that facilitate longer-term secondments in place of agency utilization and/or overtime.

Proposed Leaders: Health-care organizations, workforce alliances and unions

Health-care organizations in rural, remote and northern communities are experiencing staffing challenges in response to recruitment and retention issues. The three main factors in resolving staffing gaps are: overtime, agency nurse utilization and/or reducing service levels. Each of these carries quality of care and resource utilization risks. As a short-term solution to relieve immediate staffing gaps, the task force encourages the development of networks that connect health-care organizations with significant staffing capacity, to those who are experiencing challenges. Short and medium term secondments (two to six months) can be used to share human resources, especially during peak periods (i.e. summer and holidays). This cost-effective solution not only relieves staffing gaps, it also serves as an opportunity to promote capacity building. An opportunity is created to share mentorship, skills development and knowledge exchange between nurses. Attempts are being made to co-ordinate this type of initiative through the Ontario Nursing Workforce Alliance. The task force encourages continued growth in this concept as an immediate first step. However, it is not meant to serve as a long-term solution towards promoting the sustainability of the rural, remote and northern nursing workforce.

Recommendation #10 Collaborate with rural, remote and northern nurses to create dedicated continuing education programs that recognize the unique nature of rural, remote and northern nursing practice.

Proposed Leaders: Professional associations, educators and rural/remote/northern nurses

As already identified, rural, remote and northern nursing practice is unique. Nurses may not see their role within existing continuing educational programs because often there is an unintentional urban focus. Therefore, there is a need to develop contextually-appropriate and specific continuing education. To ensure relevance to meet learning needs, it is important to engage the voice of rural, remote and northern nurses in the development of the curriculum. Given the interprofessional nature of care delivery in Ontario's modern health-care system, it is also important to consider opportunities to allow for interprofessional education through the engagement of other health-care professionals.

Recommendation #11 Maintain current government interventions that promote the retention and recruitment of nurses in rural, remote and northern communities and expand them to all health-care settings, minimizing eligibility restrictions and optimizing their administration.

Proposed Leader: Ministry of Health and Long-Term Care

Stakeholders: Professional associations, health-care organizations and unions

Examples of current government interventions that promote the recruitment and retention of nurses include the following:

- Tuition Support Program for Nurses,
- Nursing Community Assessment Program,
- Nursing Graduate Guarantee (NGG),
- Late Career Nurse Initiative (LCNI),
- Grow Your Own Nurse Practitioner (GYONP)
- Nursing Career OrIENtation and
- Nursing Education Initiative (NEI).

Some of these programs are rural-specific, while others are provincial in scope. Key informant interviews conducted by the task force indicate great support from employers and nurses to continue and even expand these programs to all areas of the health-care system including primary care, public health, correctional institutions, hospitals, long-term care, complex continuing care, rehabilitation, home health care and support service organizations. Employers should also consider the synergies that exist across the initiatives. For example, the Nursing Community Assessment Program, Nursing Graduate Guarantee Initiative and Tuition Support Program for Nurses could be used in tandem to access significant resources that can serve to attract, recruit and integrate new graduates. Similarly, the Nursing Education Initiative and Late Career Nurse Initiative could be used together to support the retention of nurses in the latter stages of their career.

In addition, there are some eligibility requirements that could be improved. For example, the Grow Your Own Nurse Practitioner program requires that an NP position remains vacant for two years before the program can be pursued. This restriction leads to a significant gap in service. Instead, the task force feels that a one year vacancy requirement is more appropriate and demonstrates recruitment

challenges for the purposes of eligibility in this program.

Lastly, the application process to access these initiatives can be onerous. There is often a significant period of time that elapses between application and notification of the outcome. For smaller health-care organizations with limited infrastructure, this delay is a barrier to pursuing the initiatives (Nursing Health Services Research Unit, 2014). There needs to be recognition of the capacity of rural, remote and northern health-care organizations when structuring the application and funding process. The government must be able to strike a balance that ensures accountability for funds, while enabling organizations with great need to pursue the programs. For clarity, this recommendation, or any other recommendation within this report, should not be interpreted in ways that contravene collective agreements.

Recommendation #12 Establish a rural nursing education initiative to augment the Nursing Education Initiative (NEI) to provide reimbursement for tuition and transportation/accommodation costs associated with pursuing education.

Proposed Leader: Ministry of Health and Long-Term Care

Stakeholders: Professional associations

Given that rural, remote and northern nurses are required to maintain competency in a number of clinical specialties, there is an increased demand for continuing education. The Nursing Education Initiative (NEI) is a celebrated opportunity for nurses, enabling them to apply for reimbursement for up to $1,500 to pursue eligible education. However, this program only provides reimbursement for tuition/registration costs. Given the geographic isolation of rural, remote and northern communities, nurses may have to travel to pursue education. If an employer is unable to financially support them, the nurse must bear the costs of travel and accommodation, which can be significant. The task force is requesting the Ministry of Health and Long-Term Care provide additional funding for the NEI that will be dedicated to nurses practising in rural, remote and northern communities. Moreover, the dedicated fund should also include reasonable transportation and accommodation costs as eligible expenses.

Recommendation #13 Enable collaboration between health organizations with capacity to deliver specialty care and rural, remote and northern organizations, to support ongoing education and competency development.

Proposed Leaders: Health-care organizations and educators

Nurses in rural, remote and northern communities are expected to maintain a high level of competency in a number of clinical specialties. The smaller population sizes of these regions affect service delivery volumes. Therefore, while nurses are expected to maintain proficiency, nurses may have limited opportunity to apply this knowledge and skill. Conversely, there are health-care organizations in urban areas that maintain a high degree of specialization. The task force feels that as a health-care community, there is an opportunity and obligation for these organizations to provide support in the form of specialty education and training. More work is needed to explore how these relationships can be effectively established and what resources may be needed to make it happen. Accountability agreements for northern, rural and remote health-care organizations should specifically identify how the organization intends to implement the proposed recommendation.

Recommendation #14 Expand access to, and utilization of, the Ontario Telemedicine Network (OTN) and leverage other forms of virtual connectivity to deliver education and consultation in rural, remote and northern areas, augmented with in-person opportunities.

Proposed Leaders: Ontario Telemedicine Network, Ministry of Health and Long-Term Care and health-care organizations

Stakeholders: Local Health Integration Networks, Contact North, health-care organizations and other virtual connectivity vendors

Gagnon et al (2011) identified that information and communication technologies have a positive influence on the recruitment and retention of health-care professionals. Given the geographic isolation of rural, remote and northern communities, virtual forms of connectivity are a reality and expected to grow. There are a number of applications of this technology. Two key applications include supporting the delivery of care through real time and asynchronous consultation/collaboration and providing platforms for learning and information sharing. As a starting point, it is important for health-care organizations to thoroughly examine their requirements, setting and needs when assessing information and communications technologies.

OTN is a made-in-Ontario not-for-profit telemedicine service, which aims to connect providers across the province through technology. At present there are 1,748 OTN sites across the province, which facilitated service to 390,906 Ontarians and enabled 21,477 learning events (OTN, 2014). The positive impact of OTN is being embraced across rural, remote and northern communities. Despite significant growth in the network, including the emergence of personal videoconferencing and webcasting, not all health-care organizations in Ontario are accessing OTN services. This was expressed to the task force during provincial consultations. Cost and available funding were cited as common barriers to pursuing traditional room-based OTN technologies, however, an increased awareness is needed around other OTN services that may be less cost-prohibitive. For example, OTN's personal videoconferencing service requires a modest startup investment and the fee for ongoing use is currently waived for government-funded organizations. However, this technology requires a stable high-speed internet connection that may not be accessible in remote regions. Therefore, it is important that the Ministry of Health and Long-Term Care, OTN, LHINs and health-care organizations continue to explore ways to make the network even more accessible across all sectors of health care.

There are also other methods of facilitating virtual connectivity in addition to OTN that can be leveraged in rural, remote and northern areas. One such example is Contact North, which is a not-for-profit corporation established by the Ontario Government to support access to education and training programs through distance education across Ontario. This service helps students access education and training through web, video and audio conferencing.

Health-care organizations are also pursuing other forms of connectivity through teleconferencing, videoconferencing and webinar technology. While other approaches are being studied and used, consistency and interoperability are key. There is a risk that if too many vendors and options are engaged, rural, remote and northern health-care organizations could get overwhelmed having to switch between multiple platforms. Moreover, there are complex accessibility, reliability, security

and privacy considerations that must be carefully reviewed before pursuing new information and communications technologies.

Lastly, while technology is a tool for communicating and sharing knowledge, it can never replace face-to-face contact. The task force encourages that technology never be used as a total substitute for in-person interaction, as this risks further isolating nurses in rural, remote and northern communities. Some of the richest education and communication can only occur when people are brought together.

Recommendation #15 Ensure effective standards exist to guide the appropriate use of technology in service delivery models and develop new standards, where needed.

Proposed Leaders: Ministry of Health and Long-Term Care, Local Health Integration Networks and Community Care Access Centres

Stakeholders: Health-care organizations and eHealth Ontario

The use of technology is increasingly being implemented as a resource to deliver care in all reaches of the province. Telemedicine and telehealth are necessary tools needed to ensure access to care in rural, remote and northern communities. While technology brings great opportunity, there is also a need for a thoughtful review of a number of factors including: safety, quality of care, effectiveness, privacy, reliability and outcomes. A thoughtful discourse is needed that brings together service providers, funders and policy-makers, professional associations, nurses and the public to ensure the appropriate application of technology is being used. While the development of standards for the appropriate application of technology is the first essential step, education support to effectively utilize and implement the standards is also required. Moreover, technology cannot and should not be used as a complete substitute for in-person interaction. Rather it should be used as one of many resources to enable access to care in appropriate circumstances.

Recommendation #16 Address compensation and benefit inequities for RNs, NPs and RPNs that exist between the community (including primary care) and hospital sectors and ensure that compensation reflects the realities of rural living.

Proposed Leaders: Ministry of Health and Long-Term Care, Local Health Integration Networks, Community Care Access Centres and Health Canada

Stakeholders: Health-care organizations

There are substantial compensation and benefit inequities that exist between nurses practising in the community sector and institutional sector. This issue is compounded in rural, remote and northern communities as community care organizations compete with the institutional sector, largely hospitals for staff. Tourangeau et al (2014) identified that income and benefit inequality are primary reasons for nurses' consideration of leaving the current home health-care environment. This concern dates back to as early as when the Nursing Task Force released its report in 1999 and even before then. The community sector across Ontario will not be able to demonstrate its full potential, especially in rural, remote and northern communities, until compensation and benefit inequities are eliminated across sectors.

Primary care is of great importance to the growth and development of the health-care system. However, nurses in Nurse Practitioner-led clinics, Family Health Teams and Community Health Centres are compensated significantly less than in other sectors (RNAO, 2012; Association of Family Health Teams of Ontario et al, 2013; RNAO, 2013; RNAO, 2014b; RNAO 2015a). Nurses face a similar experience in provincially-funded nursing stations. It has been almost nine years since most primary care nurses have received an increase in their compensation and the discrepancy with the hospital sector can be as much as a 20 per cent difference. As a result, one in five primary care NP positions are vacant (Association of Family Health Teams of Ontario et al, 2013).

It is critical that compensation models for all sectors incorporate the cost of living within rural, remote and northern areas. The more isolated a community is, the more expensive it can be to live there. This often is a result of the cost of delivering goods and services to these regions and larger transportation distances.

Recommendation #17 Develop a framework, including practice standards and education pathways that support the expanded utilization role of nurses in rural, remote and northern settings, including RN prescribing.

Proposed Leader: College of Nurses of Ontario

Stakeholders: Educators, professional associations and Health Canada

Given the realities of practice in rural, remote and northern communities, nurses often practise to their full scope of practice. These nurses can also be utilized in an expanded role through delegation. At present there are limited practice standards and/or dedicated education pathways to support the expanded utilization of nurses in rural, remote and northern settings. To ensure accountability, safety and optimal patient/client/population outcomes, it is imperative that these supports be implemented. This recommendation is especially relevant for RNs practising in remote regions where there are unique complexities and demands for an expanded role.

In 2012, RNAO released a report (*Primary Solutions for Primary Care*) calling for the full and expanded utilization of the RN and RPN in primary care settings. This recommendation included enabling RNs to prescribe medications, order diagnostic testing and communicate a diagnosis within their scope of practice. This call has gone beyond the primary care setting and beyond rural, remote and northern communities, to encompass all areas that RNs practise in. The Premier of Ontario announced her commitment to expanding the scope of the RN to include prescribing (Government of Ontario, 2013). The Minister of Health and Long-Term Care announced that consultations to enable RN prescribing will commence in the spring of 2015 (RNAO, 2015b). Once RN prescribing is fully implemented across the province, there will be a framework in place that can better support the expanded role of nurses in rural, remote and northern communities. However, more may be needed, especially given the uniqueness of remote areas. For example, the College of Registered Nurses of British Columbia has established a remote nursing certified practice program. A similar program could be developed in Ontario to ensure that remote RNs are prepared to handle the complexities of practising in these areas. However, a thoughtful discussion must occur between regulators, professional associations, Health Canada and remote nurses themselves to enable access to care without compromising safety.

SYSTEM POLICY AND PLANNING

Recommendation #18 Identify ways to develop and support the capacity of rural, remote and northern nurse administrators to effectively respond to clinical and human resource complexities.

Proposed Leaders: Professional associations

Nurse administrators in rural, remote and northern communities are responsible for ensuring safe and effective staffing practices in the face of significant recruitment and retention challenges. At the same time, these administrators are co-ordinating service delivery programs that are also responding to complex clinical challenges related to geography and available resources. There is a need to support nurse administrators during the transitional period from clinician to manager and continuously to improve/strengthen their talents as nurse leaders, while recognizing the uniqueness of rural, remote and northern practice settings.

Recommendation #19 Bridge research gaps by funding studies that focus on rural, remote and northern nursing practice and issues/interventions affecting recruitment and retention in these areas.

Proposed Leaders: Ministry of Research and Innovation, Ministry of Health and Long-Term Care and researchers

Stakeholders: Academic institutions and research funders

The health-care system and nursing workforce is dynamic. While the knowledge base concerning the rural, remote and northern nursing workforce is growing, there is a need and opportunity to continue generating research around the profile of the workforce (Baumann et al, 2008) and interventions that can provide relief. Evidence-based policy is essential to ensuring the best possible outcomes for all parties involved. In addition, each intervention that is applied (including the recommendations within this report) will benefit from a meaningful evaluation. This recommendation will require the dedication of sufficient resources and the willingness of researchers to pursue this area of study.

Recommendation #20 Consider the context of rural, remote and northern health-care delivery through meaningful engagement of relevant stakeholders and conducting an impact analysis, when developing new provincial initiatives.

Proposed Leaders: Government of Ontario, Government Agencies and Municipalities

Baumann et al (2008) have identified that policy makers tend to focus more on the majority of Ontarians who live in urban centres, than those living in rural areas and even less on remote communities, and this focus bleeds into health human resource policy. To avoid a cookie-cutter approach, it is important for policy-makers to consider the uniqueness and context of rural, remote and northern areas when making decisions. A helpful way of doing so is through the meaningful engagement of all stakeholders, including representatives from rural, remote and northern communities. Another strategy is to conduct a structured impact analysis to better understand what impact provincial policy will have in rural, remote and northern communities. This will generate valuable information to guide the implementation of policy in these regions.

Recommendation #21 Enable local health human resource planning that is inclusive of all sectors, engages the local voice and is informed by evidence and appropriate data.

Proposed Leaders: Ministry of Health and Long-Term Care and Local Health Integration Networks

Stakeholders: Professional associations, HealthForceOntario, communities

Health human resource (HHR) planning must not occur in a vacuum. Planners need to consider how all areas of health care are connected and assess what impact a decision in one area will have on another. Adequate HHR planning is needed at the macro, mezzo and micro levels. Planning at the macro and mezzo level must consider all sectors. At present there is limited regional health human resource planning capacity within the province due to different mandates and reporting structures. The need for inclusive regional HHR planning is further demonstrated by the requirement to ensure planning is evidence-informed and regularly monitors data and trends. Given the importance of culture and context in rural, remote and northern communities, this type of planning cannot be accomplished solely at the provincial level. It needs to be responsive and consider the local voice through robust and meaningful public consultation. Effective HHR planning also requires that nurses and other health-care professionals from rural, remote and northern communities be engaged as part of the process in finding solutions to rural, remote and northern issues (Baumann et al, 2008).

Recommendation #22 Support evidence-informed funding models that consider population health needs and local context to enable person-centred care.

Proposed Leaders: Ministry of Health and Long-Term Care and Local Health Integration Networks

Stakeholders: Health-care organizations and communities

It is important that funding models respond to population health needs and effective HHR planning. However, given that rural, remote and northern communities tend to have smaller populations and significant variation within their population, local context must also be considered when making funding decisions. Ontario's rural, remote and northern communities deserve a nursing workforce that is effective in responding to their needs.

Recommendation #23 Invest in ongoing infrastructure renewal and growth in rural and remote communities (i.e. telecommunications, hydro, transportation, housing, etc).

Proposed Leaders: All levels of government, industry and telecommunications/technology sectors

One of the most important enablers of recruitment and retention in rural, remote and northern communities is ongoing development of community infrastructure (Mbemba et al, 2013; Buykx et al, 2010; Martin-Misener et al, 2008) which will benefit not only nurses, but communities as a whole. Ongoing development of infrastructure includes (but not limited to) access to quality housing, secure hydro supply, reliable transportation options, water and sanitation and effective telecommunications technology. The task force calls for all levels of government to come together and make investments in rural, remote and northern communities a priority. Doing so will not only support residents of these communities and the recruitment and retention of nurses, but will also represent an investment in the future of Ontario.

Conclusion

RNAO's Rural, Remote and Northern Nursing Task Force is pleased to provide these recommendations. They aim to promote the recruitment and retention of nurses in rural remote and northern communities. The task force recognizes that culture and context are integral to the implementation of the recommendations and have attempted to deliver recommendations that respect the richness and diversity of these communities. Moving forward, the task force hopes that stakeholders will use this framework to work together to make recruitment and retention of nurses in rural, remote and northern communities a priority. The aspiration of this work is to foster the development of a sustainable nursing workforce to promote access to care and the best possible health outcomes for residents of rural, remote and northern areas.

Breakdown of Nursing Positions and Employment Status by LHIN

The rural, remote and northern nursing workforce has many unique, complex and rewarding facets. It is helpful to begin by considering the distribution of nurses across the province. The following table provides a breakdown of the number of nursing positions* per Local Health Integration Network (LHIN) (CNO Data Query Tool, 2014a)

LHIN	RN							RPN							NP						
	FT	%	PT	%	Casual	%	Total	FT	%	PT	%	Casual	%	Total	FT	%	PT	%	Casual	%	Total
Erie St. Clair	2,734	53.1	1,733	33.7	681	13.2	5,148	1,118	43.5	1,153	44.9	297	11.6	2,568	114	64.8	31	17.6	31	17.6	176
South West	5,533	56.4	2,735	27.9	1,540	15.7	9,808	1,856	47.7	1,354	34.8	679	17.5	3,889	170	74.9	31	13.7	26	11.5	227
Waterloo Wellington	2,709	52.9	1,563	30.6	845	16.5	5,117	1,224	47.7	922	35.9	421	16.4	2,567	100	55.2	44	24.3	37	20.4	181
Hamilton Niagara Haldimand Brant	6,880	56.8	3,483	28.8	1,742	14.4	12,105	2,658	48.0	1,706	30.8	1,171	21.2	5,535	174	64.4	61	22.6	35	13.0	270
Central West	1,987	53.7	945	25.5	770	20.8	3,702	601	40.4	517	34.8	368	24.8	1,486	38	66.7	10	17.5	9	15.8	57
Mississauga Halton	4,231	55.1	1,845	24.0	1,601	20.6	7,677	1,162	44.7	842	32.4	595	22.9	2,599	65	63.7	24	23.5	13	12.7	102
Toronto Central	12,361	62.7	3,716	18.9	3,640	18.5	19,717	2,030	44.2	1,526	33.2	1,038	22.6	4,594	374	66.1	80	14.1	112	19.8	566
Central	5,321	55.2	2,387	24.8	1,929	20.0	9,637	1,761	42.0	1,480	35.3	948	22.6	4,189	80	67.8	20	16.9	18	15.3	118
Central East	5,130	54.6	2,764	29.4	1,498	16.0	9,392	2,081	46.4	1,728	38.5	675	15.1	4,484	134	65.4	42	20.5	29	14.1	205
South East	2,882	55.6	1,470	28.4	829	16.0	5,181	1,119	45.3	906	36.7	447	18.1	2,472	103	64.8	40	25.2	16	10.1	159
Champlain	6,872	57.5	3,417	28.6	1,672	14.0	11,961	2,113	45.4	1,570	33.7	972	20.9	4,655	121	46.2	86	32.8	55	21.0	262
North Simcoe Muskoka	2,051	54.3	1,056	28.0	669	17.7	3,776	1,031	52.3	609	30.9	331	16.8	1,971	80	65.6	23	18.9	19	15.6	122
North East	3,605	59.1	1,682	27.6	817	13.4	6,104	1,492	48.9	1,191	39.0	367	12.0	3,050	190	70.9	49	18.3	29	10.8	268
North West	1,558	53.7	762	26.3	580	20.0	2,900	689	48.2	445	31.1	296	20.7	1,430	88	60.7	16	11.0	41	28.3	145
Not Specified	74	39.8	61	32.8	51	27.4	186	99	39.1	112	44.3	42	16.6	253	*		*		5		11
Total	**63,928**	53.1	**29,619**	26.4	**18,864**	16.8	**112,411**	**21,034**	46.0	**16,061**	35.1	**8,647**	18.9	**45,742**	1,834		**560**		**475**	16.6	**2,869**

*This data reflects the number of nursing positions within each LHIN. The CNO no longer reports headcount data.

References

Association of Family Health Teams of Ontario, Nurse Practitioners' Association of Ontario, Association of Ontario Health Centres (2013). Toward a primary care recruitment and retention strategy for Ontario: Compensation structure for Ontario's interprofessional primary care organizations. Retrieved from: http://www.afhto.ca/

Auditor General of Ontario (2013). Chapter 3 – Health human resources. Retrieved from: http://www.auditor.on.ca/

Baumann, A., Hunsberger, M., Blythe, J. & Crea, M. (2006). Rural Nursing Workforce: How sustainable is it? Retrieved from: http://www.teamgrant.ca/

Browne, A. (2010). Issues affecting access to health services in northern, rural and remote regions of Canada. Retrieved from: http://www.unbc.ca/

Canadian Nurses Association (n.d.) Rural and remote nursing. Retrieved from: http://www.nurseone.ca

Centre for Rural and Northern Health Research (2005). Full-time/part-time nursing in Ontario's rural hospitals. *Research in Focus.* Retrieved from: http://www.cranhr.ca/

College of Nurses of Ontario (2014a). Data query tool. Retrieved from: http://www.cno.org/

College of Nurses of Ontario (2014b). Membership statistics highlights 2014. Retrieved from: http://www.cno.org/

College of Registered Nurses of British Columbia (n.d.). Introduction to remote nursing certified practice. Retrieved from: https://www.crnbc.ca/

Conference Board of Canada (2015). Healthy foundations. Nursing's role in building strong aboriginal communities. Retrieved from: http://www.conferenceboard.ca/
Contact North (2014). About Contact North. Retrieved from: http://www.studyonline.ca/

Dolea, C., Stormont, L. & Braichet, J-M. (2010). Evaluated strategies to increase attraction and retention of health workers in remote and rural areas. *Bulletin of the World Health Organization,* 88, 379-385.

Gagnon, M-P., Pollender, H., Trépanier, A., Duplàa, Apho Ly, B. (2011). Supporting Health Professionals Through Information and Communication Technologies: A Systematic Review of the Effects of Information and Communication Technologies on Recruitment and Retention. *Telemedicine and e-Health*, 17(4), 269-274.

Government of Ontario (2015). About Ontario. Retrieved from: https://www.ontario.ca/

Grinspun, D. 2000. "Taking Care of the Bottom Line: Shifting Paradigms in Hospital Management." In D.L. Gustafson, ed., *Care and Consequences: Health Care Reform and Its Impact on Canadian Women*. Halifax: Fernwood Publishing.

Grinspun, D. (2001). A flexible nursing workforce: realities and fallouts. *Hospital Quarterly*, 6(1), 79-84.

Grinspun, D. (2003). Part-time and casual nursing work: the perils of healthcare restructuring. *International Journal of Sociology and Social Policy,* 23, 54-80.

Grinspun, D. (2007). Healthy workplaces: the case for shared clinical decision making and increased full-time employment. *Health Care Papers*, 7, 109-119.

Hunsberger, M., Baumann, A., Blythe, J., & Crea, M. (2009). Sustaining the Rural Workforce: Nursing Perspectives on Worklife Challenges. *The Journal of Rural Health*, 25(1), 17-25.

Industry Canada (2010). Summative evaluation of the Northern Ontario Economic Development Fund (NODF). Retrieved from: http://www.ic.gc.ca/

Lakehead University (n.d.). Native nurses entry program: https://www.lakeheadu.ca/

Lea, J. Cruickshank, M. (2005). Factors that influence the recruitment and retention of graduate nurses in rural health care facilities. *Collegian*, 12(2), 22-27.

Liberal Party of Ontario (2003). The health care we need: The Ontario Liberal plan for better health care. p. 13.

MacLeod, M.L.P., Kulig, J.C., Stewart, N.J., Pitblado, J.R., Banks, K., D'Arcy, C., Forbes, D., Lazure, G., Martin-Misener, R., Medves, J., Morgan, D., Morton, M., Remus, G., Smith, B., Thomlinson, E., Vogt, C., Zimmer, L., & Bentham, D. (2004). The Nature of Nursing Practice in Rural and Remote Canada. *CHSRF Report*.

Martin Misener, R.M., MacLeod, M.L.P., Banks, K., Morton, A.M., Vogt, C., & Bentham, D. (2008). "There's Rural, and Then There's Rural": Advice from Nurses Providing Primary Healthcare in Northern Remote Communities. *Nursing Research*, 21(3), 54-63.

Ministry of Health and Long-Term Care (1999). Good nursing, good health: An investment for the 21st century. Retrieved from: http://www.health.gov.on.ca/

Ministry of Health and Long-Term Care (2004). Population health profiles. Retrieved from: http://www.health.gov.on.ca/

Ministry of Health and Long-Term Care (2011). Rural and northern health care report. Retrieved from: http://www.health.gov.on.ca/

Ministry of Health and Long-Term Care (2013). Northern health programs. Communities by rurality index of Ontario (RIO) score. Retrieved from: http://www.health.gov.on.ca/

Ministry of Training, Colleges and Universities (2011). Aboriginal postsecondary education and training policy framework. Retrieved from: http://www.tcu.gov.on.ca/

Minore, B., Boone, M., Katt, M., Kinch, P., Birch, S. & Mushquash, C. (2005). The Effects of Nursing Turnover on Continuity of Care in Isolated First Nation Communities. *Canadian Journal of Nursing Research, 37*(1), 86-100.

Montour, A., Baumann, A., Blythe, J., & Hunsberger, M. (2008). The changing nature of nursing work in rural and small community hospitals. *Rural and Remote Health*, 9 (1), 1089.

Muskoka Region (2013). Four new nursing stations proposed for Muskoka. Retrieved from: http://www.muskokaregion.com/

North East Local Health Integration Network (2014). Community hospitals and health care in Northeastern Ontario. Transforming the patient experience. Retrieved from: http://www.nelhin.on.ca/

North East Local Health Integration Network (n.d.). Teaching, learning, helping with far north PSW program. Retrieved from: www.nelhin.on.ca/

Nursing Health Services Research Unit (2010). Strategies to advance 70% full-time nursing employment toolkit. Retrieved from: http://www.nhsru.com/

Nursing Health Services Research Unit (2014). Maintaining Ontario's nursing workforce: Evaluating the impact of Ontario's late career nurse initiative (LCNI) 2012-2013. Retrieved from: http://nhsru.com/

Ontario Medical Association (2009). Measuring rurality – RIO2008_BASIC: methodology and results. Retrieved from: http://www.oma.org/

Ontario Telemedicine Network (2014). Telemedicine: Where health care meets innovation. Retrieved from: http://www.otnresults.ca/

Paterson, J., Place, J., & MacLeod, M. (2014). Nursing practice in rural and remote Ontario: An analysis of CIHI's nursing database. Retrieved from: http://www.ruralnursing.unbc.ca/

Pitblado, R., Koren, I., MacLeod, M., Place, J., Kulig, J., & Stewart, N. (2013). Characteristics and distribution of the regulated nursing workforce in rural and small town Canada, 2003 and 2010. Retrieved from: http://www.ruralnursing.unbc.ca/

Registered Nurses' Association of Ontario (2001). Earning their return: when and why Ontario RNs left Canada, and what will bring them back.

Registered Nurses' Association of Ontario (2003). Survey of casual and part-time registered nurses in Ontario.

Registered Nurses' Association of Ontario (2005). RNAO's 70 per cent full-time employment for nurses survey: hospital and long-term care sectors. Retrieved from: http://rnao.ca/

Registered Nurses' Association of Ontario (2007a). Developing and sustaining effective staffing and workload practices. Retrieved from: http://www.rnao.ca/

Registered Nurses' Association of Ontario (2007b). Embracing cultural diversity in health care: developing cultural competence. Retrieved from: http://www.rnao.ca/

Registered Nurses' Association of Ontario (2010). Position statement: Strengthening client centred care in hospitals. Retrieved from: http://www.rnao.ca/

Registered Nurses' Association of Ontario (2012). Primary solutions for primary care. Maximizing and expanding the role of the primary care nurse. Retrieved from: http://www.rnao.ca/

Registered Nurses' Association of Ontario (2013). Nursing care policy platform backgrounder. Retrieved from: http://rnao.ca/sites/rnao-ca/files/Nursing_Care_RNAO_2013.pdf

Registered Nurses' Association of Ontario (2014a). RNAO's 70 per cent full-time employment for nurses survey: Hospital and long-term care sectors. Retrieved from: http://www.rnao.ca/

Registered Nurses' Association of Ontario (2014b). RN workforce backgrounder. Retrieved from: http://rnao.ca/

Registered Nurses' Association of Ontario (2015a). Nurse practitioner compensation. Retrieved from: https://myrnao.ca/

Registered Nurses' Association of Ontario (2015b). Premier, Minister of Health say province is moving forward on RN prescribing. Retrieved from http://www.rnao.ca/
Roberge, C.M. (2009). Who Stays in Rural Nursing Practice? An International review of the Literature on Factors Influencing Rural Nurse Retention. *Online Journal of Rural Nursing and Health Care*, 9(1), 82-93.

Rural Ontario Institute (2013). Number of non-metro communities by size. F*OCUS on Rural Ontario*, 1(2).

Statistics Canada (2005). Land and freshwater area, by province and territory. Retrieved from: http://www.statcan.gc.ca/

Statistics Canada (2011). Population, urban and rural, by province and territory (Ontario). Retrieved from: http://www.statcan.gc.ca/

Statistics Canada (2014a). Dependency ratio (Table 109-5336). Retrieved from: http://www.statcan.gc.ca/

Statistics Canada (2014b). Unemployment rate (Table 109-5324). Retrieved from: http://www.statcan.gc.ca/

Statistics Canada (2014c). Health indicator profile (Table 105-0501). Retreived from: http://www.statcan.gc.ca/

Strasser, R., Hogenbirk, J.C., Minore, B., Marsha, D.C., Berry, S., McCready, W.G., & Graves, L. (2013). Transforming health professional education through social accountability: Canada's Northern Ontario School of Medicine. *Medical Teacher*, 35, 490-496.

Tourangeau, A., Squires, M., Macdonald, G., & Cranley, L. (2014). Understanding determinants of home care nurse retention. Retrieved from: www.tourangeauresearch.com/

World Health Organization (1978). Declaration of Alma-Ata. Retrieved from: http://www.who.int/

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses, nurse practitioners and nursing students in Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contribution to shaping the health-care system, and influenced decisions that affect nurses and the public they serve.

Registered Nurses' Association of Ontario
158 Pearl Street, Toronto, Ontario M5H 1L3
Tel: (416) 599-1925 / 1-800-268-7199
Fax: (416) 599-1926 Email: info@RNAO.ca

RNAO.ca

MAY 2015