Influence of Certification on Community Health Nursing

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EXECUTIVE SUMMARY

Certification in community health nursing (designated as CCHN(C)) was launched by CNA in 2006. With certification valid for 5 years, the First Cohort of nurses certified in 2006 will be eligible to renew their CCHN(C) credential in 2011. Of all the certifications offered by CNA, community health has experienced the highest growth; from 2007 to 2008, the total number of nurses holding the CCHN(C) rose from 216 to 338, an increase of 56.5% in one year (CNA, 2009b).

The purposes of this mixed-methods study (survey, interview and focus group methods) were to:

- Identify the influences of CNA's community health nursing certification on nursing practice;
- Identify the influences of CNA's community health nursing certification on employing agencies;
- Identify organizational facilitators and barriers for CCHN(C) renewal;
- Explore the intentions of the First Cohort of CCHN(C) certified nurses to re-certify; and
- Create a template that can be used by other CNA specialties/areas of practice.

While our results demonstrate profound influence of the CCHN(C) on CHNs that have achieved it, these are mostly personally held influences that affect the way they carry out their responsibilities. We could not demonstrate other than anecdotally the effect of certification, or of CHNs with CCHN(C), on client outcomes. The effect of certification on employing organizations is coming about slowly with respect to changes in job descriptions, performance appraisals, and preferred qualifications for recruits. There has been little to no recognition of CCHN(C) in compensation packages.

Many of the facilitators for CCHN(C) certification are intrinsic and personal (enhanced feelings of personal accomplishment, higher personal satisfaction, validation of specialized knowledge, better professional growth, attainment of a practice standard or competency, evidence of professional commitment, and acceptance of professional challenge). Organizational facilitators for certification come in the form of reimbursement for examination costs, work time to study, provision of mentors, reference materials and continuing education on-site and celebration and recognition of achievement. Barriers to certification come in the form of absence of salary adjustment, perceived lack of recognition of expertise, and perceived lack of support by the employer.

Most members of the first cohort of CHNs with CCHN(C) that responded to the study indicated that they intended to renew in 2011, largely because of the intrinsic value of the CCHN(C) to them personally. All intended to renew using the continuing education option.

Five broad recommendations were made on the basis of the results of this study:

1. Promote a broad definition of community health nursing
2. Improve the profile of CCHN(C) certification among CHNs, employers, and educators
3. Recognize and reward those CHNS with CCHN(C)
4. Support research on the effects and impacts of CCHN(C) on community health nursing and client outcomes
5. CNA should continue to work closely with CHNC to ensure the balance in the content of the CCHN(C) exam is appropriate and current.

Further details on each of these recommendations can be found in the report.

This study provides a template for CNA to use with other specialties/areas of practice.

INTRODUCTION

Certification is a voluntary and periodic process by which the Canadian Nurses Association (CNA) confirms that a registered nurse (RN) has demonstrated competence in a nursing specialty/area of nursing practice by having met predetermined standards for that specialty/area of practice (CNA, 2009a).

The Community Health Nurses of Canada (CHNC) held a series of consultations in 2009 that defined community health nursing:

> Community health nurses (CHNs) work and promote health in the community and partner with people where they live, work, learn, meet and play. They work autonomously in many diverse settings, including schools, workplaces, homes, faith organizations, clinics, community health centres and on the street. Their clients are individuals, families, groups, communities and populations. Their focus is health promotion and disease/injury prevention using multiple intervention approaches through partnerships with other professionals, sectors and the public. (Schofield, 2010, p.48)

Certification in community health nursing (designated as CCHN(C)) was launched by CNA in 2006. With certification valid for 5 years, the First Cohort of nurses certified in 2006 will be eligible to renew their CCHN(C) credential in 2011. Of all the certifications offered by CNA, community health has experienced the highest growth; from 2007 to 2008, the total number of nurses holding the CCHN(C) rose from 216 to 338, an increase of 56.5% in one year (CNA, 2009b).

CNA (2009a) states the purposes of certification are to promote excellence in nursing care by establishing national standards of practice in specialties/areas of practice; to provide practitioners an opportunity to confirm their competence in specialties/areas of practice; and to identify those nurses meeting the national standards of their specialties/areas of practice. Further, it claims the following benefits of certification:

- Confirms that knowledge is current;
- Demonstrates sincere commitment to the profession and specialty/area of practice;
- Shows desire to challenge skills and knowledge at the national level;
- Prepares for positions of greater responsibility;
- Increases credibility, marketability, and recognition; and
- Creates an inclusive community of nurses committed to nursing excellence and continuing competence.

To date, no evaluation of the impact of CNA certification has taken place for any of the specialties/areas of practice. There is a need to develop a strategy for assessing the longer-term outcomes and impacts of certification on nursing practice in Canada by gathering information and perspectives on those factors that positively and negatively influence certification. This study will focus on the community health nursing specialty/area of practice and builds upon the work of Bassendowski and Petrucka (2008), who investigated the perceptions of the CNA certification exam and facilitators and barriers related to preparing for and writing the exam by those nurses who had achieved CCHN(C) certification in 2006 and 2007.

The Community Health Nurses of Canada (CHNC) Standing Committee on Certification, Standards and Competency acted as the Advisory Committee for the current evaluation research study, and named a project liaison contact person (Ruth Schofield) to facilitate the work of the consultants.

Purpose of the Evaluation Research Study

Funded by a grant from the Public Health Agency of Canada (PHAC), this evaluation research study is a joint effort of the CNA and the CHNC to gather information about the influence of certification on community health nursing practice in Canada. The activities carried out for this evaluation research study were aimed at:

1. Identifying the influences of CNA's community health nursing certification on nursing practice;
2. Identifying the influences of CNA's community health nursing certification on employing agencies;
3. Identifying organizational facilitators for CCHN(C) renewal;
4. Identifying organizational barriers to CCHN(C) renewal;
5. Exploring the intentions of the First Cohort of CCHN(C) certified nurses to re-certify; and
6. Creating an evaluation template that can be generalized to other CNA specialties/areas of practice.

The overarching research question is: "Does certification support excellence, competence, and quality in community health nursing practice? If so; how? What are the facilitators? If not; what are the obstacles?"

Background and Literature

Specialty certification is commonly used by various health care disciplines as well as other professional sectors. The requirements of certification processes vary considerably but typically include elements to evaluate specialized knowledge, lifelong learning, and quality improvement. Certification in a variety of specialty areas of nursing has existed for decades in Canada and the United States. Both CNA and several American nursing organizations endorse the value of certification (American Nurses Credentialing Center, 2010; American Board of Nursing Specialities, 2009). This section outlines the relevant literature related to certification. It appraises the results of two comprehensive literature reviews and a bibliography as well as primary studies that focus specifically on community health nursing.

Eldred (2005) conducted a comprehensive review of the nursing certification literature for the PHAC, CNA, and CHNC. The review aimed to identify papers, published and unpublished from 1996 onwards, that addressed measurement and evaluation of outcomes as a result of nursing specialty certification. The review found that the most common reasons for seeking certification were: recognition by co-workers and patients (credibility); feelings of personal growth and satisfaction; demonstration of professional knowledge and commitment; and maintenance and validation of specialized nursing knowledge. Other noted reasons to certify were the increased opportunities for career advancement, marketability, and higher pay; increased confidence; personal achievement; establishing professional credentials; and to meet employer requests. The reasons for not seeking certification were initial and maintenance costs; lack of organizational support or reward; lack of experience; and lack of preparation time or access to preparational materials for the examination. The

principal reasons for deciding to re-certify or not were lack of recognition and compensation; cost to re-certify; lack of time for continuing education; and personal circumstances.

According to Eldred, the most frequently cited paper in the certification literature was a paper by Cary (2001, cited in Eldred, 2005), which presented findings from nurses' perspectives on the effect of certification, one component of the International Study of Certified Registered Nurse Workforce. This study used a randomized sample of American and Canadian certified nurses (response rate of 48%; 19,452 of 40,426 surveyed). The international study, the only one found in Eldred's review that included community health nursing, was conducted in 1999, which was 7 years before CNA launched its CHN certification. Eldred observed that few studies have evaluated the outcome of certification on client care and those that have attempted to do so have unclear and conflicting results.

Wade (2009) conducted an integrative literature review of published literature from 1998 to 2008 to examine the effect of certification on patient outcomes, nurses' relationships with each other and with other health team members, and nurses' competence development, job satisfaction, sense of empowerment, and perceptions of their jobs. Twelve articles were included in the review, all of which were published between 2001 and 2007. Of these, six focussed on a specific subspecialty including one that focussed on public health nursing. This primary study will be described in more detail later. All but one of the 12 articles in Wade's review used a cross-sectional survey method. RNs were participants in all of the studies and health administrators/managers in five. The review categorized findings as nurses' perception of the intrinsic value of certification, empowerment, enhanced collaboration, patient satisfaction, clinical nursing competence and expertise, and lastly, patient outcomes. Overall the review found a positive association between certification and nurses' job satisfaction, sense of empowerment (defined as the extrinsic rewards of certification related to achievement and success), and sense of collaboration with other team members. Patient/client satisfaction was assessed in three studies based on nurses' self-report and found to be positively associated with certification in two. Eight studies assessed whether certification increased nurses' perceptions of their own competence and all but one showed a positive association. These studies also found that mangers valued certification but had no means to publicly acknowledge the credential. Two studies measured the effect of certification on patient/client outcomes. Both used self-report and one also included a chart review. One study reported better outcomes with certification and in the other there were no differences. Wade commented on the limitations of the reliance on self-reported perceptions but acknowledged the challenges with using more rigorous study designs. She recommended future studies should use a longitudinal design and be guided by a theoretical framework.

The American Board of Nursing Specialties (2010) recently published a bibliography of articles pertaining to a wide range of topics related to certification. A number of descriptive studies are identified, some of which demonstrate positive association between certification and patient/client care. For example, Coleman et al. (2009) determined that certified oncology nurses had better symptom management scores for pain and nausea treatment and followed clinical guidelines better than non-certified nurses. No articles in the bibliography focussed on outcome studies of community health nursing certification.

Two primary studies were related to community health nursing certification. A cross-sectional survey of American public health nurses (PHNs) in leadership roles, reported in two articles (Bekemeier, 2007; 2009), examined the extent to which PHNs value certification and the barriers they encounter to becoming certified. The study findings showed that participants perceived that certification was highly

valued by PHNs but that there was little extrinsic recognition for the credential and less awareness of certification among practising nurses than those in academic settings.

The other primary study was conducted in Canada by Bassendowski and Petrucka (2008) for CHNC. This study used a cross-sectional paper-based survey of community health nurses (CHNs) to examine the facilitators and barriers to CHN certification in Canada. Although there was a desire to also investigate the impact of certification on practice, this was not done because of the short time span between nurses writing the exam and the survey being conducted. Survey participants were CHNs who completed the certification examination in 2006 and 2007. The response to the survey was 44% (58 of 131 surveyed). The main motivators for completing certification were intrinsic factors of personal growth and validation of specialized knowledge and extrinsic recognition of having an advanced status. The main barriers to writing the exam were having one examination both for public health nursing and home care, inadequate preparation time, and lack of pay differential. The authors of the report recommended that CHNC should: investigate the feasibility of having separate certification examinations for public health and home care nurses; investigate the quantity and quality of materials provided by CNA to prepare for the exam and the possibility of developing or accessing additional materials; encourage members to form or join study groups to prepare for the exam; and consider dissemination of the results of the survey.

In summary, there is a substantial body of literature about specialty certification in nursing; however, only two studies have reported specifically on community health nursing certification. Most of the literature about certification in nursing has focused on the factors that influence the certification process. There are a growing number of articles that report on studies conducted to determine the impact of certification on nurses, employers, and patients/clients. To date these studies have relied on self-report by nurses in cross-sectional surveys. Overall, the results show a positive association between certification and nurses' sense of personal growth and validation of their specialized knowledge, external reward for their advanced status, and collaboration with other health team members. Measurement of the impact and outcomes of certification is at an earlier stage of development and has shown mixed results.

Methods

This evaluation research study used a mixed methods design to acquire data to meet the stated goal and objectives – that is, to assess the longer-term influences of certification on community health nursing practice in Canada, from the perspectives of members of the CHNC, CHNs with CCHN(C), and agencies that employ CHNs with CCHN(C).

Table 1. Data collection methods

Phase	Sample	Data Collection Method
1a	CHNC members plus CHNs with CCHN(C) not eligible for renewal in 2011 [Members+]	Electronic survey to identify influences of certification on individual nursing practice and on the employing agency; facilitators; barriers; ideas for improvement.
1b	Employers of CHNs with CCHN(C)	

Phase	Sample	Data Collection Method
2a	CHNC members plus CHNs with CCHN(C) not eligible for renewal in 2011 [Members+]	Focus group discussions (by teleconference or in person) regarding influences of certification on practice and on the employer; facilitators; barriers; ideas for improvement.
2b	Employers of CHNs with CCHN(C)	
3a	CHNC members plus CHNs with CCHN(C) not eligible for renewal in 2011	Individual telephone interviews to acquire in-depth stories of practice implications of certification; facilitators; barriers; ideas for improvement.
3b	Employers of CHNs with CCHN(C)	
4	CCHN(C) Cohort 1	Electronic survey about intent to renew certification and reasons for their choice (e.g., facilitators; barriers; ideas for improvement).
5	CCHN(C) Cohort 1	Focus group discussions and individual telephone interviews to acquire in-depth stories of practice implications of certification, intent to renew, barriers/facilitators in the renewal process, and suggestions to improve the process of recertification.

This evaluation research study was approved by the Ethics Review Board of both the University of Calgary and Dalhousie University (see Appendix A).

Three surveys were designed and approved by the Advisory Committee: one for CHNC members plus CHNs with CCHN(C) (not eligible for renewal in 2011); one for employers; and one for the First Cohort of CHNs with CCHN(C), that is, those who are eligible for renewal in 2011 (see Appendix B). The surveys were designed based on the Perceived Value of Certification Tool (PVCT) developed by Gaberson et al. (2003) for use with perioperative nurses. The PVCT was found to have an internal consistency reliability (Cronbach's standardized α) of .924. The PVCT has been adapted for use with other nursing specialties, including one survey with public health nurses. We attempted to contact the author of the PVCT but were unsuccessful. Therefore the content of the surveys for this evaluation study were validated by a panel of three experts in community health nursing and pilot tested by six volunteers for readability, clarity, and length of time to complete the survey forms (see Appendix C).

A list of CHNs with CCHN(C), including contact information, was provided by CNA; those in the First Cohort (2006) were separated out for the re-certification survey. CHNC members were identified in a list maintained by the Administrative Manager of the CHNC, with employers (e.g., self-identified as administrators, directors, managers) being separated out for the employer survey. A modified snowball sampling strategy was also carried out to locate employers for surveys and interviews. Both CNA and CHNC put notices on their respective websites to encourage CHNs to respond to the survey; web links were provided in these notices so those interested could select the correct survey.

The three surveys were delivered electronically[1] using a method that did not disclose recipients' names and protected their privacy. Embedded within each survey was a cover letter that explained the survey and its purpose; respondents had to indicate consent before the survey itself was made available for completion. Reminders were sent to non-responders each week for three weeks to elicit the best

[1] The CHNC subscription to Survey Monkey™ was used.

possible response rate. Within the surveys there was an option to volunteer for a focus group (by teleconference) or an individual interview.

Participants were selected purposively for teleconferenced focus groups and interviews from among volunteers from the electronic survey to ensure participation from across the Canadian provinces and territories. Invitations to participate included a link to an information sheet (Appendix D) so that informed consent (Appendix E) could be acquired. Focus group participants and interviewees either returned signed consent forms by scan or fax or provided oral consent at the beginning of the teleconference. Codes were provided for each participant to use in lieu of names to protect their privacy. An interview and focus group guide was developed, approved by the Advisory Committee, and used by the researchers to engage the selected participants in meaningful conversations about the impact of certification on practice, employing agencies, community partners, and clients (Appendix F).

The intent of the three different surveys, focus groups, and interviews was to collect perspectives from those employing CHNs (both certified and not), CHNs with and without CCHN(C), and from those CHNs with CCHN(C) from the first cohort that had the longest duration of experience with CCHN(C). By triangulating the perspectives, we will be able to see if and where there are similarities and differences and what sorts of recommendations can be made to address emerging issues.

Analysis

Survey Monkey™ provided the collated response numbers from each survey. The research team performed simple descriptive statistics and calculated proportions. Phases 1 and 4 were analysed in this way.

Phases 2, 3, and 5 (focus group discussions and individual interviews) were analysed qualitatively by seeking themes and patterns in the data. The literature, data from the other phases of the evaluation research study, and member-checking with the CHNC Advisory Committee informed the analysis.

Presentation of Results

This section begins with the description of participation, including survey response rates, survey sample, and focus group and interview (narrative) sample. In the presentation of results by theme areas that follows, each section presents the survey results first, followed by the results of the narrative data.

Participation

This study invited participation in two methods of data collection, surveys and focus groups and interviews.

Survey response rates

Surveys were used to collect data in Phases 1 and 4 of the study. In Phase 1, surveys were sent to two groups: CHNC members and CHNs with CCHN(C) not eligible for renewal in 2011, group referred to as “Members+”; and those identified from CHNC membership information as directors, managers, and administrators, group referred to as “Employers”. The surveys for these two groups were the same, except for questions about demographics. In Phase 4, surveys were used to collect data from the first

cohort of nurses to receive CCHN(C) in 2006 and eligible for rectification in 2011; we refer to this group as “First Cohort”.

Of a total of 513 surveys sent, 256 surveys were completed: 177 from the Members+ survey (62.1% response rate); 31 from the Employers survey (26.1% response rate); and 48 from the First Cohort survey (44.0% response rate).

There was a four week period for survey data collection. Members+ and First Cohort surveys were sent out in Week 1. Because of the process used to identify Employers, the distribution of these surveys was delayed by about two weeks. It may be that the response rate for Employers was affected by the shorter time frame for response. It is also possible that Employers may have inadvertently received and completed the Members+ survey before receiving the Employers survey; we assume respondents would have completed only one survey even if duplicates were received so this too may have affected the response rate for the Employers survey. Weekly reminders to complete the surveys, sent to non-responders, resulted in small increases in responses, allowing the researchers to conclude that adequate steps were taken to achieve the best response rate in the time allocated for data collection.

There is some variation in the response rates for the individual survey items, as the survey allowed for “no response” (i.e., not selecting an answer to a question) and some respondents did not answer all the questions. The response rates tended to decrease slightly for the questions related to certification, and especially the items related to facilitators to certification. We can speculate that this may be due to the fact that not all respondents have achieved certification, and therefore may have chosen not to comment for these items.

Please refer to Appendix G for the response rates for each survey.

Description of survey sample

Each of the three surveys asked a number of questions related to the demographic information of the community health nurse or to organizations that employ CHNs (See Appendix B.)

The demographic information gleaned from the Members+ survey and the First Cohort survey appears to be fairly similar, only diverging in a few areas. For both groups the vast majority of respondents are female (Members+ 98.3%; First Cohort 97.9%). Age distribution is similar for both groups.

Table 2. Age distribution of survey respondents

Group	20-29 years	30-39 years	40-49 years	50-59 years	60+ years
Members+	4.1%	14.5%	37.2%	39.0%	5.2%
First Cohort	0.0%	12.8%	34.0%	46.8%	6.4%

The majority of respondents are working full-time in the area of public health (Members+ 58.5%; First Cohort 46.8%). For Members+, the scope of practice was primarily in direct care such as clinical or front line (63.3%), whereas those in the First Cohort tended to have a greater focus on administrative roles (46.7%).

Table 3. Focus of practice for survey respondents

Practice Area	Members+	First Cohort
Direct care	63.3%	37.8%
Administration	18.9%	46.7%
Professional Development	15.4%	15.6%
Education	2.4%	0.0%

There were other similarities for repondents in the Members+ and First Cohort surveys. For organizational structure and size, the majority of respondents reported working for a local health unit or regional health authority (Members+ 81.4%; First Cohort 76.2%), with a small number in community health centres, government agencies and education institutions. The majority of respondents indicated that they have been working in community health nursing for eleven or more years (Members+ 64.7%; First Cohort 93.5%), which is consistent with the age patterns in the responses (as reported in Table 2). A baccalaureate in nursing was the most common educational credential among the respondents (Members+ 75.2%; First Cohort 77.3%). Respondents were not limited to one choice for educational credential, so some of these respondents may have achieved additional educational credentials beyond a baccalaureate in nursing.

Demographic information collected in the Employers survey was consistent with the information reported by the Members+ and First Cohort. Employers worked primarily the area of public health (77.8%). Most Employers indicated they represented local or regional level organizations (85.1%).

Survey respondents came from across Canada, although not all groups had respondents from all provinces and territories.There were no respondents from Quebec in any of the three surveys.

A complete presentation of the survey results can be found in Appendix H, I, & J.

Description of narrative sample

Those that responded to the three surveys were invited to indicate their willingness to be contacted for a focus group, interview, or both. Table 4 shows the numbers of respondents who volunteered and the number who participated in Phases 2, 3, and 5 data collection.

Table 4. Number of volunteers and participants in focus groups and interviews

Group	Volunteered	Participants in Focus Groups	Participants in Interviews
Members+ and Employers	90	24	9
First Cohort	30	9	5

We were able to engage 37% of the Members+ and Employers respondents that volunteered to be contacted in either focus group discussions or interviews. Forty-six percent of the volunteers from the First Cohort were engaged in either a focus group discussion or interview. The participants in Phases 2, 3, and 5 of the study were from all parts of the country except Quebec and the three Territories. They were divided fairly evenly between managers and front-line staff, with a smaller proportion from the ranks of clinical practice leaders. Similar to survey respondents, there was a bias toward public health, but it was not as great as with the surveys.

Table 5. Demographic data for participants in focus groups and interviews

Location	Atlantic	5
	QC/ON*	12
	MB/SK	6
	AB/BC	24
	YK/NT/NU	0
Role	Manager	22
	Clinical Leader	8
	CHN (front line)	17
Type of Agency	PHN	31
	Home/Visiting	13
	Other	3

* All from Ontario.

THE INFLUENCE OF CCHN(C) CERTIFICATION ON COMMUNITY HEALTH NURSING PRACTICE

In this section we illustrate how certification influences CHNs and their practice, along with examples that pertain to community practice. As well, the influence of certification on the workplace is discussed. How community partners and clients benefit from the certification of CHNs is also discussed, and challenges are detailed. Note that a complete presentation of the survey data is found in appendices H, I, and J.

Influences on CHNs

According to the survey, Members+ reported that CHNs with CCHN(C) are more likely than CHNs without CCHN(C) to promote certification among their colleagues (90.1%), are better prepared for positions of added responsibility (65.7%), to apply and talk about research in practice decisions (64.8%), and are more up-to-date in their knowledge (76.1%). They are somewhat more able to work to full scope of practice (49.7%), are more credible in interprofessional and multidisciplinary roles (62.0%), and satisfy their clients with the service they provide (59.9%). They do not cause tension among their colleagues without CCHN(C) (85.3%). Interestingly, CHNs with CCHN(C) are not viewed as more credible with clients than CHNs without CCHN(C) (56.4%). Employers agreed with Members+ on all of the statements above. Of Employers that expressed an opinion (n=12), 67% disagreed that CHNs with CCHN(C) worked more autonomously than CHNs without CCHN(C). From the perspective of the First Cohort, they reported they felt more empowered (68.8%), more satisfied with their work (66.7%), and better able to collaborate with others than their colleagues without CCHN(C) (51.1%). In other aspects, they were in agreement with the responses of Members+ and Employers.

Most of the interviewees reported that CCHN(C) certification made them feel more confident and more professionally competent. Studying for the exam opened them to a breadth of information that they might otherwise not have been exposed. For example, home care nurses learned about vaccination and public health nurses learned about new advances in wound care as they became more familiar with the wider field of community health nursing so that they could locate themselves better on the continuum of care. They described themselves as “thinking at a higher level” and being more likely to use the literature in making practice decisions in terms of “synthesizing and connecting the dots”. Certification was an acknowledgement of professional and content expertise and the interviewees felt they were making a difference in their peer groups since certification. They felt they had current knowledge and “had the language, the words” to better articulate their concerns and their suggestions

for action. Indeed, certification made many of them feel "enriched, energized, excited and enthusiastic" about their work. They said that while the pre-reading and preparation was "daunting" and the exam challenging (indeed, "terrifying") achieving certification was "fabulous, and a huge piece of pride" in their accomplishment. Passing the exam and becoming certified "validated their knowledge" and lent credibility to their expertise in their workplaces.

Certification is not about gathering letters after your name – it's a signal of excellence.

Did they feel appreciated by their workplaces? Yes. They used phrases like "I felt competent, valuable, needed and wanted" by my manager and team. They also reported feeling a better sense of opportunity within their work – they were more confident about speaking up, about volunteering, about outreach to new community partners, and about career opportunities.

> "I am not sure certification itself improves my ability to move up the career ladder, but I am certainly more confident about answering interview questions. I think that gives me an edge."

Because they felt more confident, competent, and more capable of learning, several interviewees reported taking leadership courses and taking the steps toward a graduate degree (e.g., MN, MPH) since becoming CCHN(C) certified. To demonstrate their pride, several nurses displayed their certificates in their cubicles, used the red CNA certification lanyards, and wore their certification pin at work.

Influences on practice

According to the survey, Members+ and First Cohort respondents agreed overwhelmingly that CCHN(C) certification demonstrated their acceptance of a professional challenge (Members+ 97.5%; First Cohort 97.7%) and showed evidence of professional commitment (Members+ 98.2%; First Cohort 97.8%). Not only did they attain a practice standard and competency (Members+ 96.9%; First Cohort 97.8%), CCHN(C) certification gave them greater personal satisfaction (Members+ 98.2%; First Cohort 97.8%), enhanced their feelings of personal accomplishment (Members+ 98.8%; First Cohort 97.8%), and offered opportunity for professional growth (Members+ 96.3%; First Cohort 80.0%). The First Cohort only slightly agreed more than disagreed with the statement that quality of communication with colleagues has improved since they achieved CCHN(C) certification. The First Cohort did not agree that they had different work assignments than their CHN colleagues without CCHN(C) (84.4%). Both Members+ and First Cohort respondents agreed that they felt more professional accountability (Members+ 83.3%; First Cohort 73.4%), higher level of clinical competence (Members+ 79.1%; First Cohort 62.2%), enhanced professional credibility (Members+ 90.0%; First Cohort 86.6%), and that their specialized knowledge was validated as a result of CCHN(C) certification (Members+ 94.4%; First Cohort 91.1%). The First Cohort reported enhanced personal confidence (75.6%) and managerial confidence (55.6%) in their clinical abilities, and both Members+ and First Cohort reported increased job satisfaction (Members+ 73.6%; First Cohort 60.0%).

CCHN(C) certification was viewed as having several influences on CHN practice, as compared to the practice of CHNs without CCHN(C). Members+ see the major areas of distinction as the currency of knowledge and promotion of certification among colleagues. They do not see being certified as a cause tension with colleagues.

Table 6. Members+ responses comparing practice of CHNs with and without CCHN(C)

Answer Options	No opinion	Disagree/Strongly Disagree	Agree/Strongly Agree
Work to a more full scope of practice	9.2%	4.1%	47.9%
Are more up-to-date in their knowledge	6.7%	17.2%	76.1%
Are noted by clients as credible specialists in their area of practice	17.8%	56.4%	25.8%
Satisfy clients with the service provided	19.1%	21.0%	59.9%
Are more credible in interprofessional/multidisciplinary contexts	12.9%	25.1%	62.0%
Apply and talk about research in practice decisions	14.2%	21.0%	64.8%
Are better prepared for positions of added responsibility	10.4%	24.0%	65.7%
Are more likely to promote certification among colleagues	3.8%	6.3%	90.1%
Are more likely to create tension among non-certified colleagues	9.2%	85.3%	5.5%

*Percentages may not add to 100 because of rounding

First Cohort responded similarly, agreeing and disagreeing on the same items as Members+. One-third of the Employers respondents skipped the question comparing CHNs with and without CCHN(C). Of those that did respond (n=21), on average more than 1/3 of them (mean = 8.5) responded with "no opinion". Those that did express an opinion reported that CHNs with CCHN(C) were more likely than CHNs without CCHN(C) to be up-to-date on their knowledge (73.3% of 15), to be more credible in inter-professional/multidisciplinary contexts (64.2% of 14), and to be more likely to promote certification among colleagues (87.5% of 16).

Within the context of focus groups and interviews, how certification influenced community health nursing practice was difficult to articulate for all groups. Interviewees and focus group participants reported carrying out many of the same tasks, but with a different perspective.

> "It's a lens or framework to mobilize practice in the community, whether with individuals, families, or community partners."

One CHN commented that she felt more "evidence-minded" since she achieved her CCHN(C) certification. She realizes the effects of her practice on clients and communities, and feels she has become more client centred, a better listener, and more focused on root causes of problems and upstream implications. By encouraging participation and community involvement she puts the CCHN Standards (CHNC, 2003, 2008) into practice and reaps the benefits along with the clients and communities she serves. Many CHNs interviewed reported feeling more effective as advocates for practice, for clients, and for the community since achieving certification. "I am working more to my full potential now" and more to full scope of practice.

In one focus group with CHNs both with and without CCHN(C), participants with CCHN(C) certification tried to explain to those without how their practice had changed since becoming certified. Those without CCHN(C) claimed they "couldn't really see the difference" in their certified colleagues' work. In response the following was offered:

I am changed on the inside. You can't see it from the outside looking in.

> "I am changed on the inside. You can't see it from the outside looking in. I just *know* I think differently and I look at things differently now."

> "Before, I couldn't really articulate what I was doing and why. Then, after being introduced to theory and reading the material for the exam, I could see how the theory was exemplified in my practice - how theory informs practice."

> "As a clinical educator, I mentored many of the nurses who went for certification. I can see the difference. It is very apparent when they talk about their clients, their work, their plans."

When asked if the CCHN Standards of Practice (CHNC, 2003, 2008) inform their performance appraisals, most CHNs said "not really". Performance appraisal tools were, in the main, generic to the employer and not specific to CHN practice. This prevented CHNs with CCHN(C) from being able to state with any degree of confidence how their care was "better" or how clients benefited. Nor were they able to present any ideas of what practices might be used to demonstrate changes in effectiveness, efficiency, quality, and safety (other than in the vaccination, medication, wound care) areas.

What indicators could be employed to measure quality and safety were not raised for discussion, other than to say "we don't (or can't) collect data on that". Several CHNs commented on the lack of technology to roll up important client data to uncover trends in health status whether for individuals, families, or communities. Those CHNs with CCHN(C) did note, however, that this inability to demonstrate the effect their CCHN(C) certification had on their clients was troubling. Because of certification they claimed to be more "evaluation-minded" and were concerned that without evidence to convey the impact of their expertise on client outcomes they would not gain ground in comparison to other nursing specialties (e.g., critical care).

CHNs with CCHN(C) found themselves becoming role models and mentors, and felt that they were part of a learning and practice community that they had not experienced previously. They saw the identity of community health as a nursing practice specialty as extending across the nation, not only as a local phenomenon – they expressed feeling a "comradeship" with CHNs across the country in all the settings they practice. Many said it was the CCHN Standards of Practice (CHNC, 2003, 2008) that drew them together and validated their work. The Standards allowed them to view practice in a different light, and understanding the breadth of community health nursing allowed them to consolidate and broaden their networks. Many of the CHNs with CCHN(C) interviewed talked about certification as a demonstration of their commitment to the profession and to the specialty.

Certification is not without its personal and professional downsides. Several interviewees noted that there were few tangible rewards in many organizations – certification had to be of intrinsic value to the nurse him/herself. CHNS with CCHN(C) talked about the challenges of being certified. Managers and team members had higher expectations of CHNs with CCHN(C) for orienting new staff and taking the lead on projects and new initiatives. Schools of nursing asked for them more often as preceptors for students. In such examples, CCHN(C) certification became a "burden". However, most reported these burdens were light in comparison to the professional benefits and personal rewards they enjoyed as a result of becoming certified. An important downside reported was knowing now what best practices were, and how a nurse "should respond if being guided by the Standards", CHNs with CCHN(C) felt challenged by the ethical issues they faced when they were unable to fulfil those expectations.

"If there is no time, no resources, and no budget, it's hard to pull back when you know what could and should be done. But if you do it, there are consequences to yourself – overtime, stress, a slap on the hand (or worse). It can be frustrating."

Several managers agreed there were more ethical issues being brought to their attention by CHNs with CCHN(C) and being raised at staff meetings than in the past. However, they felt this was a positive result of CCHN(C) certification – one that opened practice to scrutiny in a context where CHNs practised (for the most part) outside the view of others.

Influences on the organizations employing CHNs with CCHN(C)

Members+ were asked to indicate how their employing organizations had responded to CCHN(C) certification for CHNs. CCHN(C) certification was viewed as having several influences on employing organizations. Most respondents felt that organizations had made little response as a result of certification, except in the areas of support provision and recognition who CHNs who became certified.

Table 7. Members+ opinions on employing organizations' response to CCHN(C) certification for CHNs

Answer Options	No Opinion	Disagree/Strongly Disagree	Agree/Strongly Agree
Amended its job descriptions to fit the CCHN Standards	11.7%	54.6%	33.8
Amended its performance appraisal formats to fit the CCHN Standards	9.8%	55.2%	35.0%
Changed the qualifications it seeks when hiring registered nurses	13.8%	65.4%	20.8%
Adjusted pay scales to accommodate nurses with certification	4.3%	83.3%	12.1%
Become more aware of its continuing education responsibilities for certified nurses	5.5%	60.1%	34.3%
Offered more access to continuing education or professional development opportunities now than in the past	5.6%	65.5%	29.1%
Provided recognition for nurses who become certified	4.3%	44.1%	51.6%
Offered incentives for certification	4.3%	66.9%	28.9%
Provided support for certification	4.9%	28.4%	66.7%
Expressed desire that nurses who are currently certified maintain and renew their CCHN certification	14.8%	51.2%	34.0%
Acted to reduce or eliminate obstacles they were made aware of	25.8%	36.8%	37.4%
Informed the public that we have specialist nurses on staff	9.9%	80.3%	9.9%

*Percentages may not add to 100 because of rounding

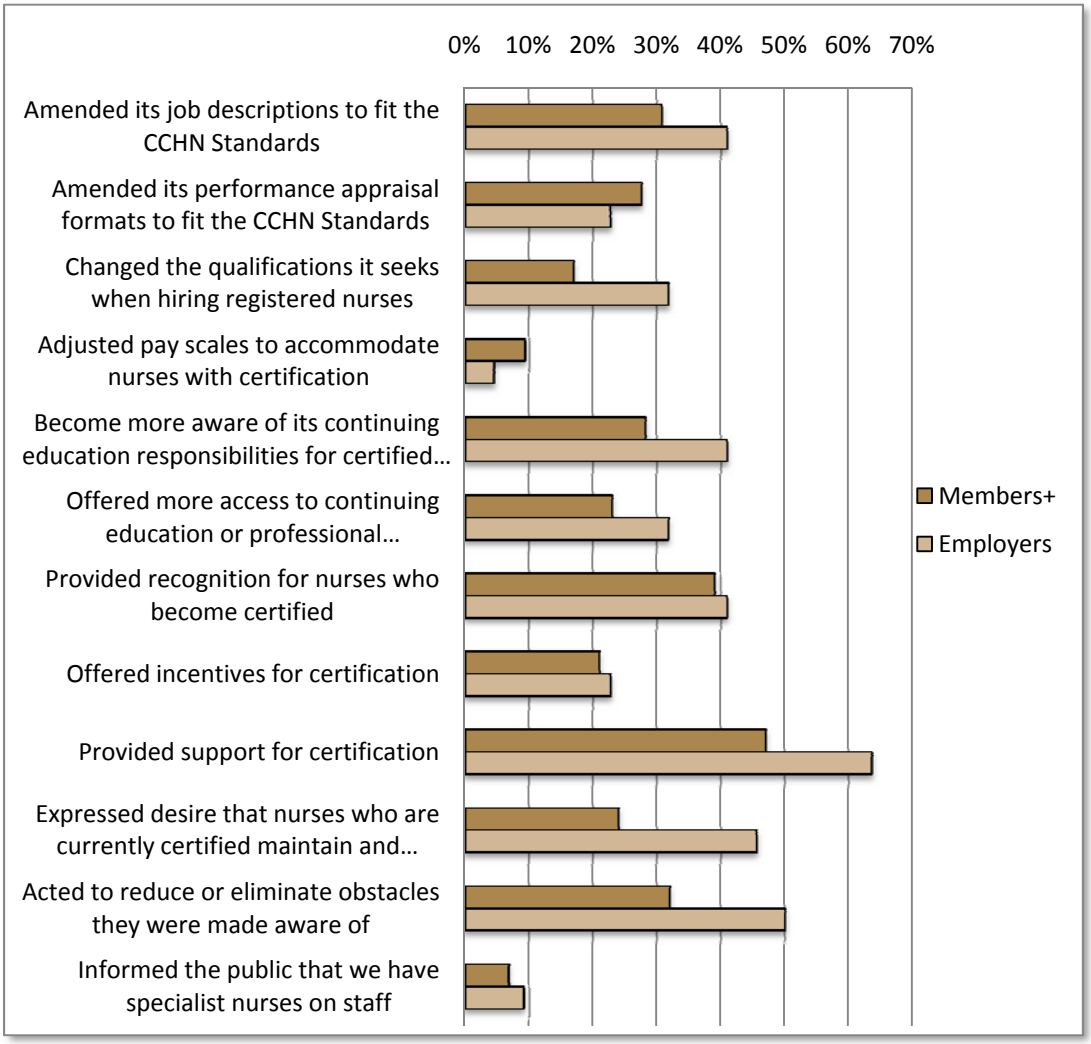
Results of the Employers survey show some disagreement with the perceptions of Members+ on items regarding the amendment of job descriptions to fit the CCHN Standards; awareness of and access to continuing education responsibilities for CHNs with CCHN(C); support for CCHN(C) certification; and desiring the maintenance and renewal CCHN(C) certification. Employers claim they take action upon hearing about barriers or obstacles to certification to reduce them. They also report that their organizations are implementing more evidence-based practice guidelines.

The majority of Employers did recognize that performance appraisal formats have not yet been amended to fit CCHN Standards (59.1%), that they have not changed officially the qualifications they seek when hiring CHNs (45.5%), that they have not been able to adjust pay scales to remunerate CHNs with CCHN(C) (77.3%), and that they do not offer incentives for CCHN(C) certification (63.6%). Employers were evenly divided as to whether they agreed (45.4%) or disagreed (40.9%) with the statement that they provide recognition for CHNs who become CCHN(C)-certified.

The majority of Employers had no opinion when it came to determining if collaborative relationships with other organizations had improved (36.4%), if collaborative relationships with other disciplines had improved (33.3%), or if client/patient care outcomes had improved (57.1%).

Therefore, while there is agreement between Members+ and Employers as to the influence of the CCHN(C) on organizations that employ CHNs, it appears that Employers tend to hold the opinion that they are being more responsive to the needs of CCHN(C) certification than Members+ find them to be. Of key importance, however, is the finding that 60% of Employers expressed "no opinion" about improvement in community (individual, family, population) care outcomes as a result of having CHNs with CCHN(C) on staff.

Figure 1. Comparison of Members+ and Employers agreement to organization response to CCHN(C)



Managers who were interviewed worked in diverse settings – home care, community care, public health – in large or small departments, with reporting relationships to nurses or non-nurses, in environments with more or less union involvement, in government, not-for-profit or in competitive markets for service contracts. We spoke with managers who were having difficulty getting their staff to become certified, and with others who had high rates of uptake of certification. As a result, there was diversity in the responses to the questions posed to them.

Overall, managers felt that having CHNs with CCHN(C) on staff (and the more the better) garnered a positive status and a reputation for excellence. It put the department, agency, or unit "on the map" by demonstrating that the key players (i.e., middle managers, clinical educators, front-line nurses) were experts in their field with current knowledge and credibility that could be counted on to ensure quality service provision. Some self-labelled cynics (from the Members+ group) called this "public relations" when they felt lip service was being paid to their achievements rather than true appreciation being expressed for their hard work and accomplishments. In actual fact, being able to demonstrate the quality of nursing personnel was a key factor in successfully competing for contract work for several home visiting agencies.

Prior to the advent of CCHN(C) certification, many managers noted a separation between the public health and home/community care roles of CHNs. With the certification process and the formation of study groups with members from diverse employment settings, this gap is beginning to close as each group is developing a better understanding of the broader field of community health nursing (Schofield, 2010). Closing the gap has had positive influence on the workplace since networks and contacts have grown and blossomed. This situation, however, was not universal. Funding arrangements differ across jurisdictions, and home care and public health service providers do not enjoy close relations in all parts of the country.

All managers noted that certification has increased the energy in their workplaces and improved morale as job satisfaction has increased, and they talked about how CHNs with CCHN(C) now were more vocal in presenting issues, advocating for clients and programs, and using the CCHN Standards to reflect on practice. They observed with pride the role of their organization's CHNs with CCHN(C) in policy development and review, community partnerships, and professional advocacy.

Because of the currency and strength of their knowledge and expertise, managers felt that CHNs with CCHN(C) were in a position to be "first responders" when emergent situations arose, such as H1N1. They saw this credential as evidence of the ability to "think and process a lot of information quickly and accurately" because they knew where to go for the best practice literature and were confident in their knowledge in group situations with other providers (e.g., medical officers).

Managers are often in a situation where they know that doing something will produce beneficial results, but they cannot attain it. For instance, most would like to put "CCHN(C) preferred" on job postings but are precluded from doing so because of union contracts and other agreements. Further, they are aware that if they do this in the context of a nursing shortage, they might not be able to recruit and develop nurses because RNs without the required certification will not apply for the posted positions. In home/community care, other sorts of certification are needed to serve clients – specialisation in enterostomal nursing, gerontology, nephrology, oncology, psych-mental health, rehabilitation – and adding CCHN(C) to the job requirements for home/community care CHNs poses a challenge that most managers cannot address. Adding further to the challenges faced, managers are trying to cope with increasing demands for services, constraints on budgets, and lack of understanding of community health nursing in the acute care settings that demand the bulk of health care funds.

With regard to retention, the requirement for continuous learning means that many managers have advocated successfully for a greater organizational commitment to professional development support and continuous learning activities in community health. Many contracts allow for a certain amount of time or financial support for continuous learning, but others do not. In many cases, managers find external sources of funding and encourage and provide reference letters and other support for CHNs to access financial support for certification and continuous learning.

The context of community health nursing is changing, and because of that, there are changes in organizational culture. The average age of the community health nursing workforce means that with retirements increasing there is increasing turnover in the workforce. With the move to population-focused practice in public health nursing, higher technological demands in home care nursing, the implementation of multiple disciplines in both settings, and shortage in the supply of nurses, some employers see CCHN(C) certification as a means of "levelling the playing field" by placing focus on the CCHN Standards of Practice (CHNC, 2003, 2008) and Public Health Nursing Discipline Specific Competencies (CHNC, 2009). This caused more than one interviewee to comment on the growing "generation gap" in the workforce, and that more senior front-line CHNs may not be as interested in CCHN(C) certification as younger nurses just coming on board. Many of the more experienced CHNs may have come from a time and place where BN education was not an option (some may be RN diploma prepared, particularly in remote and rural areas of the country) and seeking credentials ("papers; letters after their names") was not a priority. By implication, new BN-prepared CHNs – many coming to community health organizations from acute care hospitals – were seen as hungrier for specialist credentials and more nimble with population-focused practice since they were exposed to it during their undergraduate BN education. The changing context of practice can set up either positive opportunities for mentorship or frustrating experiences for all parties. Managers maintained a high level of watchfulness for instances of tension and communication problems when junior CHNs became more credentialed than senior staff, but could not provide examples where this has occurred.

Managers recognized that an investment in CCHN(C) certification would reap benefits to their workplace, but often felt that their "hands were tied" by senior levels of administration, contracts, and competing organizational priorities. They felt unable to influence human resource policies or compensation for nurses. They were under "very tight budgets" in virtually all cases. Nevertheless, they were as one committed to advocating for systems that acknowledged and supported excellence in community health nursing practice. There was a great deal of variation across the country in terms of compensation for CHNs with CCHN(C) and support for the certification process, and no manager reported a financial examination of the costs of certification on budgets or the benefits potentially associated with improved recruitment, retention, or quality of care as a result of certification. This assessment may be seen as somewhat premature due to the relatively small numbers of CHNs with CCHN(C) in most agencies; however, even those with a large proportion of CHNs with CCHN(C) had not examined budget impacts of certification.

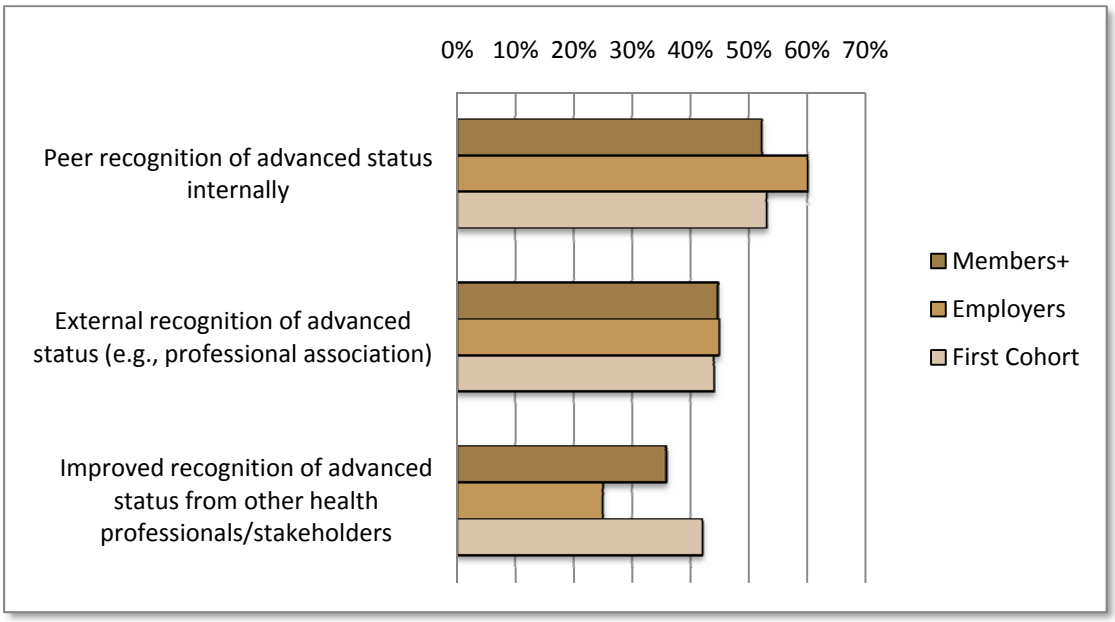
Almost all managers interviewed valued the role that the CCHN Standards of Practice (CHNC 2003, 2008), Core Competencies for Public Health in Canada (PHAC, 2007), and the Public Health Nursing Discipline Specific Competencies (CHNC, 2009) have brought to their departments. They were all informally (and deftly) weaving these into job calls, position descriptions, performance management tools, and interview questions. Informally, and carefully, they let people on the casual rolls know that certification "might give them a leg up" in hiring decisions. The Standards, reported some, described what community health nursing "can be" and "should be" in order to ensure quality and safety. All wanted to know what aspects of nursing care could and should be used to demonstrate changes in

performance, quality and safety, and what on indicators they should be collecting data to make the case for CCHN(C) certification. A challenge all were facing was the diversity in settings across the country; they called for a national approach to the demonstration of the impact of CCHN(C) certification on community health nursing practice to the community, and to clients – "not a patchwork quilt". They did not want each province to take action and end up with different types of evaluations, measuring different indicators, and using different outcome measures, thus preventing useful and comparative results on which to build decisions. They wanted a cohesive, collaborative, common approach that would serve the profession well.

Influences on community partners

Outcomes of CCHN(C) certification related to community partners were identified within all three surveys. The majority of Members+, Employers, and First Cohort respondents reported that CCHN(C) certification improved recognition of their status internally (Members+ 66.8%; Employers 65.0%; First Cohort 71.1%) and externally (Members+ 56.6%; Employers 45.0%; First Cohort 55.5%) within a professional association. Respondents from all three surveys did not agree that CCHN(C) certification improved recognition of advanced status from other health professionals or stakeholders (Members+ 45.3%; Employers %; First Cohort 48.9%). The majority of Employers responded that they had "no opinion" when asked whether there was improved recognition of advanced status from other health professionals and stakeholders (50.0%).

Figure 2. Outcomes of CCHN(C) certification related to community partners



When asked during focus groups and interviews about the influence of certification on partners, many of those interviewed saw two types of partners: internal and external. Internal partners were those other people and departments that were essential to the work of community health. Externally were the partners in the community with whom they collaborated to improve the health of individual clients or of population groups. They also spoke about "partners in nursing"; that is, having a stronger identity as a specialty in nursing gave more impetus to a stronger link to the nursing profession as a whole.

Many of the CHNs interviewed put their CCHN(C) designation on their business cards. If partners noticed, CHNs were prepared to answer questions about what the letters meant and how they achieved them. None had ever been asked! In community health nursing work settings, other CHNs knew what the letters denoted and what the process was to achieve them. But even though CHNs with CCHN(C) were acknowledged in agency newsletters or by other internal communications when they achieved their certificates, other internal partners (e.g., senior administration, human resource department, medical officers) were silent. As to community agencies or groups, they too evinced little to no curiosity about the CCHN(C) designation and what impact it might have on their relationship with that CHN.

Let's begin with internal partners that were viewed as instrumental in community health nursing work. The first internal department that affected community health nursing was Human Relations (HR), the department responsible for policies regarding recruitment, hiring, performance appraisal, compensation, and managing the collective agreement. Managers felt they had little influence in HR policies; several reported experiencing challenges in implementing the CCHN Standards of Practice (CHNC, 2003, 2008) into recruitment and hiring processes and into performance appraisal systems, regardless of whether they were part of a large nursing union collective agreement, local agreement, or part of a non-nursing contract (e.g., when the employer was a city, not a health care agency).

Community health nursing staff and managers in general held a healthy mistrust of senior administration in regional governance models of health care administration. In the midst of H1N1, administration and HR in one organization, as a cost-cutting measure, replaced a number of CHN (BN required) positions with LPNs (licensed practical nurses) without consultation, and immediately hired to fill those positions. No amount of argument or advocacy has been able to change this situation. Participants stated that regardless of whether or not you believe LPNs have a place in community health nursing, changes in personnel qualifications require planning and discussion about what accommodations have to be made in the work situation and how these will be accomplished.

We need to toot our horns a bit more!

For those CHNs with a public health focus, other internal partners were those people and departments/units that were part of the larger public health field. Today, particularly in larger organizations, public health workers are isolated in narrow fields of practice – sexual health, communicable disease (CD), schools – and there is not a great deal of interaction among these narrow fields. In fact, there are often competition and little cross-communication among the nurses in those areas; examples of misunderstandings and disrespect were shared in interviews. In one example, CHNs with CCHN(C) could have supplemented the CD nurses in response to H1N1, but instead senior officials opted to hire new graduates to support the H1N1 mass vaccination efforts. This flew in the face of the CHNs with CCHN(C) who had demonstrated competence in CD on the certification exam, and (in the opinion of the interviewee) would have been a safer option. Some nurse managers believed that other nurses (e.g., in acute care) did not value community health nursing as "real nursing" and referred to CHNs as "high heeled nurses" who didn't do shift work (incorrect) and didn't work weekends (also incorrect). There was also concern expressed that Medical Officers and family (primary care) physicians did not understand the role of CHNs and as a result undermined their ability to work to full scope.

The situation is changing in some instances, however. Examples were provided that illustrated how having CCHN(C) certification and becoming more confident in personal knowledge and skill were creating situations where individual nurses, or groups of nurses, were becoming more assertive (less subservient) and questioning the status quo effectively. In one instance, a community nurse needed to

contact a physician about a client issue and, rather than asking how to handle a particular situation, told the physician how she wanted to handle it and what she needed the physician to do. The physician followed up this conversation with a call to her manager - and complimented the nurse on her initiative and knowledge.

With respect to community partners, overall there seemed to be little notice taken of CCHN(C) certification on their parts. The CHNs and managers saw a difference in practice, however, with CHNs having more confidence and capacity to advocate for individual clients or population groups. In one example, a CHN with CCHN(C) working in home care heard from her client that the local church had just hired a parish nurse. The client was curious about what that nurse would do. The home care nurse had several clients in the area, so she met with the parish nurse and together they planned how home-bound clients could benefit from the services of the parish. Without being involved in a study group that crossed many aspects of community health nursing practice, the CHN might otherwise not have thought about her clients as a population group, nor would she have been aware of faith-based community services that could provide an additional service to them.

The CHNs interviewed described how the process of becoming certified exposed them to new knowledge and approaches. Being more aware of the role of the CHN in community capacity building made them more likely to reach out to service providers/agencies in the community with whom they might not have partnered in the past. They reported finding it easier to talk to them about common issues (examples included: immigrants and refugees, schools, justice, mental health, family violence, dental) in populations of mutual interest. One downside they experienced was that after raising expectations of working together "H1N1 came along and sucked the energy out of everything" and they were not able to meet their commitments; CHNs suffered a blow to their community credibility they are now working hard to overcome. In many cases the pandemic response was managed regionally or provincially, not locally, so the CHNs had less control over their time and work than they otherwise would have, and communications broke down with local community partners.

Two other benefits of certification to community agencies are the ability of CHNs with CCHN(C) to use the language and evidence to write successful proposals (either for funding or for new programs), and their commitment to evaluation. What indicators to use and how to collect data still poses problems, but CHNs are making gains in creating a context where evaluation of a program's outcomes and impacts are, at a minimum, being talked about. While partners might not "see" the impact of CCHN(C) certification, CHNs doing their annual school work plans were able to identify how certification helped them:

> "Now we are naming what we were doing – we have the language to explain! We were doing it, but didn't know what it was called: needs-based assessments, relationship-building."

We consider the post-secondary institutions that educate nurses to be a critical community partner. A number of times the role of nurse educators in community health was raised both in the survey and in interviews. It became apparent that while employers of CHNs were making strides to put "certification preferred" on job descriptions, the same was not true of nursing education programs in undergraduate or graduate education. One university-based nurse educator interviewed said CCHN(C) certification was a "hard sell" in her faculty, even for clinical instructors who were in the community with students. The prevailing notion is that because community health nursing faculty are doctorally prepared, there is no need for them to acquire CCHN(C) certification. Yet, she asked, how do they hope to provide real life examples for students? Upon reflecting on her own preparation for CCHN(C) certification, she explained

how the opportunity to follow, observe, and participate in the work of CHNs – in home care and public health – was an enriching and exciting experience. Another participant described how a clinical instructor called her to find out what CHNs did! "She was teaching in our health unit but had no clue about what we do!" Interestingly, as this study unfolded, the Canadian Association of Schools of Nursing (CASN) released the report *Guidelines for Quality Community Health Nursing Clinical Placements for Baccalaureate Nursing Students* (CASN, 2010) and in it no mention was made about certification preferences or requirements for either clinical faculty or preceptors.

Another key external partner is the nursing profession as a whole. "Now that we are a recognized specialty area of practice, we need to be treated with the same respect that other specialties get", said one manager. "More of my staff members are involved with provincial groups and initiatives than before – and I encourage it". By being involved, they are better able to advocate for CHNs and nursing as a whole. For instance, when one provincial regulatory body decided to do its registration by online only, CHNs protested on behalf of rural/remote, home care, public health, and other nurses who may not have easy access to a computer. As a result, the regulatory body rescinded that policy.

In another example that took place during H1N1, legislation in one province aimed to take the requirement for CHNs to be baccalaureate prepared out of previous legislation. The provincial nursing association tried to mobilize a response against this plan, but some employers (i.e., acute care sector) and senior nurses did not see the importance of the issue and as a result did not take any action to support the Association's position. When senior community health nursing managers intervened and supported the Association, others became better informed about the issue and its potential impact, causing them to rescind their neutral positions. The proposed legislation was overturned. It is these sorts of actions by politicians that create mistrust – "when our minds are occupied elsewhere, we still can't let our guard down" – but lead also to opportunity to better create bridges and foster unity among the different parts of the profession and the organizations that employ them.

CHNs with CCHN(C) were more interested in attending nursing conferences, not only for the continuous learning credits, but also for the opportunity to talk about their specialty practice to a wider audience of CHNs and other nurses. For instance, one CHN with CCHN(C) presented at a concurrent session on parenting – while others presented from the perspectives of postnatal attachment, parenting a child on a critical care unit, and parenting a child with a mental health diagnosis, this CHN talked about a community initiative to better engage teen fathers (not living with the infants' mothers) in parenting. In this way, community health nursing work is made more visible to nurses in other parts of the profession.

Influences on clients

Respondents from the Members+ and the First Cohort surveys agreed with the statement that they satisfied their clients with the services provided (Members+ 59.9%; First Cohort 44.4%). However, when asked if they are noted by their clients as credible specialists in their area of practice, the majority of Members+ (56.4%) and First Cohort (64.4%) disagreed with this statement. Members+ were divided when asked if CCHN(C) certification increased client confidence (40.9% agreed; 45.9% disagreed) and increased client satisfaction with the service provided (41.2% agreed; 46.9% disagreed). The majority of First Cohort disagreed that the outcome of CCHN(C) certification included increased client confidence (53.3%) or increased client satisfaction (51.1%).

The majority of Employers expressed that they had "no opinion" in regard to whether CHNs with CCHN(C) satisfy clients with the service provided (40.0%) or provide higher quality service to clients

(50.0%). The majority also responded with "no opinion" when asked if client/patient outcomes had improved as a result of CCHN(C) certification (57.1%).

In the focus groups and interviews, for the most part CHNs in both home/community care and public health said their clients were "blissfully unaware" of their CCHN(C) credential. In some instances, home care nurses had shared with clients that they were studying for an exam, but did not talk about what they hoped they would be able to change or achieve as a result of achieving CCHN(C) certification.

Some CHNs with a designated office or clinic framed their CCHN(C) certificates and mounted them on office/clinic walls. This did raise curiosity of clients, some of whom asked about the meaning of the certificates. Many urban CHNs were reluctant to mount certificates in public areas because they did not want to be identified and contacted at home by clients who would learn their last names; this decision was constituted as a safety issue. For home/community care nurses that worked mainly from their vehicles and shared cubicles, posting their CCHN(C) certificates was not possible. They were able to wear their CNA specialty certification pins and use the red lanyards provided to certified RNs (of all specialties) to hold their identification cards.

Because of the multifaceted nature of CHN/client contacts, it is hard to uncover the implications of CCHN(C) certification on clients. Home/community care nurses told us they gained a broader view of their clients in the context of the larger community and this new knowledge allowed them to process information differently, but it did not change the fundamental nature of their practice.

> "Maybe I ask more questions when I am doing care – questions about what's going on outside of their health problem and the person/family."

In another example, a recently CCHN(C)-certified CHN talked about how she now worked differently with a newcomer/settlement agency that served immigrants and refugees. She approached the agency staff in a different way, engaging them in dialogue about the larger context of the lives of the people served, not just about their health, and listening respectfully to diverse opinions and perspectives. She spoke about using the determinants of health to understand better the challenges faced by both clients and service providers, and engaged in a shared learning process with other providers of care to this population group. As such, all parties enjoyed a reciprocal learning experience and the CHN was better able to bring forward community issues to her manager and team, make them understandable in light of the determinants of health, and use the CCHN Standards of Practice (CHNC, 2003, 2008) to suggest how these community issues might be addressed.

In another example, a home care nurse with CCHN(C) certification who had studied the communicable disease module in preparation for the certification exam was doing a home visit with an elder client when she discovered the symptoms of a communicable disease in a young family member that she would previously have missed. She made a referral to public health and informed the client about the condition, about the care required, and about what would happen with public health. In so doing, she prevented what would have inevitably become an outbreak in a school, calmed the family's fears, and took action to soothe the symptoms that presented (rash, fever).

> *How do we know we are making a difference? We don't even know what to measure!! And then we have to ask: do we have the capacity to measure it - whatever it is?*

The narratives we heard in interviews were very powerful; but what indicators of quality and impact can be devised to parse out

the effects of CCHN(C) certification on client outcomes? There were few suggestions brought forward by interviewees. However, there was almost universal support for research to be done that might inform indicators of how the impact of CHNs with CCHN(C) on clients (individuals, families, communities, and populations) could be measured in a cost-effective and efficient way.

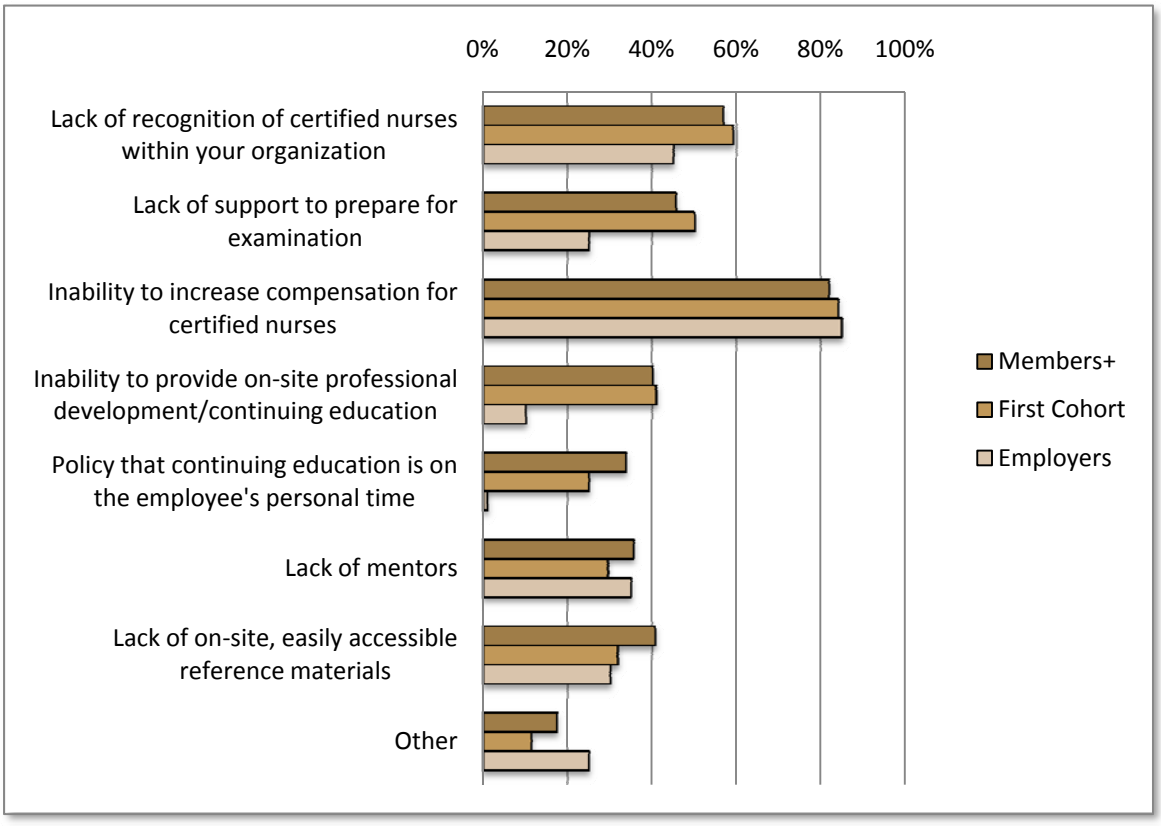
> "At this point we aren't able to map the impact [of CCHN(C) certification] to client outcomes but that doesn't mean they are not there. I think there is some work to be done to determine how, for example, facilitating access would show up, to actually map it to a measurable outcome. I think we have some work to do and I would like to see us do it."

Organization facilitators and barriers to CCHN(C) certification and renewal

The main organizational barrier to seeking CCHN(C) certification identified by respondents in the Members+ survey is lack of increased salary or compensation for CHNs with CCHN(C) (81.9%). This was echoed by Employers, where the majority of respondents reported that the inability to increase remuneration for CHNs with CCHN(C) was the greatest barrier (85.0%).

Respondents were divided on their feelings about recognition within their organization for CHNs with CCHN(C). Over half of the respondents in the Member+ survey felt that a lack of organizational recognition of certification created a barrier (56.9%). Similarly, for the First Cohort survey, over half of the respondents agreed that a lack of organizational recognition presented a barrier to re-certification (59.1%). Again, CHNs were more likely than Employers to identify this as a barrier existing within their organization

Figure 3. Organizational barriers to CCHN(C) certification



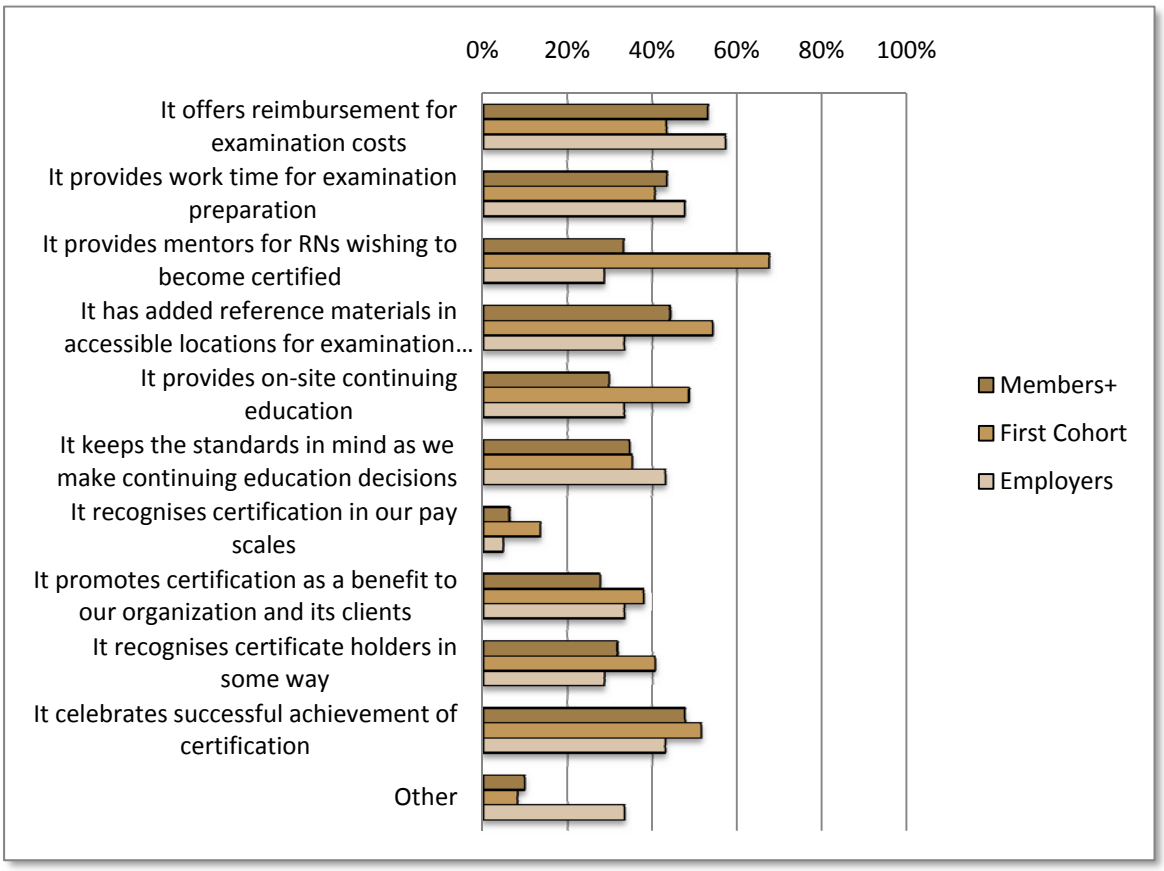
Respondents from the Members+ survey identified the following "other" organizational barriers to certification in the comments section of the questionnaire:

- Lack of understanding from community health nurses in other settings creating obstacles if asked to observe a clinic or borrow some references;
- Other continuing education opportunities competing for time;
- Geographical constraints, perception of the time to prepare for the exam, and the upfront cost of writing exam, although many apply and receive financial compensation after writing the exam;
- Current employer is a hospital and therefore not abreast of community nursing issues;
- Employers don't consider it important, necessary or valid. Other PHNs don't think it's worth the time or money to attempt because there is no support and takes a huge amount of time to achieve;
- Not a requirement for a faculty position;
- Not enough of a critical mass of CHNs with CCHN(C) to make any difference in addressing re-certification needs;
- Cost; depending on the professional development it is on own time; this certification is seen as irrelevant, studying for exam and exam content too diverse and much is not directly applicable to public health – it's good for nurses working in the community; and
- No value attached to certification.

A number of organizational facilitators for certification and re-certification were confirmed by respondents. The main facilitator for *entering into the process* of CCHN(C) certification was identified as reimbursement of examination costs, with nearly half of all respondents (Members+ 53.1%; Employers 57.1%; First Cohort 43.2%) reporting that certification examination costs were reimbursed by the employer. Facilitators for *completing the process of certification* most commonly identified among Members+, Employers, and First Cohort were: the addition of reference materials in accessible locations; the provision of mentors for CHNs who are seeking CCHN(C) certification; the provision of work time for certification exam preparation; and on-site continuing education to support re-certification. Members+ were more likely than Employers to identify these barriers as existing within their organization, although both groups did acknowledge them. Interestingly, for the First Cohort, the items related to the process of CCHN(C) certification and re-certification identified as facilitators to certification were also identified to an equivalent degree as barriers (i.e., lack of materials, mentors, support to prepare for examination, and on-site continuing education, and also a policy that continuing education is on the employee's personal time. The consistency in the results provides confidence in the reliability of the survey. Upon the *achievement of the CCHN(C) credential*, organizational recognition through celebrations of various kinds was reported as valuable. Approximately half of the respondents (Members+ 47.6%; Employers 42.9%; First Cohort 51.4%) identified that their organizations celebrates the successful achievement of certification.

It should be noted that few respondents in all three surveys (Members+ 6.2%; Employers 4.8%; First Cohort 13.5%) indicated that their organization recognized certification in its pay scales; this finding is consistent throughout the study.

Figure 4. Organizational facilitators for CCHN(C) certification

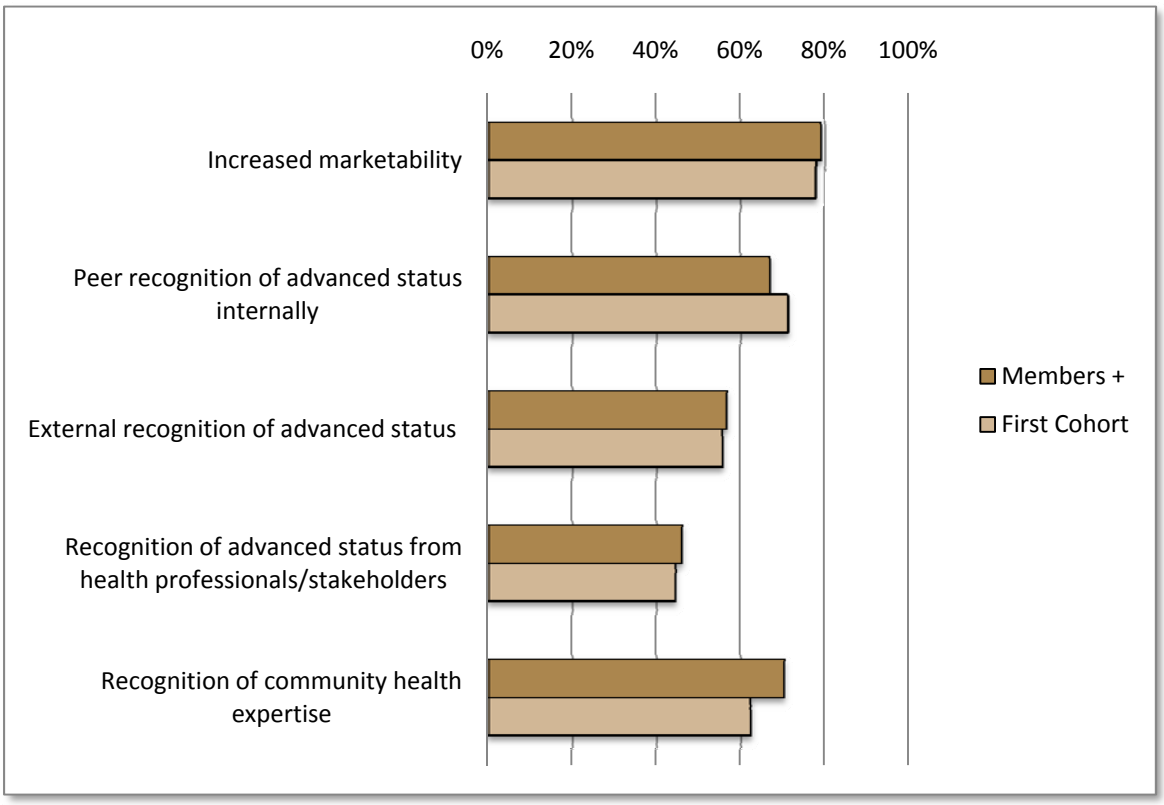


"Other" organizational facilitators for CCNN(C) certification were identified by Members+ responding in the comments section on the survey:

- Access to an online study group, and flexing work time to participate in the study group;
- Immediate manager was aware of exam preparation demands, even if senior managers were not aware;
- Weekly on-site study group ran for 12 weeks, followed by a debrief meeting post-exam to evaluate the study group process;
- Working time was provided for exam preparation using the allotted number of professional development days per year;
- Reimbursement was provided through a professional development expense account;
- Links to external mentorship and educational sessions were provided through study groups; and
- Allowed time off to write certification exam, and travel costs associated with writing the exam were covered.

Why do CHNs seek CCHN(C) certification? There are a number of external reasons, including impressing managers with their competence, improving their marketability for career advancement, reputation among peers and external colleagues, and recognition or validation of their enhanced expertise. There was consistent agreement about the extrinsic value of CCHN(C) certification found between the Members+ and First Cohort.

Figure 5. Extrinsic value of CCHN(C) certification



A number of intrinsic values as a result of certification were identified by both the Member+ and First Cohort respondents. Of these intrinsic values, several garnered large agreement. Members+ were most likely to agree that certification resulted in enhanced feelings of personal accomplishment (98.8%), higher personal satisfaction (98.2%), validation of specialized knowledge (94.4%), better professional growth (96.3%), attainment of a practice standard or competency (96.9%), evidence of professional commitment (98.2%), and acceptance of professional challenge (97.5%).

Respondents from the First Cohort survey also agreed on a number of intrinsic values related to certification. Respondents were most likely to agree that certification resulted in enhanced feelings of personal accomplishment (97.8%), validation of specialized knowledge (91.1%), attainment of a practice standard or competency (97.8%), evidence of professional commitment (97.8%), and acceptance of professional challenge (97.7%). There were some interesting results from the First Cohort on intrinsic value of CCHN(C) on their professional role relating to job satisfaction, work assignments following CCHN(C), and practice autonomy.

Table 8. Intrinsic value of CCHN(C) certification to professional role: First Cohort

Category	Agree	Disagree
Improved job satisfaction	60.0%	33.3%
Different work assignments than non-certified colleagues	11.1%	84.4%
More autonomy in my practice	28.9%	64.4%

Note: Of 45 responses; Agree/Disagree does not add to 100% because “no opinion” responses not presented.

Overall, the respondents of both Members+ and First Cohort surveys identified intrinsic factors as being more important to their professional role than extrinsic factors. This is not to say that they did not recognize the extrinsic values of certification, but rather to point out the greater agreement found on survey items related to intrinsic values. This was found for both the Members+ and the First Cohort.

During the interviews and focus groups, there were many stories of what was done in the workplace to encourage certification and to acknowledge those that were successful. These stories built on the information and examples gained from the survey. The following examples are a compilation of what we heard; no organization was able to implement all of the examples.

To encourage and support preparation for certification, employers allotted a certain amount of work time for study and to take the certification exam itself. Employers supported study groups on work time – whether in-house or by sending their staff to another site. Employers allowed work computers to be used for study and research, purchased textbooks, circulated journal articles, and allowed the use of VOIP or teleconference facilities for study purposes. Employers also provided mentors and speakers to study groups.

Once certification was achieved we heard that there were many ways in which this achievement was recognized and acknowledged:

- CCHN(C) designation on business cards;
- Lunch/dinner celebrations;
- Congratulations at meetings;
- Newsletter announcements;
- Personal letters from senior management;
- Frames for certificates;
- Mounting certificates on a “wall of honour”; and
- Special tributes during Nurses Week.

Interestingly, few organizations were able to offer salaried compensation in the form of an achievement bonus or regular salary increases for certification, but there were some whose contracts allowed increased compensation for certification. There was an overwhelming consensus among all three surveys that the inability to increase compensation for CHNs with CCHN(C) is a significant barrier to certification and re-certification within their organizations.

Some employers were able to reimburse the costs associated with certification (and planned to do the same for re-certification) while others could not. In these instances, managers sought sources for CHNs to make claims for reimbursement (e.g., foundations, clubs, and continuing education grants) and provided a letter of support for staff applications. If travel and accommodation were required either to study or to take the exam, again some employers were able to cover those costs. Virtually all employers recognized the imperative for continuous learning and to the best of their ability (often constrained by contracts) they contributed to those costs either in part or in full.

For the most part, every person interviewed agreed that the impetus for certification was rarely external recognition or reward; they were motivated by the intrinsic rewards such as: validation of their knowledge; the opportunity to refresh and update their knowledge and skill; desire for career opportunity and mobility; and dedication and commitment to the profession. We heard that certification improved their sense of competence and confidence and increased their credibility with managers, colleagues, community partners, and clients. The hard work and accomplishment gave CHNs

with CCHN(C) pride, excitement, enthusiasm, and personal satisfaction. They talked about having a broader understanding of community nursing, more evidence for their practice, more ability to use literature, a larger network of like-minded colleagues, and higher morale and job satisfaction. They felt more able to work to full scope of practice because they had a better understanding of the CCHN Standards of Practice (2003, 2008).

Would they have acquired CCHN(C) certification without some external "push"? Many CHNs with whom we talked were eager to be among the "early elite" in their field and described themselves as "keeners" with a large "thirst for knowledge" that initially prompted them to consider CCHN(C) certification. However, they often cited a mentor or manager who challenged them to "be the best I could be" as an important trigger in coming to the decision. Some senior nurses also felt some peer pressure from colleagues to take the exam; once one team member achieved CCHN(C) certification there was pressure on others in the team to follow the same path. In many instances, CHNs looked up to mentors who "blazed the trail" they could follow with confidence.

As with everything, there are indeed disincentives or barriers to certification. After the first round of CCHN(C) certification exams in 2006 when "not everyone passed" there was a certain amount of trepidation. But the fact that some people did not pass induced others who were somewhat dismissive to think otherwise – "obviously this was no walk in the park. If it's that hard to get, maybe it's worth trying to get it!"

Other barriers cited related to the cost (particularly if the costs had to be borne entirely by individual nurses without reimbursement partially or fully); time (many nurse with young families had other obligations that precluded them from joining study groups and studying on their own time); and the lack of salary compensation for certification. Some felt there was no organizational support or value for certification or continuous learning:

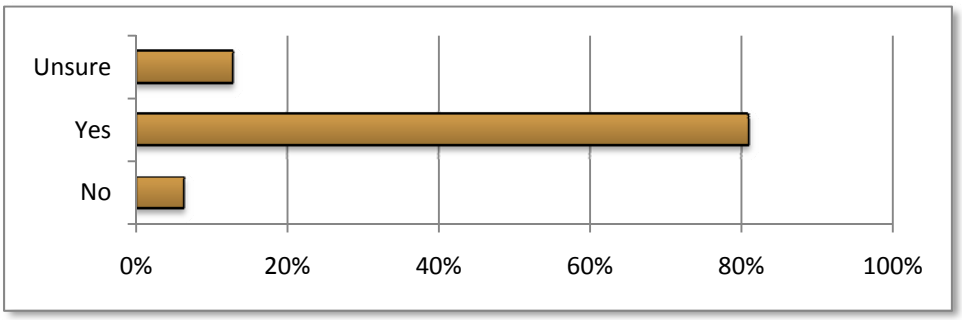
> "My manager, who is not a nurse, is very dismissive about certification. [S/he] rejects every application for learning, conferences, or courses. Anything I do is on my own time and I pay for it myself."

Some reported their workplace had generally low morale and CHNs were largely "a dissatisfied bunch" and "invisible" in the larger organizational context that values acute care nurses, particularly critical care nurses, as more valuable than nurses in the community.

Intentions of First Cohort of CHNs with CCHN(C) to re-certify

The First Cohort of CHNs became certified in the community health nursing specialty in 2006; the period of certification is five years, meaning that this group of CHNs with CCHN(C) will be eligible to renew certification in 2011. When the First Cohort was surveyed about their intent to re-certify, the majority (80.9%) indicated that they planned to re-certify when their current CCHN(C) expired. Only 6.4% of respondents indicated that they would not be seeking re-certification, while 12.8% of respondents remained undecided.

Figure 6. First Cohort's intent to renew CCHN(C) certification in 2011



When examining facilitators for re-certification, the First Cohort indicated several factors that played a role in their decision: accessible mentors (67.6%); reference materials in accessible locations (54.1%); and on-site continuing education (48.6%). Also identified, although slightly less noted, were the following: reimbursement for re-certification costs (43.2%), and work time for re-certification preparation (40.5%). Celebration of successful certification within the organization (51.4%) was identified as being an important facilitator for re-certification.

Consistent with the survey results, almost all of the First Cohort interviewees indicated that they planned to re-certify. One participant indicated s/he would not re-certify because s/he was leaving the field, and two indicated they were unsure whether they would re-certify or not. The cost of certification/re-certification was an issue but was not the determining factor in the decision. In general, cost was regarded as a larger obstacle if they were employed in settings that did not recognize or value the CCHN(C) credential in any way. Several CHNs with CCHN(C) eligible for re-certification in 2011 indicated that they planned to recruit others to certify at that time. For example, one CHN described how a group from the First Cohort "each made the commitment to re-certify and each bring one more person along".

From the First Cohort interviewees, all CHNs with CCHN(C) planning to re-certify anticipated doing so based on continuing education hours. No one from this group *wanted* to write the exam again, explaining that the exam was "gruelling" and generated uncomfortable feelings such as a "pressure to pass" and "fear of failure". This was particularly nerve-wracking for those CHNs who were in positions of leadership and needed to maintain their credibility. Some of the CHNs we interviewed indicated the exam was too heavily focussed on public health while others thought the exam was too general. Having said this, the majority of CHNs in the First Cohort interviewed were satisfied with the exam content and recognized that the exam and the preparatory material had improved from when they had written it. Some actually recalled their preparation for the exam with fondness and talked enthusiastically about the value of having participated in study groups with multiple types of CHNs. They commented that the partnerships established during those study groups had endured and, although they could not be specific, indicated that these partnerships were impacting positively on nursing practice.

For many CHNs in the First Cohort interviews the main motivation for re-certifying is for intrinsic reward. They described how CCHN(C) certification has given them "a sense of personal pride", "accomplishment", "confidence" and validation of their specialty knowledge. As one person described it:

> "It's truly the first certification that is about us because community health is so eclectic and this one is truly about us and there is a huge sense of pride about this."

About half of the CHNs in the First Cohort interviews indicated minimal or "zero" recognition of certification within their employing agency. For these CHNs the motivation to re-certify was totally based on the personal value they attributed to CCHN(C) certification. Some also described a sense of "having gone so far down the certification road" and wanting to build on that investment even in the absence of an extrinsic valuing of the CCHN(C) credential within their employing organization. As one CHN with CCHN(C) from the First Cohort stated,

"Once you have achieved certification, it's hard to let it go."

There were also some extrinsic motivators for re-certifying identified by CHNs in the First Cohort interviews. These included "the importance of being a role model", "enhancing the likelihood of a promotion", and the credibility certification gave them with partners external to their agency. For example, one CHN described how certification had led to "being invited to new planning and decision-making tables".

The small number of CHNs in the First Cohort interviews that were unsure about whether they would re-certify indicated this was because of the lack of extrinsic value given to the credential in their organization. One of the interviewees commented that the results of the study we are conducting should be widely disseminated to inform the field of community health nursing about the value of CCHN(C) certification.

When asked whether their CCHN(C) certification has had an impact on clients, one CHN in the First Cohort interviews responded:

"Absolutely. It's influenced the whole development of how we do our business."

This tendency to think of impact on clients at the organizational level was more common among those CHNs in the First Cohort that held leadership positions. They commented that there had been improvements in evidence-based practice and better charting, and observed that front-line staff (CHNs with CCHN(C)) were better able to problem solve and integrate their knowledge of the determinants of health and community resources into client care. Although the CHNs in the First Cohort interviews believed that CCHN(C) certification had a direct impact on individuals and families, none could articulate specifically what that impact was.

Discussion

This was the first study to evaluate the impact of certification in nursing specialities/areas of practice in Canada. Our goal was to assess the outcomes and influence of certification on community health nursing practice. Specifically we aimed to: 1) identify the influences of CNA's community health certification on nursing practice and employing agencies as well as the organizational facilitators for and barriers to certification renewal; 2) explore the intentions of the CHNs with CCHN(C) certification to re-certify; and 3) create an evaluation template that could be generalized to other CNA certifications. The overarching research question was: "Does certification support excellence, competence, and quality in community health nursing practice?" To achieve our aims we used a mixed methods approach that included surveys of CHNC Members, Employers, and the First Cohort of CHNs with CCHN(C), followed by focus group and individual interviews with participants from each of the aforementioned groups.

The response rate was excellent (64.9%) for the Member+ survey, very good (45%) for the First Cohort survey, and less than hoped-for (28.6%) for Employers. Nevertheless, all rates are in the range of response rates expected in social science research. The Employer group may be under-represented because they may have been surveyed in the Members+ group if their CHNC membership information did not provide clues to their job titles and they could not be separated out for the Employers survey.

CHNC membership data indicate an overall balance between home health and public health members, with variation in the balance across provinces (personal communication, Evelyn Butler, March 15, 2010). Our study favoured public health in terms of respondents to the surveys and participants in the focus groups and interviews. Perhaps there is variation in the settings for practice that allowed public health CHNs to have more easy access to computers during work hours to complete the survey and telephones during the times focus groups/interviews were scheduled. Evening and weekend options were offered, but the uptake was minimal so they were cancelled. It is also possible that some CHNs from the home health sector have less positive perspectives of CCHN(C) certification in light of other certificates that might be considered more relevant to their client groups (e.g., enterostomal, mental health) and therefore chose not to participate.

With respect to informing the public that they had certified CHNs on staff, those Employers from the home health sector that we interviewed told us that this was an important organizational attribute when competing for contracts. Their responses might have been obscured in the survey results because of the greater number of responses from public health.

There was a higher proportion in the First Cohort of those reporting being in administrative roles than in direct care, as compared to the Members+ group where there was a higher proportion in direct care. This may be a result of employers' initial thrust to get people in positions of added responsibility to get their CCHN(C) certification first; managers and practice leaders might have been setting an example for their staff. We can speculate that managers and practice leaders command a higher salary and may be at a later stage in life without young children at home, allowing them the funds to pay for the costs of CCHN(C) certification and the time to prepare. Managers and practice leaders may also have been more likely to be at the CHNC conferences where certification was first announced and promoted.

CHNs with CCHN(C) from the First Cohort were remarkably unmoved by barriers within the process; as a group they were very internally motivated. Facilitators helped them, but were not key factors in their motivation to become certified. They were the "trail blazers" – the innovators. Following attainment of their CCHN(C) credential, they tried to convince colleagues to undertake CCHN(C) certification. Colleagues observed how CHNs with CCHN(C) performed in the certification process (e.g., Did they pass? How hard was it to study?). They examined how CHNs handled their CCHN(C) in the workplace (e.g., Were they arrogant? Did they create tension or cause arguments? What difference did they make?). Then, if they were satisfied, they undertook the process of becoming certified.

The qualitative and quantitative results of this study showed remarkably consistent results. In the surveys, the results bore out the hypotheses that the intrinsic rewards and acquisition of knowledge associated with the certification process would offer improved work satisfaction, provide the underpinnings for the application of evidence into practice, and enhance the credibility of CHNs with CCHN(C) working in interprofessional and interdisciplinary contexts. These findings are consistent with those of Gaberson et al. (2003) who found that personal value, recognition by others, and professional practice were the key values of certification for perioperative nurses.

The mechanisms of how CHN practice was influenced by CCHN(C) were explicated more fully in interviews and focus groups: we were told that CCHN(C) certification enhanced confidence, built capacity for using evidence, and furnished language to articulate practice. These enabling factors were the means by which participants measured success. But perhaps there is more at play than participants were able to articulate. For example, Rowland et al. (2009) report on a study of the positive impact of certified medical directors on quality of care in nursing homes. These authors found that the following factors were associated with improved quality of care: the relationship between the medical director and other administrators improved; the medical director spent more time in the facility working on system issues; and more time was devoted to reviewing the care provided to residents. From the narratives collected in this study, we can speculate that CHNs with CCHN(C) employ similar strategies that influence the quality and outcomes of the service they provide.

Since for many CHNs their practice is focussed on aggregates/populations, measuring the impact of CCHN(C) certification on client outcomes is more challenging, as is measuring the differential impact of CHNs with and without CCHN(C) on client outcomes. From our study we found that CCHN(C) certification was reported to improve collaboration among CHNs at the organizational level, especially between public health and home health nurses, and this is thought to have had a positive effect on care delivery processes, for example, in the recent H1N1 pandemic. Another example of collaboration, in this case on the certification process, is in the study modules for certification located on the members-only section of the CHNC website. The Middlesex-London Health Unit and Para-Med together created this learning tool, which many participants lauded as an excellent study guide that influenced their ability to collaborate better with CHN colleagues in diverse settings. Tracking the number and intensity of collaborations among CHNs with CCHN(C) in a variety of community settings may be an indicator of the effect that CCHN(C) has on CHN practice and ultimately on the impact of CCHN(C) certification on client outcomes.

The impact of CCHN(C) certification on clients – at individual, family, community, and population levels – requires further investigation. Over and over again we found ourselves faced with the inability of CHNs with CCHN(C) in our study to articulate how certification influenced or changed their practice and how that influence could be measured, that is, what indicators would demonstrate changes in practice and resultant improved outcomes for clients. CHNs with CCHN(C) could describe how they were "changed internally as people and as nurses" but how those changes were not visible "from the outside looking in". According to our results, there was little difference in *what* CHNs with CCHN(C) did that was different – in terms of work assignments and degree of autonomy in practice – from what they did prior to certification and in comparison with CHNs without CCHN(C). It should be noted that Employers were most likely to answer "no opinion" for survey items asking about the differences between CHNs with and without CCHN(C).

Head and colleagues (2004) suggested that "community-level nursing-sensitive outcomes will potentially enable the study of efficacy and effectiveness of public health [nursing] interventions focused on improving the health of populations and communities." They tested six community-level outcomes from the Iowa Nursing Outcomes Classification (NOC). The NOC is a taxonomy of nursing-sensitive client outcomes that includes definitions of each outcome, indicators for each, a rating scale, and a list of references. The six outcomes in order of nursing sensitivity were: community health - immunity; community risk control - communicable disease; community health status; community risk control - lead exposure; community risk control - chronic disease; and community competence. All were deemed important and sensitive to nursing intervention. A similar study with a focus on older clients was also carried out by Head and colleagues (2003) with implications for home care as well as

population-focused care. These sorts of studies should be considered imperative for the Canadian context as well if we are to move from rhetoric to action on measuring the impact of CHNs, and CHNs with CCHN(C) certification, on clients.

In Canada, the Canadian Institute for Health Information (CIHI) has established a Primary Health Care Information Program. To date this program has developed a Primary Health Care Indicators Chartbook (CIHI, 2008) and produced reports on the Experiences with Primary Health Care in Canada (CIHI, 2009) and Diabetes Care Gaps and Disparities in Canada (CIHI, 2009). This work is based on a definition of primary health care as community-based first contact care over time, which may not be reflective of the practice of all CHNs. However, it and the work of CIHI's Canadian Population Health Initiative (http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_e) may be helpful in moving forward.

Another valuable resource is the National Collaborating Centre for Methods and Tools (NCCMT) housed at McMaster University (http://www.nccmt.ca/index-eng.html), which aims to promote and facilitate evidence-informed decision making in public health. Related to this, raising awareness among CHNs about the importance of understanding the impact of their practice either at an individual, organizational, or systems level will also be important. Some re-certification processes in medicine are now incorporating a requirement for the demonstration of patient outcomes (e.g., patient satisfaction) as a measure of practice quality (Rosier, 2006; DeLisa, 2009). In addition to continuing education, CNA might consider this an option for re-certification purposes.

Ontario has implemented *Health Outcomes for Better Information and Care (HOBIC),* a province-wide information management strategy that collects standardized patient health outcomes, staffing and quality of work life information reflecting a variety of disciplines including nursing to provide valid, reliable information that is patient-centred, evidence based, outcome-focused and comparable across all sectors. HOBIC will focus initially on acute care, long-term care, complex continuing care and community care (home care) and subsequently will include rehabilitation, primary health care, mental health, and public health. http://www.health.gov.on.ca/english/providers/project/nursing/nursing_mn.html

At present some 338 RNs in Canada are CHNs with CCHN(C) (CNA, 2009c). That is 0.7% (at best) of CHNs who have achieved CCHN(C) certification based on Underwood's estimate that there were 46,273 CHNs in Canada that in 2007 (Underwood et al., 2009). Yet, we spoke with people whose organizations had achieved 100% CCHN(C) certification and others who were at 10% and higher; obviously the sample was biased towards those for whom CCHN(C) certification was a high priority. Awareness among CHNs and among employers of CHNs with CCHN(C) varied. If there had been introduction of the CCHN Standards of Practice (CHNC, 2003, 2008) and the Public Health Nursing Discipline Specific Competencies (CHNC, 2009) within the settings that employed CHNs, or if managers, clinical practice leaders, or CHNs attended CHNC conferences, then the Standards and CCHN(C) certification were often championed. If not, then the lack of awareness was cause for lack of intention or support for certification.

Those CHNs that were among the first to achieve the CCHN(C) credential became the verbal persuaders for the next groups that undertook the certification process. Then, as others saw the benefits of certification to their colleagues in the form of increased confidence and better ability to use the evidence and provide rationale for decisions, they were convinced to take steps towards certification themselves. Verbal persuasion and vicarious experience as means of motivating others to become certified must be bolstered by strong leadership that promotes CHNC(C) certification, values the work of front-line staff, and invests in continuous learning (Underwood et al., 2009).

In their report on CHNC members' perceptions of the CNA certification exam, Bassendowski and Petrucka (2008) identified as a barrier that there was a single exam for public health and home care nursing, and suggested that CHNC investigate the feasibility of having two separate exams. We did not hear this suggestion to any great degree in our focus groups or interviews. There was some discussion of the breadth and depth of the exam and the need to get the balance right in terms of content. While there was some concern expressed about the CCHN(C) exam becoming more focused on the specifics of either public health or community/home health practice areas, there were more positive comments about the value of working in study groups with CHNs from a variety of work settings. The opportunity to interact with others and understand how the Standards were enacted in different settings seemed to create cohesiveness among those CHNs involved and an excitement about how practice similarities converged around the Standards. Most CHNs with CCHN(C) valued the breadth of the exam and did not recommend major changes. We did note, however, that First Cohort participants hoped there were improved resources for preparing for the exam than in 2006. Those CHNs with CCHN(C) from later years indicated that the CNA resources were of far less help than the ones available through CHNC.

We further noted that there were several different categories of practice and practice settings for CHNs, although those with public health and home health foci were most numerous. We agree with Underwood et al. (2009) that less variation (more consistency and less interchangeability) in job title would be helpful to tease out the similarities and differences in community health nursing. Schofield (2010) concurred with Underwood, and called for a consolidated approach to community health nursing, rather than the development of sub-specialties that serve to divide, rather than unite, the field. Witness the number of items CHNs could choose from on the surveys for this study (n=11) to provide information on where they worked – and still they added to the list by specifying new options in the "other" category!

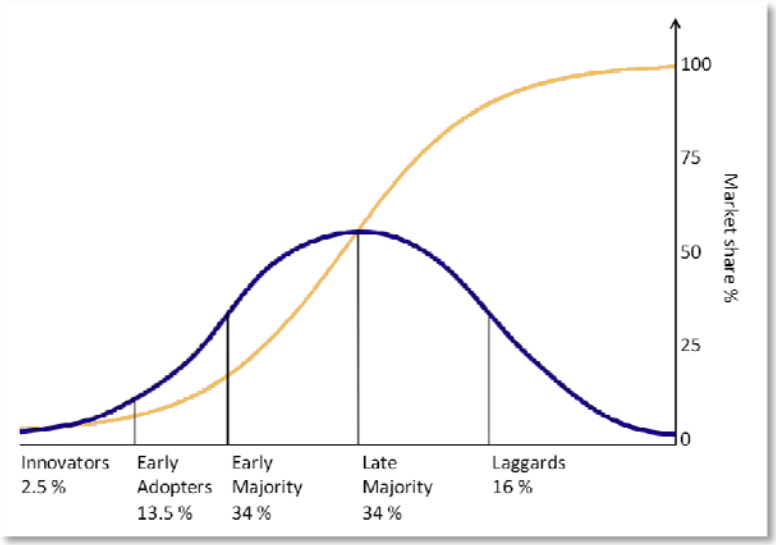
Underwood et al. (2009) report also that CHNs could sustain their competencies and confidence in professional abilities with more access to continuing education. In this regard, a recently developed questionnaire to assess the learning needs of CHNs will be helpful (Akhtar-Danesh et al., 2010). Certification could be regarded as a contributing strategy to building community health nursing capacity; if so, the "reach" of the CNA's CCHN(C) certification program will need to be expanded.

Expansion in numbers of CHNs with CCHN(C) and in the numbers of employers that recruit and hire CHNs with CCHN(C) is likely to improve if CNA and CHNC were to make a concerted effort to inform employers about the benefits of certification and encourage them to utilize means to improve the CCHN(C) rates among their CHN staff. Those certified in the first years of the program are referred to as "keeners", people who are the early adopters of this opportunity. They are characterized as people who love learning and want to demonstrate their expertise.

Some efforts are required to clarify the intentions of the multiple documents that support community health nursing: the CCHN Standards of Practice (CHNC, 2003, 2008), the Core Competencies for Public Health in Canada (Release 1.0) (PHAC, 2007); the Public Health Nursing Discipline Specific Competencies (Version1.0) (CHNC, 2009); and the anticipated release in June 2010 of the home health nursing competencies. There is much confusion about the difference between competencies and standards and about which document takes priority. While Underwood (2009) has mapped the CCHN Standards to the Public Health Nursing Discipline Specific Competencies, and developed a discussion document on standards and competencies (Underwood, 2007) for the Public Health Agency of Canada, her findings have not been widely disseminated.

In his theory of diffusion of innovations, Rogers defines diffusion as "the process by which an innovation is communicated through certain channels over time among the members of a social system" (Rogers and Shoemaker, 1971; Rogers, 2003). Rogers categorizes adopters of innovations (in this case, CCHN(C) certification) into various categories based on the notion that some people are more or less open to adopting change than others. He refers to innovators as “brave people” who are pulling the change by their example and powerful communication. Early adopters are opinion leaders who try out new things in a careful way. Early majority people accept change faster than the average, but are still careful. Late majority, in contrast, will use new ideas only once the majority has taken them up. Laggards, people who prefer the “old ways”, are critical of new ideas and only accept them when they have become mainstream. The diffusion of innovation curve suggests that it is most effective to focus action on the left side of the curve in the early stages of implementing a change.

Figure 7. Rogers’ diffusion of innovation curve



(Source: Rogers, 2003)

If we consider the CHNs with CCHN(C) to date as the innovators, we have a long way to go to reach the 2.5% mark – that would be 1157 CHNs certified, or another 819 – before we could safely say we were into the “early adopters” group! At this rate, it will be another 5 years before we could reach that mark, and at this pace, another generation before we could hope to have a reasonable expectation that CHNs be certified as a matter of course.

Research on diffusion of innovations focuses on five key elements: the characteristics of the innovation that can affect its adoption; the decision making process that occurs when individuals consider adopting a new idea; the characteristics of those individuals that make them likely to adopt innovation; the consequences to individuals and society of adopting an innovation; and communication channels used in the adoption process (Rogers & Shoemaker, 1971). Our study has focussed primarily on the fourth element, the consequences of CCHN(C) to CHNs and their employers. In addition to CNA and CHNC mobilizing a concerted campaign addressed to employers, undergraduate university nurse educators have an important role to play in promoting community health nursing as a specialty practice area, endorsing CCHN(C) certification, and encouraging new graduates entering the field to become certified – much as they do in other specialty areas of hospital-based nursing practice (e.g.,

neuroscience, cardiovascular, critical care, oncology and others. As respected opinion leaders, university nurse educators should themselves be certified (Collier et al., 2010) and should act as leaders, role models, and mentors not only for their students but also for nurses in practice. In fact, the US Association of Community Health Nursing Educators (ACHNE) calls for certification of faculty at all levels (undergraduate and graduate programs) that educate nurses for community practice (Collier et al., 2010). Joint appointments might be an appropriate model to encourage their leadership in professional development, continuing education, and in the development of the evidence-base for best practice guidelines in community health nursing. There is no question that improved links between practice and education must be forged for CCHN(C) certification to move forward along Rogers' trajectory.

The strengths of this study are that it used multiple methods to evaluate the influences of CCHN(C) certification on CHNs, on CHN practice, on the employing agency, on internal and external partners, and on clients. The survey enabled us to obtain broad data from a wide range of CHNs and employers, while the focus groups and individual interviews enabled us to obtain a deeper understanding of the various factors influencing the process of achieving CCHN(C) and the influence of CCHN(C) on CHNs (with and without CCHN(C), employing agencies, partners, and clients. Both methods included participants from across Canada, except for Quebec. The response rate overall was excellent and supports the transferability of the study results. This is a seminal study that can be replicated regularly to find trends in CCHN(C) uptake and perceptions of its value and impact. It provides new insights and rich descriptions of the experience of CHNs with CCHN(C) certification.

Caution must be exercised as we "language" the results: we uncovered several *influences* of CCHN(C) on practice and on organizations; we heard narratives about the *effects* of CCHN(C) on CHNs and others; but we were not able to articulate the *impacts* or *outcomes* of the practice of CHNs with and without CCHN(C) on clients – individuals, families, aggregates, communities, or the population. More research is required to describe desired outcomes, define reliable, valid, and nursing-sensitive indicators, and measure them.

RECOMMENDATIONS

Based on our analysis of the data, we offer the following recommendations to CHNC. In addition we offer recommendations to CNA for future evaluative studies of other specialty certification.

1. Promote a broad definition of community health nursing
    a. Begin collection of the same information in the same format by all provincial/territorial affiliates of CHNC
    b. Reach out to sub-specialties[2] to become engaged with CHNC as a unifying voice and advocate

2. Improve the profile of CCHN(C) certification among CHNs, employers, and educators
    a. Work with CNA to promote CCHN(C) certification to employers of CHNs
    b. Engage with schools/faculties of nursing and CASN to promote CCHN(C) as a preferred requirement for faculty teaching community health
    c. Engage with schools/faculties of nursing to promote CCHN(C) to graduating students
    d. Promote CCHN(C) rewards and benefits to CHNs in practice

[2] Schofield (2010) identifies occupational health as one subspecialty of community health nursing.

3. Recognize and reward those CHNS with CCHN(C)
    a. Promulgate widely the results of research that support quality community health nursing with diverse populations in a variety of settings
    b. Engage with nursing unions and professional associations to improve compensation and recognition for CHNs with CCHN(C)
    c. Offer reduced fees at the CHNC annual conference
    d. Initiate a CCHN(C) Day
    e. Consider using technology to support relevant evidence-informed continuing education approaches – webinars, distance learning, e-health, and other vehicles – to support capacity-building and maintenance of competency

4. Support research on the effects and impacts of CCHN(C) on community health nursing practice and client outcomes
    a. Engage in discussions and actions to articulate community health nursing practice and client outcomes and indicators
    b. Aid in the development of reliable and valid tools to measure community health outcomes and impact
    c. Support research that measures outcomes and impact of community health nursing
    d. Support research that compares the effects of the practice of CHNs with and without CCHN(C)

5. CNA should continue to work closely with CHNC to ensure the balance in the content of the CCHN(C) exam is appropriate and current
    a. CNA should, in concert with CHNC, develop more and more helpful resources for those preparing for the CCHN(C) exam
    b. CNA and CHNC should consider expanding its support for study groups and mentors to provide support to CHNs in rural and remote areas
    c. CNA should use the template from this evaluation research study to examine the impact of certification in other specialties/areas of practice

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APPENDICES

A. ETHICS CERTIFICATES

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

OFFICE OF MEDICAL BIOETHICS
Room 93, Heritage Medical Research Bldg
3330 Hospital Drive NW
Calgary, AB, Canada T2N 4N1
Telephone: (403) 220-7990
Fax: (403) 283-8524
Email: omb@ucalgary.ca

2009-11-25

Dr. Ardene R. Vollman
Department of Community Health Sciences
HMB G029
Calgary, AB

Dear Dr. Vollman:

RE: Assessing the impact of Canadian Nurses Association (CNA) certification on community health nursing practice in Canada

Ethics ID: E-22822

The above-named research, including the Survey (CCHNC Certified RNs; Emoplyees of CCHNC Certified RNs; Intent to Pursue Re-Certifications; CCHNC Certified RNs; Certification Survey: Members not Surveyed), Information Letter (Infoermation Package for Informed Consent Process), Letter of Invitation , Ethics Approval Form (Community Health Nurses of Canada, November 2, 2009), Form (Critical Path and Timeline), Interview Guide (Focus Group: Consent and Interrview Guide; Individual Interviews: Consent and Interview Guide), Protocol (October 2009), Budget (Reminder Post Card), Email (Invitation in French and English) has been granted ethical approval by the Conjoint Health Research Ethics Board of the Faculties of Medicine, Nursing and Kinesiology, University of Calgary, and the Affiliated Teaching Institutions. The Board conforms to the Tri-Council Guidelines, ICH Guidelines and amendments to regulations of the Food and Drugs Act re clinical trials, including membership and requirements for a quorum.

You and your co-investigators are not members of the CHREB and did not participate in review or voting on this study.
Please note that this approval is subject to the following conditions:
(1) access to personal identifiable health information was not requested in this submission;
(2) a copy of the informed consent form must have been given to each research subject, if required for this study;
(3) a Progress Report must be submitted by **November 25, 2010**, containing the following information:

i) the number of subjects recruited;
ii) a description of any protocol modification;
iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
iv) a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
v) a copy of the current informed consent form;
vi) the expected date of termination of this project.

4) a Final Report must be submitted at the termination of the project.

Please accept the Board's best wishes for success in your research.
Yours sincerely,

Glenys Godlovitch, BA(Hons), LLB, PhD
Chair, Conjoint Health Research Ethics Board

GG/emcg
c.c. Ms. Gladys Glowacki (Health Records) Ms. Donna McDonald (RTA) Dr. T. Noseworthy (information) Research Services Dr. Ruth Martin Misener (Co-Investigatror)
Office of Information & Privacy

DALHOUSIE UNIVERSITY
Inspiring Minds

Health Sciences Human Research Ethics Board
Letter of Approval

Date: February 9,2010.

To: Ruth Martin-Misener, School of Nursing

The Health Sciences Research Ethics Board has examined the following application for research involving human subjects:

Project # 2010-2140 (version 2)

Title: Assessing the Impact of Canadian Nurses Association (CNA) Certification on Community Health Nursing Practice in Canada

and found the proposed research involving human subjects to be in accordance with Dalhousie Guidelines and the Tricouncil Policy Statement on *Ethical Conduct in Research Using Human Subjects.* This approval will be in effect for 12 months from the date indicated below and is subject to the following conditions:

1. Prior to the expiry date of this approval an annual report must be submitted and approved.
2. Any significant changes to either the research methodology, or the consent form used, must be submitted for ethics review and approval *prior to their implementation.*
3. You must also notify Research Ethics when the project is completed or terminated, at which time a final report should be completed.
4. Any adverse events involving study participants are reported immediately to the REB

Effective Date: February 9,2010.
Expiry Date: February 9,2011.

signed: Jeannette McGlone
Jeannette McGlone (Chair HSHREB)

IMPORTANT FUNDING INFORMATION - *Do not ignore*

To ensure that funding for this project is available for use, you must provide the following information and FAX this page to RESEARCH SERVICES at 494-1595

Name of grant /contract holder _____ Dept. _____
Signature of grant / contract holder _____
Funding agency _____
Award Number _____ Dal Account # (if known) _____

Dalhousie Research Services • Research Ethics • 5248 Morris Street • Halifax, NS, Canada • B3J 1B4
Tel: 902-494-1462 • Fax: 902-494-1595 • Email: Patricia.Lindley@dal.ca • www.dal.ca/~research

B. Survey Instruments

Survey – Members + and Employers Groups

Note: The questionnaires for members and employers were the same, except for differences in demographic data collected.

Certification Survey: CHNC Members

1. CONSENT FORM

Assessing the influence of Canadian Nurses Association (CNA) certification on community health nursing practice in Canada

Contact person at Dalhousie University:
Ruth Martin Misener RN, NP, PhD
Associate Professor and Associate Director, Graduate Programs
Dalhousie University, School of Nursing
5869 University Ave, Halifax NS B3H 3J5
902-494-2250 (office telephone)
902-494-3487 (fax)
ruth.martin-misener@dal.ca

Contact Person at University of Calgary:
Ardene Robinson Vollman PhD, RN
Adjunct Associate Professor
Department of Community Health Sciences
403-239-3180
avollman@shaw.ca

Introduction

We invite you to take part in a research study being conducted by Dr. Ardene Robinson Vollman of the University of Calgary (as Robinson Vollman Inc.) and Dr. Ruth Martin Misener who is an associate professor at Dalhousie University. This evaluation research is on behalf of the Community Health Nurses of Canada. Your participation in this study is voluntary and you may withdraw from the study at any time. Your membership in the Community Health Nurses of Canada and/or your certification by the Canadian Nurses Association will not be affected by your participation or choice to not participate. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Dr. Martin Misener (information provided above) or Dr. Robinson Vollman (403-239-3180; avollman@shaw.ca).

Purpose of the study

The Community Health Nurses of Canada (CHNC) want to understand the outcomes of certification and its impacts on community health nursing practice. To do so, they have hired Dr. Robinson Vollman and Dr. Martin Misener to design and carry out an evaluation research project in order to provide feedback for the CNA certification process in general, to CHNC about community health nursing certification, and to inform any refinements to the process of certification and recertification. In order to better understand how people perceive the influences on and impacts of CCHNC certification, we want to hear from RNs and employers first hand.

Study design

This evaluation research project uses three methods to collect data: an electronic survey; focus group discussions by teleconference; and individual interviews. The purpose of the survey is to find out from community health nurses (certified and not) if and how certification affects practice and the employing agency. Those who return the survey will have the opportunity to volunteer for either a focus group discussion by teleconference or individual telephone interviews. The purpose of this group discussion/interview is to acquire your perspectives on the impacts of certification on nursing practice of individuals and the employing agencies, as well the facilitators and barriers to certification. This information will be an important addition to the survey data and will provide us with a more detailed and complete picture of influences and impacts. If you volunteer, you will be contacted as to if and how you will be invited to continue your participation in the study.

Who can participate in the study?

Certification Survey: CHNC Members

Registered nurses (RNs) in Canada that are members of the Community Health Nurses Association of Canada (CHNC) and/or are certified in community health nursing by the Canadian Nurses Association (CNA) will be invited to participate in this evaluation research project. Only those who have agreed to release their information for research purposes will be contacted.

Who will be conducting the study?

Dr. Ardene Robinson Vollman, RN and Dr. Ruth Martin Misener, RN NP are the investigators contracted by the Community Health Nurses of Canada to lead this project. Ms. Heather Rowe is the research assistant on the project; she is a Master's student at the University of Calgary.

What you will be asked to do

You will be asked to complete an electronic survey, which will take about 15 minutes. You will also have the chance to volunteer for a second project phase that includes either a focus group discussion by teleconference or an individual telephone interview to learn about:
1. The influence of CNA certification on your community health nursing practice and on employing agencies;
2. Organizational facilitators and obstacles to CCHNC certification and renewal; and
3. Stories that describe real-life contributions of certification to quality nursing practice.

If you volunteer for phase two, you will be contacted by e-mail or telephone to set a convenient time for a telephone conference or interview. You will then be given information to join the teleconference. If you are being interviewed, one of the investigators will call you at the time agreed upon. You will be asked to participate as fully as you are able in these activities. The focus group discussions and interviewed will be digitally audio-taped.

Possible Risks and Discomforts

While confidentiality cannot be guaranteed in group settings and participants may feel constrained or inhibited from openly sharing their views, we will give each participant a "code name" to protect your privacy. The time period may be insufficient for participants to feel that they have adequately presented their views. If they so desire, participants may provide additional information by e-mail to the investigators after the interview is closed.

Possible Benefits

If you agree to participate in this study there may or may not be a direct benefit to you. The information we get from this study may help CHNC and CNA to revise and update the certification and recertification processes for future use.

Compensation / Reimbursement

There is no compensation for participation. You will be contacted by a research team member and given information on how to join the teleconference; there is no cost to you if you use a land line. Unfortunately we are not able to reimburse cell phone costs. For interviews, a research team member will contact you.

Confidentiality & Anonymity

All efforts to ensure anonymity have been taken and you will not be identified by name. Each participant has been provided with a code that will be used for the survey, as well as in the teleconferences and interviews. These codes are linked to your contact information in a database accessible only to the project personnel; the database file is password-protected, and the file is stored on a password-protected computer in a secure location. You will be addressed throughout the discussion by code rather than by name. We expect that what is stated in this group discussion will remain in confidence among all participants. No participant will be identified in the report; all data will be aggregated and anonymized.

The survey uses a subscription service called Survey Monkey, a US firm that specializes in survey design, collection, and analysis. Survey Monkey will use your e-mail address to send out the survey and receive your data. Survey Monkey

Certification Survey: CHNC Members

takes data security seriously and has many strategies in place to protect privacy. For more information: http://help.surveymonkey.com/app/answers/detail/a_id/337

QUESTIONS

If you have any questions about the study itself, please contact Dr. Ardene Robinson Vollman at avollman@shaw.ca. If you have any questions concerning your rights as a possible participant in this evaluation, please contact the Director of the Office of Medical Bioethics, University of Calgary, at 403-220-7990. If you prefer to avoid long-distance charges, please e-mail omb@ucalgary.ca and put E-22822 in the subject line.

Problems or Concerns

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance (902) 494-1462, or e-mail patricia.lindley@dal.ca.

*** 1. After reading the information above, please indicate:**

- ◯ I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time.
- ◯ I do not consent to participating in this study.

2. In this section, please tell us about yourself:

2. Sex

- ◯ Male
- ◯ Female

3. Age

- ◯ 20-29
- ◯ 30-39
- ◯ 40-49
- ◯ 50-59
- ◯ 60-69

4. Number of years in your current position?

Page 3

Certification Survey: CHNC Members

5. Employment Status:

- ◯ Full-time
- ◯ Part-time
- ◯ Casual full-time
- ◯ Casual part-time

6. In which province/territory(s) do you practice?

7. What is your MAIN area of practice? Please choose one:

- ◯ Public health
- ◯ Home care
- ◯ Education institution
- ◯ Parish nursing
- ◯ Occupational health nursing
- ◯ Community health nursing
- ◯ Primary care/family practice nursing
- ◯ Prison nursing
- ◯ Telehealth
- ◯ Nursing station (outpost or clinic)
- ◯ Government
- ◯ Other (please specify)

8. What is the MAIN focus of your practice? Please choose one:

- ◯ Direct (clinical, front line)
- ◯ Administration
- ◯ Professional development or staff education
- ◯ Educational institution

Certification Survey: CHNC Members

9. How many years have you been working in community health nursing (direct practice, administration, staff education and teaching/research)? Please choose one:

- ◯ Less than 1 year
- ◯ 1 to 2 years experience
- ◯ 3 to 5 years experience
- ◯ 6 to 10 years experience
- ◯ 11 or more years experience

10. In what type of organizational structure/size do you practice? Please choose one:

- ◯ Local/district public health unit/department
- ◯ Regional health authority
- ◯ Provincial/Territorial Government Agency
- ◯ Public Health Association or Society
- ◯ Primary Care
- ◯ Private Agency
- ◯ Not-for-profit agency (VON, St. Elizabeth)

11. Besides your RN, what educational credentials do you hold?

- ☐ Bachelor's degree in Nursing
- ☐ Bachelor's degree other than Nursing
- ☐ Master's degree in Nursing
- ☐ Master's degree other than Nursing
- ☐ Doctoral degree in Nursing
- ☐ Doctoral degree other than Nursing
- ☐ Other (please specify)

12. Have you ever achieved CCHN certification?

- ◯ No
- ◯ Yes

Certification Survey: CHNC Members

3. In this next section...

Please tell us about how CCHN certification (which implies that Canadian Community Health Nursing Standards of Practice and Competencies are in use) have affected your organization

13. Please indicate your response to each of the statements by choosing the option that best represents your opinion:

Our organization has...

	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Ammended its job descriptions to fit the CCHN Standards	○	○	○	○	○
b. Ammended its performance appraisal formats to fit the CCHN Standards	○	○	○	○	○
c. Changed the qualifications it seeks when hiring registered nurses	○	○	○	○	○
d. Adjusted pay scales to accomodate nurses with certification	○	○	○	○	○
e. Become more aware of its continuing education responsibilities for certified nurses	○	○	○	○	○
f. Offered more access to continuing education or professional development opportunities now than in the past	○	○	○	○	○
g. Provided recognition for nurses who become certified	○	○	○	○	○
h. Offered incentives for certification	○	○	○	○	○
i. Provided support for certification	○	○	○	○	○
j. Expressed desire that nurses who are currently certified maintain and renew their CCHN certification	○	○	○	○	○
k. Acted to reduce or eliminate obstacles they were made aware of	○	○	○	○	○
l. Informed the public that we have specialist nurses on staff	○	○	○	○	○

Certification Survey: CHNC Members

14. Please indicate your response to each of the statements by choosing the option that best represents your opinion:

Compared to non-certified community health nurses, certified nurses...

	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Work to a more full scope of practice	◯	◯	◯	◯	◯
b. Are more up-to-date in their knowledge	◯	◯	◯	◯	◯
c. Are noted by clients as credible specialists in their area of practice	◯	◯	◯	◯	◯
d. Satisfy clients with the service provided	◯	◯	◯	◯	◯
e. Are more credible in interprofessional/multidisciplinary contexts	◯	◯	◯	◯	◯
f. Apply and talk about research in practice decisions	◯	◯	◯	◯	◯
g. Are better prepared for positions of added responsibility	◯	◯	◯	◯	◯
h. Are more likely to promote certification among colleagues	◯	◯	◯	◯	◯
i. Are more likely to create tension among non-certified colleagues	◯	◯	◯	◯	◯

15. Below are some BARRIERS to certification. Please choose as many as apply to your organization

- ☐ Lack of recognition of certified nurses within your organization
- ☐ Lack of support to prepare for examination
- ☐ Inability to increase compensation for certified nurses
- ☐ Inability to provide on-site professional development/continuing education
- ☐ Policy that continuing education is on the employee's personal time
- ☐ Lack of mentors
- ☐ Lack of on-site, easily accessible reference materials
- ☐ Other? (please specify)

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Certification Survey: CHNC Members

17. Below are some statements about the value of certification to you personally. Please choose the option that best represents your opinion:

The outcomes of nursing certification for me could include...

	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Enhanced feelings of personal accomplishment	○	○	○	○	○
b. Personal satisfaction	○	○	○	○	○
c. Job satisfaction	○	○	○	○	○
d. Validation of specialized knowledge	○	○	○	○	○
e. Professional growth	○	○	○	○	○
f. Attainment of a practice standard/competency.	○	○	○	○	○
g. Evidence of professional commitment	○	○	○	○	○
h. Acceptance of professional challenge	○	○	○	○	○
i. Professional credibility	○	○	○	○	○
j. Enhanced personal confidence in clinical abilities	○	○	○	○	○
k. Higher level of clinical competence	○	○	○	○	○
l. Enhanced professional accountability	○	○	○	○	○

Other (please specify)

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Certification Survey: CHNC Members

18. Below are some statements about the value of certification to you in your professional role. Please choose the option that best represents your opinion:

The outcomes of nursing certification for me could include...

	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Enhanced managerial confidence in my clinical abilities	◯	◯	◯	◯	◯
b. Increased marketability	◯	◯	◯	◯	◯
c. Peer recognition of advanced status internally	◯	◯	◯	◯	◯
d. External recognition of advanced status (e.g., professional association)	◯	◯	◯	◯	◯
e. Improved recognition of advanced status from other health professionals/stakeholders	◯	◯	◯	◯	◯
f. Better recognition of community health expertise	◯	◯	◯	◯	◯
g. Increased client confidence	◯	◯	◯	◯	◯
h. Increased client satisfaction	◯	◯	◯	◯	◯
i. Increased salary	◯	◯	◯	◯	◯

Other (please specify)

4. Further Involvement:

Below, we ask you to indicate if you would be interested in participating in a focus group discussion by teleconference or individual telephone interviews. The purpose of this group discussion/interview is to acquire your perspectives on the impacts of certification on nursing practice of individuals and the employing agencies, as well the facilitators and barriers to certification. This information will be an important addition to the survey data and will provide us with a more detailed and complete picture of influences and impacts. If you volunteer, you will be contacted as to if and how you will be invited to continue your participation in the study.

19. I would be willing to participate in:

☐ A focus group discussion by teleconference

☐ An individual telephone interview

20. If you are willing to participate, please provide a telephone number at which we can contact you:

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Certification Survey: CHNC Members

21. Please indicate a time of day that would be most convenient for us to contact you:

- ◯ Day
- ◯ Evening
- ◯ Either

22. If you are willing to participate, can you also please provide an email address at which we can contact you:

5. THANK YOU!

Thank you for taking the time to complete this survey. We understand that your time is valuable, and your feedback is greatly appreciated.

If you have volunteered to participate in a focus group or individual interview, you will be contacted shortly.

Thank you!

Survey – First Cohort Group

Value of Certification and Intent to Pursue Re-Certification:

1. CONSENT FORM

Assessing the influence of Canadian Nurses Association (CNA) certification on community health nursing practice in Canada

Contact person at Dalhousie University:
Ruth Martin Misener RN, NP, PhD
Associate Professor and Associate Director, Graduate Programs
Dalhousie University, School of Nursing
5869 University Ave, Halifax NS B3H 3J5
902-494-2250 (office telephone)
902-494-3487 (fax)
ruth.martin-misener@dal.ca

Contact Person at University of Calgary:
Ardene Robinson Vollman PhD, RN
Adjunct Associate Professor
Department of Community Health Sciences
403-239-3180
avollman@shaw.ca

Introduction

We invite you to take part in a research study being conducted by Dr. Ardene Robinson Vollman of the University of Calgary (as Robinson Vollman Inc.) and Dr. Ruth Martin Misener who is an associate professor at Dalhousie University. This evaluation research is on behalf of the Community Health Nurses of Canada. Your participation in this study is voluntary and you may withdraw from the study at any time. Your membership in the Community Health Nurses of Canada and/or your certification by the Canadian Nurses Association will not be affected by your participation or choice to not participate. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Dr. Martin Misener (information provided above) or Dr. Robinson Vollman (403-239-3180; avollman@shaw.ca).

Purpose of the study

The Community Health Nurses of Canada (CHNC) want to understand the outcomes of certification and its impacts on community health nursing practice. To do so, they have hired Dr. Robinson Vollman and Dr. Martin Misener to design and carry out an evaluation research project in order to provide feedback for the CNA certification process in general, to CHNC about community health nursing certification, and to inform any refinements to the process of certification and recertification. In order to better understand how people perceive the influences on and impacts of CCHNC certification, we want to hear from RNs and employers first hand.

Study design

This evaluation research project uses three methods to collect data: an electronic survey; focus group discussions by teleconference; and individual interviews. The purpose of the survey is to find out from community health nurses (certified and not) if and how certification affects practice and the employing agency. Those who return the survey will have the opportunity to volunteer for either a focus group discussion by teleconference or individual telephone interviews. The purpose of this group discussion/interview is to acquire your perspectives on the impacts of certification on nursing practice of individuals and the employing agencies, as well the facilitators and barriers to certification. This information will be an important addition to the survey data and will provide us with a more detailed and complete picture of influences and impacts. If you volunteer, you will be contacted as to if and how you will be invited to continue your participation in the study.

Who can participate in the study?

Value of Certification and Intent to Pursue Re-Certification:

Registered nurses (RNs) in Canada that are members of the Community Health Nurses Association of Canada (CHNC) and/or are certified in community health nursing by the Canadian Nurses Association (CNA) will be invited to participate in this evaluation research project. Only those who have agreed to release their information for research purposes will be contacted.

Who will be conducting the study?

Dr. Ardene Robinson Vollman, RN and Dr. Ruth Martin Misener, RN NP are the investigators contracted by the Community Health Nurses of Canada to lead this project. Ms. Heather Rowe is the research assistant on the project; she is a Master's student at the University of Calgary.

What you will be asked to do

You will be asked to complete an electronic survey, which will take about 15 minutes. You will also have the chance to volunteer for a second project phase that includes either a focus group discussion by teleconference or an individual telephone interview to learn about:
1. The influence of CNA certification on your community health nursing practice and on employing agencies;
2. Organizational facilitators and obstacles to CCHNC certification and renewal; and
3. Stories that describe real-life contributions of certification to quality nursing practice.

If you volunteer for phase two, you will be contacted by e-mail or telephone to set a convenient time for a telephone conference or interview. You will then be given information to join the teleconference. If you are being interviewed, one of the investigators will call you at the time agreed upon. You will be asked to participate as fully as you are able in these activities. The focus group discussions and interviewed will be digitally audio-taped.

Possible Risks and Discomforts

While confidentiality cannot be guaranteed in group settings and participants may feel constrained or inhibited from openly sharing their views, we will give each participant a "code name" to protect your privacy. The time period may be insufficient for participants to feel that they have adequately presented their views. If they so desire, participants may provide additional information by e-mail to the investigators after the interview is closed.

Possible Benefits

If you agree to participate in this study there may or may not be a direct benefit to you. The information we get from this study may help CHNC and CNA to revise and update the certification and recertification processes for future use.

Compensation / Reimbursement

There is no compensation for participation. You will be contacted by a research team member and given information on how to join the teleconference; there is no cost to you if you use a land line. Unfortunately we are not able to reimburse cell phone costs. For interviews, a research team member will contact you.

Confidentiality & Anonymity

All efforts to ensure anonymity have been taken and you will not be identified by name. Each participant has been provided with a code that will be used for the survey, as well as in the teleconferences and interviews. These codes are linked to your contact information in a database accessible only to the project personnel; the database file is password-protected, and the file is stored on a password-protected computer in a secure location. You will be addressed throughout the discussion by code rather than by name. We expect that what is stated in this group discussion will remain in confidence among all participants. No participant will be identified in the report; all data will be aggregated and anonymized.

The survey uses a subscription service called Survey Monkey, a US firm that specializes in survey design, collection, and

Value of Certification and Intent to Pursue Re-Certification:

analysis. Survey Monkey will use your e-mail address to send out the survey and receive your data. Survey Monkey takes data security seriously and has many strategies in place to protect privacy. For more information: http://help.surveymonkey.com/app/answers/detail/a_id/337

QUESTIONS

If you have any questions about the study itself, please contact Dr. Ardene Robinson Vollman at avollman@shaw.ca. If you have any questions concerning your rights as a possible participant in this evaluation, please contact the Director of the Office of Medical Bioethics, University of Calgary, at 403-220-7990. If you prefer to avoid long-distance charges, please e-mail omb@ucalgary.ca and put E-22822 in the subject line.

Problems or Concerns

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance (902) 494-1462, or e-mail patricia.lindley@dal.ca.

*** 1. After reading the above information, please indicate:**

◯ I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

◯ I do not consent to participate in this study.

Value of Certification and Intent to Pursue Re-Certification:

2. In this section, please tell us about yourself:

2. Sex

- ◯ Male
- ◯ Female

3. Age

- ◯ 20-29
- ◯ 30-39
- ◯ 40-49
- ◯ 50-59
- ◯ 60-69

4. Number of years in your current position?

5. Employment Status:

- ◯ Full-time
- ◯ Part-time
- ◯ Casual full-time
- ◯ Casual part-time

6. In which province/territory(s) do you practice?

Value of Certification and Intent to Pursue Re-Certification:

7. What is your MAIN area of practice? Please choose one:

- ◯ Public health
- ◯ Home care
- ◯ Education institution
- ◯ Parish nursing
- ◯ Occupational health nursing
- ◯ Community health nursing
- ◯ Primary care/family practice nursing
- ◯ Prison nursing
- ◯ Telehealth
- ◯ Nursing station (outpost or clinic)
- ◯ Government
- ◯ Other (please specify)

8. What is the MAIN focus of your practice? Please choose one:

- ◯ Direct (clinical, front line)
- ◯ Administration
- ◯ Professional development or staff education

9. How many years have you been working in community health nursing (direct practice, administration, staff education and teaching/research)? Please choose one:

- ◯ Less than 1 year
- ◯ 1 to 2 years experience
- ◯ 3 to 5 years experience
- ◯ 6 to 10 years experience
- ◯ 11 or more years experience

Value of Certification and Intent to Pursue Re-Certification:

10. In what type of organizational structure/size do you practice? Please choose one:

- ◯ Local/district public health unit/department
- ◯ Regional health authority
- ◯ Provincial/Territorial Government Agency
- ◯ Public Health Association or Society

11. Besides your RN, what educational credentials do you hold? Please check as many as apply

- ☐ Bachelor's degree in Nursing
- ☐ Bachelor's degree other than Nursing
- ☐ Master's degree in Nursing
- ☐ Master's degree other than Nursing
- ☐ Doctoral degree in Nursing
- ☐ Doctoral degree other than Nursing
- ☐ Other (please specify)

12. Do you intend to renew your certification when it becomes due? Please choose one

- ◯ No
- ◯ Yes
- ◯ Unsure

Value of Certification and Intent to Pursue Re-Certification:

3. In the next section, please tell us about how having CCHN-certification has...

13. Please indicate your response to each of the statements by choosing the number that best represents your opinion:

As a result of completing CCHN-certification...

	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. I have initiated discussions to change our job descriptions to fit the CCHN Standards	○	○	○	○	○
b. I have initiated discussions to modify our performance appraisal formats to fit the CCHN Standards	○	○	○	○	○
c. I am better able to establish collaborative relationships within the organization	○	○	○	○	○
d. I am better able to establish collaborative relationships with other organisations	○	○	○	○	○
e. I am better able to establish collaborative relationships with other disciplines	○	○	○	○	○
f. I work to a more full scope of practice	○	○	○	○	○
g. I stay more up-to-date with emerging knowledge in community health	○	○	○	○	○
h. I have clients who recognise my specialized knowledge	○	○	○	○	○
i. My clients are more satisfied with the service provided	○	○	○	○	○
j. I provide higher quality services to clients	○	○	○	○	○
k. I am more credible in interprofessional/multidisciplinary contexts	○	○	○	○	○
l. I apply and talk about research in practice decisions	○	○	○	○	○
m. I am better prepared for positions of added responsibility	○	○	○	○	○
n. I am more likely to promote certification among colleagues	○	○	○	○	○
o. I am more satisfied with my work	○	○	○	○	○
p. I am better able to collaborate with others	○	○	○	○	○
q. I feel more empowered to work autonomously	○	○	○	○	○
r. I use the PHAC Skill Enhancements program more	○	○	○	○	○

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Value of Certification and Intent to Pursue Re-Certification:

14. Please indicate your response to each of the statements:

As a result of completing CCHN-certification our organization has...

	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Amended its job descriptions to fit the CCHN Standards	◯	◯	◯	◯	◯
b. Amended its performance appraisal formats to fit the CCHN Standards	◯	◯	◯	◯	◯
c. Changed the qualifications it seeks when hiring registered nurses	◯	◯	◯	◯	◯
d. Adjusted pay scales to accommodate nurses with certification	◯	◯	◯	◯	◯
e. Become more aware of its continuing education responsibilities for certified nurses	◯	◯	◯	◯	◯
f. Offered more access to continuing education or professional development opportunities now than in the past	◯	◯	◯	◯	◯
g. Provided recognition for nurses who become certified	◯	◯	◯	◯	◯
h. Offered incentives for certification	◯	◯	◯	◯	◯
i. Provided support for certification	◯	◯	◯	◯	◯
j. Expressed desire that nurses who are currently certified maintain and renew their CCHN certification	◯	◯	◯	◯	◯
k. Acted to reduce or eliminate obstacles to certification	◯	◯	◯	◯	◯
l. Informed the public that we have specialist nurses on staff	◯	◯	◯	◯	◯

15. Please indicate your response to each of the statements:

Compared to non-certified community health nurses, certified nurses...

	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Work to a more full scope of practice	◯	◯	◯	◯	◯
b. Are more up-to-date in their knowledge	◯	◯	◯	◯	◯
c. Are noted by clients as credible specialists in their area of practice	◯	◯	◯	◯	◯
d. Satisfy clients with the service provided	◯	◯	◯	◯	◯
e. Are more credible in interprofessional/multidisciplinary contexts	◯	◯	◯	◯	◯
f. Apply and talk about research in practice decisions	◯	◯	◯	◯	◯
g. Are better prepared for positions of added responsibility	◯	◯	◯	◯	◯
h. Are less likely to promote certification among colleagues	◯	◯	◯	◯	◯
i. Are more likely to create tension among non-certified colleagues	◯	◯	◯	◯	◯
j. Are more satisfied with their work	◯	◯	◯	◯	◯
k. Are better able to collaborate with others	◯	◯	◯	◯	◯
l. Work more autonomously	◯	◯	◯	◯	◯
m. Are more empowered	◯	◯	◯	◯	◯

Value of Certification and Intent to Pursue Re-Certification:

16. Below are some BARRIERS TO RECERTIFICATION. Please choose as many as apply to your organization

- ☐ Lack of recognition of certified nurse
- ☐ Lack of support to prepare for recertification
- ☐ No increase in compensation for certified nurses
- ☐ Lack of on-site professional development/continuing education
- ☐ Policy that continuing education is on the employee's personal time
- ☐ Lack of accessible mentors in the organization
- ☐ Lack of on-site, easily accessible reference materials
- ☐ Other? (please specify)

17. Below are some FACILITATORS FOR RECERTIFICATION. Please choose as many as apply to your organization

- ☐ There is reimbursement for recertification costs
- ☐ There is work time for recertification preparation
- ☐ There are accessible mentors for RNs wishing to become certified
- ☐ There are added reference materials in accessible locations for examination preparation purposes
- ☐ There is on-site continuing education
- ☐ The Standards are used to make continuing education decisions
- ☐ Certification is recognized in the pay scales
- ☐ Certification is promoted as a benefit to the organization and its clients
- ☐ Certificate holders are recognized in some way
- ☐ Successful achievement of certification is celebrated in our organization
- ☐ Other? (please specify)

Value of Certification and Intent to Pursue Re-Certification:

18. Below are some statements about the value of certification to you personally:

The outcomes of nursing certification for me include...

	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Enhanced feelings of personal accomplishment	◯	◯	◯	◯	◯
b. Higher personal satisfaction	◯	◯	◯	◯	◯
c. Improved job satisfaction	◯	◯	◯	◯	◯
d. Validation of specialized knowledge	◯	◯	◯	◯	◯
e. Better professional growth	◯	◯	◯	◯	◯
f. Attainment of a practice standard/competency	◯	◯	◯	◯	◯
g. Evidence of professional commitment	◯	◯	◯	◯	◯
h. Acceptance of professional challenge	◯	◯	◯	◯	◯
i. Professional credibility	◯	◯	◯	◯	◯
j. Enhanced personal confidence in clinical abilities	◯	◯	◯	◯	◯
k. Improved quality of communication with colleagues	◯	◯	◯	◯	◯
l. Different work assignments than non-certified colleagues	◯	◯	◯	◯	◯
m. More autonomy in my practice	◯	◯	◯	◯	◯
n. Enhanced managerial confidence in my clinical abilities	◯	◯	◯	◯	◯
o. Higher level of clinical competence	◯	◯	◯	◯	◯
p. Enhanced professional accountability	◯	◯	◯	◯	◯
q. Enhanced empowerment for my practice	◯	◯	◯	◯	◯

Other (please specify)

Value of Certification and Intent to Pursue Re-Certification:

19. Below are some statements about the value of certification to me in my professional role:

The value of nursing certification for me include...

	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Increased marketability	◯	◯	◯	◯	◯
b. Peer recognition of advanced status internally	◯	◯	◯	◯	◯
c. External recognition of advanced status (e.g., professional association)	◯	◯	◯	◯	◯
d. Improved recognition of advanced status from other health professionals/stakeholders	◯	◯	◯	◯	◯
e. Better recognition of my community health expertise	◯	◯	◯	◯	◯
f. Increased client confidence	◯	◯	◯	◯	◯
g. Increased client satisfaction	◯	◯	◯	◯	◯
h. Increased salary	◯	◯	◯	◯	◯

Other (please specify)

Value of Certification and Intent to Pursue Re-Certification:

4. Further Involvement:

Below, we ask you to indicate if you would be interested in participating in a focus group discussion by teleconference or individual telephone interviews. The purpose of this group discussion/interview is to acquire your perspectives on the impacts of certification on nursing practice of individuals and the employing agencies, as well the facilitators and barriers to certification. This information will be an important addition to the survey data and will provide us with a more detailed and complete picture of influences and impacts. If you volunteer, you will be contacted as to if and how you will be invited to continue your participation in the study.

20. I would be willing to participate in:

- ☐ A focus group discussion by teleconference
- ☐ An individual telephone interview

21. If you are willing to participate, please provide a telephone number at which we can contact you:

22. Please indicate a time of day that would be most convenient for us to contact you:

- ◯ Day
- ◯ Evening
- ◯ Either

23. If you are willing to participate, can you also please provide an email address at which we can contact you:

Value of Certification and Intent to Pursue Re-Certification:

5. THANK YOU!

Thank you for taking the time to complete this survey. We understand that your time is valuable, and your feedback is greatly appreciated.

If you have volunteered to participate in a focus group or individual interview, you will be contacted shortly.

Thank you!

C. Validation Tool

Questionnaire Number: ☐☐☐

Pilot-testing Review Form
Certification Survey: _____

1. Was the letter of invitation to complete the questionnaire clear?	☐ Yes ☐ No (Please comment) _____
2. Are the instructions about how to complete the questionnaire clear?	☐ Yes ☐ No (Please comment) _____
3. Are the questions relevant to community health nursing?	☐ Yes ☐ No (Please comment) _____
4. Is the questionnaire easy to read?	☐ Yes ☐ No (Please comment) _____
5. Are there any specific questions that are unclear?	☐ Yes ☐ No (Please specify) _____
6. What length of time did it take to complete the questionnaire?	_____ minutes

Reviewer Number□□

Content Validity Expert Panel Review Form
CHNC Members Plus CCHN(C)-certified CHNs not eligible for renewal in 2011

1. Are the demographic questions (number 1-6) appropriate to ask of CHNC members?	□ Yes □ No (Please comment)
2. Are the items in question 7 appropriate and comprehensive? Please suggest items that should be added or deleted.	□ Yes □ No (Please comment)
3. Are the items in question 8 appropriate and comprehensive? Please suggest items that should be added or deleted.	□ Yes □ No (Please comment)
4. Are the barriers and facilitators to certification/recertification listed in questions 9 and 10 appropriate and comprehensive? Please suggest items that should be added or deleted.	□ Yes □ No (Please comment)
5. Are the statements about the value of certification appropriate and comprehensive? Please suggest items that should be added or deleted.	□ Yes □ No (Please comment)
6. Are there any questions that are unclear?	□ Yes □ No (Please specify)
7. Are there any questions that should be omitted?	□ Yes □ No (Please specify)
8. Are there any questions that should be added?	□ Yes □ No (Please specify)

Reviewer Number

Content Validity Expert Panel Review Form
Employers of CHNs with CCHN(C)

1. Are the demographic questions (number 1-6) appropriate to ask of **employers** of CCHNC-certified nurses?	Yes No (Please comment)
2. Are the items in question 7 appropriate and comprehensive **to ask an employer**? Suggest items that should be added or deleted.	Yes No (Please comment)
3. Are the items in question 8 appropriate and comprehensive **to ask an employer**? Suggest items that should be added or deleted.	Yes No (Please comment)
4. Are the barriers and facilitators to certification/recertification listed in question 9 and 10 appropriate and comprehensive **to ask an employer**? Suggest items that should be added or deleted.	Yes No (Please comment)
5. Are the statements about the value of certification **to an employer** appropriate and comprehensive? Suggest items that should be added or deleted.	Yes No (Please comment)
5. Are there any questions that are unclear?	Yes No (Please specify)
6. Are there any questions that should be omitted?	Yes No (Please specify)
7. Are there any questions that should be added?	Yes No (Please specify)

Reviewer Number

Content Validity Expert Panel Review Form
First Cohort CHNs with CCHN(C)

1. Are the demographic questions (number 1-11) appropriate to ask of CCHNC-certified nurses?	Yes No (Please comment)
2. Are the items in question 12 appropriate and comprehensive?	Yes No (Please comment)
3. Are the items in question 13 appropriate and comprehensive?	Yes No (Please comment)
4. Are the barriers and facilitators to certification/recertification listed in questions 14 and 15 appropriate and comprehensive?	Yes No (Please comment)
5. Are the statements about the value of certification appropriate and comprehensive?	Yes No (Please comment)
Are there any questions that are unclear?	Yes No (Please specify)
Are there any questions that should be omitted?	Yes No (Please specify)
Are there any questions that should be added?	Yes No (Please specify)

D. Information Sheet

Dr. Ardene Vollman, Adjunct Associate Professor
Department of Community Health Sciences
Heritage Medical Research Building, Room G29
Telephone: (403) 239-3180
Fax: (403) 452-0813

PROJECT INFORMATION SHEET

Assessing the influence of Canadian Nurses Association (CNA) certification on community health nursing practice in Canada

SPONSOR: Community Health Nurses of Canada.
INVESTIGATORS: **Dr. Ardene Robinson Vollman (Principal Investigator),**
Dr. Ruth Martin-Misener (co-investigator)

We invite you to take part in an evaluation research study being conducted by Dr. Ardene Robinson Vollman of the University of Calgary and Dr. Ruth Martin Misener of Dalhousie University. This evaluation research is on behalf of the Community Health Nurses of Canada. Your participation in this study is voluntary and you may withdraw from the study at any time. Your membership in the Community Health Nurses of Canada and/or your certification by the Canadian Nurses Association will not be affected by your participation or choice to not participate. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Dr. Robinson Vollman (403-239-3180; avollman@shaw.ca).

BACKGROUND

The Community Health Nurses of Canada (CHNC) want to understand the outcomes of certification and its impacts on community health nursing practice. To do so, they have hired us to design and carry out an evaluation research project in order to provide feedback for the CNA certification process in general, to CHNC about community health nursing certification, and to inform any refinements to the process of certification and recertification. In order to better understand how people perceive the influences on and impacts of CCHNC certification, we want to hear from RNs and employers first hand.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this project is to acquire perspectives on the influences on and impacts of certification on nursing practice of individuals and the employing agencies, as well the facilitators and barriers to certification and recertification.

STUDY DESIGN

This evaluation research project uses three methods to collect data: an electronic survey; focus group discussions by teleconference; and individual interviews. The purpose of the survey is to find out from community health nurses (certified and not) if and how certification affects practice and the employing agency. Those who do the survey will have the opportunity to volunteer for either a 60 – 90 minute focus group discussion by teleconference or individual telephone interviews. The purpose of this group

discussion/interview is to acquire your perspectives on the impacts of certification on nursing practice of individuals and the employing agencies, as well the facilitators and barriers to certification. This information will be an important addition to the survey data and will provide us with a more detailed and complete picture of influences and impacts. If you volunteer, you will be contacted as to if and how you will be invited to continue your participation in the study.

WHO CAN PARTICIPATE IN THE STUDY?
Registered nurses (RNs) in Canada that are members of the Community Health Nurses Association of Canada (CHNC) and/or are certified in community health nursing by the Canadian Nurses Association (CNA) will be invited to participate in this evaluation research project. Only those who have agreed to release their information for research purposes will be contacted.

WHO WILL BE CONDUCTING THE STUDY?
Dr. Ardene Robinson Vollman, RN and Dr. Ruth Martin Misener, RN NP are the investigators contracted by the Community Health Nurses of Canada to lead this project. Ms. Heather Rowe is the research assistant on the project; she is a Master's student at the University of Calgary.

WHAT WOULD I HAVE TO DO?
You will be asked to complete an electronic survey, which will take about 10-15 minutes. You will also have the chance to volunteer for a second project phase that includes either a focus group discussion by teleconference or an individual telephone interview to learn about:

1. The influence of CNA certification on your community health nursing practice and on employing agencies;
2. Organizational facilitators and obstacles to CCHNC certification and renewal; and
3. Stories that describe real-life contributions of certification to quality nursing practice.

If you volunteer for phase two, you will be contacted by e-mail or telephone to set a convenient time for a telephone conference or interview. You will then be given information to join the teleconference. If you are being interviewed, one of the investigators will call you at the time agreed upon. You will be asked to participate as fully as you are able in these activities. The focus group discussions and interviewed will be digitally audio-taped.

WHAT ARE THE RISKS?
While confidentiality cannot be guaranteed in group settings and participants may feel constrained or inhibited from openly sharing their views, we will give each participant a "code name" to protect your privacy. The time period may be insufficient for participants to feel that they have adequately presented their views. If they so desire, participants may provide additional information by e-mail to the investigators after the interview is closed.

WILL I BENEFIT IF I TAKE PART?
If you agree to participate in this study there may or may not be a direct benefit to you. The information we get from this study may help us to revise and update the certification and recertification processes for future use.

DO I HAVE TO PARTICIPATE?
No, you can decide not to complete and return the survey. You will receive up to three reminders that you can choose to ignore. If you decide to do the survey but prefer not to have any further involvement, you can decide not to volunteer for focus group or interviews. If you do choose to participate in either the focus group or interview, you do not have to respond to every question asked. You are able to withdraw from participation without penalty at any time before or during the teleconference if you

change your mind or are called away. If you feel you have something to add after the focus group or interview, you will be able to send additional comments by e-mail to Dr. Robinson Vollman for inclusion in the project.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?
Nothing else but setting an appointment time for the telephone contact.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?
No. You will be contacted by a research team member given information on how to join the teleconference. There is no cost to you if you use a land line. Unfortunately we are not able to reimburse cell phone costs. For interviews, a research team member will contact you.

WILL MY RECORDS BE KEPT PRIVATE?
All efforts to ensure anonymity have been taken and you will not be identified by name. Each participant has been provided with a code that will be used for the survey, as well as in the teleconferences and interviews. These codes are linked to your contact information in a database accessible only to the project personnel; the database file is password-protected, and the file is stored on a password-protected computer in a secure location. You will be addressed throughout the discussion by code rather than by name. We expect that what is stated in this group discussion will remain in confidence among all participants. No participant will be identified in the report; all data will be aggregated and anonymized. The survey uses a subscription service called Survey Monkey, a US firm that specializes in survey design, collection, and analysis. Survey Monkey will use your e-mail addresses to send out the survey and receive your data. Survey Monkey takes data security seriously and has many strategies in place to protect privacy. For more information:
http://help.surveymonkey.com/app/answers/detail/a_id/337

While confidentiality cannot be guaranteed in group settings and participants may feel constrained or inhibited from openly sharing their views, we will give each participant a “code” to protect their privacy. The time period may be insufficient for participants to feel that they have adequately presented their views. If they so desire, participants may provide additional information by e-mail to the investigators after the interview is closed.

USE OF QUOTES
We might like to use quotes in our report from what you say in focus group and interview discussion. We will not identify you in any quotes we use; we will obscure any identifying words, and will make the quotes anonymous. You will be asked to consent to the use of quotes.

If you have any questions concerning your rights as a possible participant in this evaluation, please contact the Director of the Office of Medical Bioethics, 403-220-7990. If you prefer to avoid long-distance charges, please e-mail omb@ucalgary.ca and put E-22822 in the subject line. Further information can also be received from Dr. Ardene Robinson Vollman whose number is 403-239-3180 and email address is avollman@shaw.ca

E. Consent Form

[on University Letterhead]

CONSENT FORM

Assessing the influence of Canadian Nurses Association (CNA) certification on community health nursing practice in Canada

Contact person at Dalhousie University:
Ruth Martin Misener RN, NP, PhD
Associate Professor and Associate Director, Graduate Programs
Dalhousie University, School of Nursing
5869 University Ave, Halifax NS B3H 3J5
902-494-2250 (office telephone)
902-494-3487 (fax)
ruth.martin-misener@dal.ca

Contact person at University of Calgary:
Ardene Robinson Vollman, PhD RN
Adjunct Associate Professor, Department of Community Health Sciences
Faculty of Medicine
Office: 19 Evergreen Rise SW
Calgary AB T2Y 3H6
403-239-3180 (phone)
403-452-0813 (fax)
avollman@shaw.ca

Introduction
We invite you to take part in a research study being conducted by Dr. Ardene Robinson Vollman of the University of Calgary (as Robinson Vollman Inc.) and Dr. Ruth Martin Misener who is an associate professor at Dalhousie University. This evaluation research is on behalf of the Community Health Nurses of Canada. Your participation in this study is voluntary and you may withdraw from the study at any time. Your membership in the Community Health Nurses of Canada and/or your certification by the Canadian Nurses Association will not be affected by your participation or choice to not participate. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Dr. Martin Misener (information provided above) or Dr. Robinson Vollman (403-239-3180; avollman@shaw.ca).

Purpose of the study
The Community Health Nurses of Canada (CHNC) want to understand the outcomes of certification and its impacts on community health nursing practice. To do so, they have hired Dr. Robinson Vollman and Dr. Martin Misener to design and carry out an evaluation research project in order to provide feedback for the CNA certification process in general, to CHNC about community health nursing certification, and to inform any refinements to the process of certification and recertification. In order to better

understand how people perceive the influences on and impacts of CCHNC certification, we want to hear from RNs and employers first hand.

Study design
This evaluation research project uses three methods to collect data: an electronic survey; focus group discussions by teleconference; and individual interviews. The purpose of the survey is to find out from community health nurses (certified and not) if and how certification affects practice and the employing agency. Those who return the survey will have the opportunity to volunteer for either a focus group discussion by teleconference or individual telephone interviews. The purpose of this group discussion/interview is to acquire your perspectives on the impacts of certification on nursing practice of individuals and the employing agencies, as well the facilitators and barriers to certification. This information will be an important addition to the survey data and will provide us with a more detailed and complete picture of influences and impacts. If you volunteer, you will be contacted as to if and how you will be invited to continue your participation in the study.

Who can participate in the study?
Registered nurses (RNs) in Canada that are members of the Community Health Nurses Association of Canada (CHNC) and/or are certified in community health nursing by the Canadian Nurses Association (CNA) will be invited to participate in this evaluation research project. Only those who have agreed to release their information for research purposes will be contacted.

Who will be conducting the study?
Dr. Ardene Robinson Vollman, RN, and Dr. Ruth Martin Misener, RN NP, are the investigators contracted by the Community Health Nurses of Canada to lead this project. Ms. Heather Rowe is the research assistant on the project; she is a Master's student at the University of Calgary.

What you will be asked to do
You will be asked to complete an electronic survey, which will take about 20 minutes. You will also have the chance to volunteer for a second project phase that includes either a focus group discussion by teleconference or an individual telephone interview to learn about:

1. The influence of CNA certification on your community health nursing practice and on employing agencies;
2. Organizational facilitators and obstacles to CCHNC certification and renewal; and
3. Stories that describe real-life contributions of certification to quality nursing practice.

If you volunteer for phase two, you will be contacted by e-mail or telephone to set a convenient time for a 60 – 90 minute telephone conference or interview. You will then be given information to join the teleconference. If you are being interviewed, one of the investigators will call you at the time agreed upon. You will be asked to participate as fully as you are able in these activities. The focus group discussions and interviewed will be digitally audio-taped.

Possible risks and discomforts
While confidentiality cannot be guaranteed in group settings and participants may feel constrained or inhibited from openly sharing their views, we will give each participant a "code name" to protect your privacy. The time period may be insufficient for participants to feel that they have adequately presented their views. If they so desire, participants may provide additional information by e-mail to the investigators after the interview is closed.

Possible benefits
If you agree to participate in this study there may or may not be a direct benefit to you. The information we get from this study may help CHNC and CNA to revise and update the certification and recertification processes for future use.

Compensation /reimbursement
There is no compensation for participation. You will be contacted by a research team member and given information on how to join the teleconference; there is no cost to you if you use a land line. Unfortunately we are not able to reimburse cell phone costs. For interviews, a research team member will contact you.

Confidentiality & anonymity
All efforts to ensure anonymity have been taken and you will not be identified by name. Each participant has been provided with a code that will be used for the survey, as well as in the teleconferences and interviews. These codes are linked to your contact information in a database accessible only to the project personnel; the database file is password-protected, and the file is stored on a password-protected computer in a secure location. You will be addressed throughout the discussion by code rather than by name. We expect that what is stated in this group discussion will remain in confidence among all participants. No participant will be identified in the report; all data will be aggregated and anonymized.

Use of quotes
We might like to use quotes in our report from what you say in focus group and interview discussion. We will not identify you in any quotes we use; we will obscure any identifying words, and will make the quotes anonymous. Below you will be asked to consent to the use of quotes.

Questions
If you have any questions about the study itself, please contact Dr. Ardene Robinson Vollman at avollman@shaw.ca. If you have any questions concerning your rights as a possible participant in this evaluation, please contact the Director of the Office of Medical Bioethics, University of Calgary, at 403-220-7990. If you prefer to avoid long-distance charges, please e-mail omb@ucalgary.ca and put E-22822 in the subject line.

Problems or concerns

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance (902) 494-1462, or e-mail patricia.lindley@dal.ca.

Signature Page

Assessing the influence of Canadian Nurses Association (CNA) certification on community health nursing practice in Canada

SPONSOR: Community Health Nurses of Canada.

☐ I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

☐ I agree to be contacted if I volunteer for a follow-up discussion or interview.

☐ I agree to the digital audio-recording of any focus groups or interviews in which I participate.

☐ I agree that the researchers can use quotes from what I say in their report as long as I cannot be identified. I understand every effort will be made to anonymize quotes.

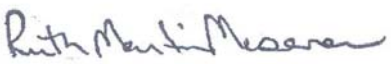
Name of study participant: _____
(please print)

Signature of study participant: _____

Date: _____

Name of researchers:

Ardene Robinson Vollman, PhD, RN
University of Calgary



Ruth Martin Misener, RN-NP, PhD
Dalhousie University

F. Focus Group and Interview Discussion Guide

1. Please tell me about the influence community health nursing certification has had on your agency. Please give an example to illustrate.

2. Please tell me about how certification in community health nursing has affected you, your practice, and/or your colleagues. Please provide an example or examples to demonstrate your point (s).

3. Tell me if you think patient/client outcomes have changed with certification. If so, how? Please illustrate by an example or examples.

4. The First Cohort of nurses who achieved certification is up for renewal next year. What advice do you have for them; for their employers, for CHNC; or for CNA?

Additional probes for First Cohort:

Do you intend to recertify next year? Why; why not?

G. Survey Response Rates: Three Groups

TABLE 1.1 – Survey Response Rate: CHNC Members+		
# of Surveys Sent	**# of Surveys Completed**	**Response Rate**
285	177	62.1%

TABLE 1.2 – Response Rate per Survey Question: CHNC Members+				
Question	**Responses**	**Skipped**	**Total Possible Responses**	**Response Rate**
2. Sex	172	5	177	97.2%
3. Age	172	5	177	97.2%
4. Number of years in your current position?	172	5	177	97.2%
5. Employment Status	172	5	177	97.2%
6. In which province/territory(s) do you practice?	171	6	177	96.6%
7. What is your MAIN area of practice?	173	4	177	97.7%
8. What is the MAIN focus of your practice?	171	6	177	96.6%
9. How many years have you been working in community health nursing (direct practice, administration, staff education and teaching/research)?	172	5	177	97.2%
10. In what type of organizational structure/size do you practice?	169	8	177	95.5%
11. Besides your RN, what educational credentials do you hold?	163	14	177	92.1%
12. Have you ever achieved CCHN certification?	172	5	177	97.2%
13. Please indicate your response to each of the statements by choosing the option that best represents your opinion: Our organization has...	163	14	177	92.1%
14. Please indicate your response to each of the statements by choosing the option that best represents your opinion: Compared to non-certified community health nurses, certified nurses...	163	14	177	92.1%
15. Below are some BARRIERS to certification. Please choose as many as apply to your organization.	160	17	177	90.4%
16. Below are some FACILITATORS for certification. Please circle as many as apply to your organization.	145	32	177	81.9%
17. Below are some statements about the value of certification to you personally. Please choose the option that best represents your opinion: The outcomes of nursing certification for me could include...	162	15	177	91.5%
18. Below are some statements about the value of certification to you in your professional role. Please choose the option that best represents your opinion: The outcomes of nursing certification for me could include...	163	14	177	92.1%

TABLE 2.1 – Survey Response Rate: Employers of CHNs with CHNC(C)		
# of Surveys Sent	**# of Surveys Completed**	**Response Rate**
119	31	26.1%

TABLE 2.2 – Response Rate per Survey Question: Employers of CHNs with CHNC(C)				
Question	**Responses**	**Skipped**	**Total Possible Responses**	**Response Rate**
2. In which province(s)/territory(s) does your organization provide service?	22	9	31	71.0%
3. What is your MAIN area of practice?	27	4	31	87.1%
4. What is the MAIN focus of your practice?	28	3	31	90.3%
5. How would you characterize your organization in terms of structure/size?	27	4	31	87.1%
6. Approximately how many registered nurses with community health nursing certification do you employ?	26	5	31	83.9%
7. Approximately how many registered nurses do you employ that do not have community health nursing certification?	26	5	31	83.9%
8. Please indicate your response to each of the statements by choosing the option that best represents your organization's opinion: In our organization...	22	9	31	71.0%
9. Please indicate your response to each of the statements by choosing the option that best represents your organization's opinion: Compared to non-certified community health nurses, certified nurses...	20	11	31	64.5%
10. Below are some BARRIERS to certification. Please choose as many as apply to your organization.	20	11	31	64.5%
11. Below are some FACILITATORS for certification. Please choose as many as apply to your organization.	21	10	31	67.7%
12. Below are some statements about the value of certification to an employer. Please choose the option which best represents your organization's opinion: The outcomes of community health nursing certification for our organization include...	20	11	31	64.5%

TABLE 3.1 – Survey Response Rate: First Cohort		
# of Surveys Sent	**# of Surveys Completed**	**Response Rate**
109	48	44.0%

TABLE 3.3 – Response Rate per Survey Question: First Cohort				
Question	**Responses**	**Skipped**	**Total Possible Responses**	**Response Rate**
2. Sex	47	1	48	97.9%
3. Age	47	1	48	97.9%
4. Number of years in your current position?	46	2	48	95.8%
5. Employment Status	47	1	48	97.9%
6. In which province/territory(s) do you practice?	46	2	48	95.8%
7. What is your MAIN area of practice?	47	1	48	97.9%
8. What is the MAIN focus of your practice?	45	3	48	93.8%
9. How many years have you been working in community health nursing (direct practice, administration, staff education and teaching/research)?	46	2	48	95.8%
10. In what type of organizational structure/size do you practice?	42	6	48	87.5%
11. Besides your RN, what educational credentials do you hold?	44	4	48	91.7%
12. Do you intend to renew your certification when it becomes due?	47	1	48	97.9%
13. Please indicate your response to each of the statements by choosing the number that best represents your opinion: As a result of completing CCHN-certification...	45	3	48	93.8%
14. Please indicate your response to each of the statements: As a result of completing CCHN-certification our organization has...	45	3	48	93.8%
15. Please indicate your response to each of the statements: Compared to non-certified community health nurses, certified nurses...	45	3	48	93.8%
16. Below are some BARRIERS TO RECERTIFICATION. Please choose as many as apply to your organization.	44	4	48	91.7%
17. Below are some FACILITATORS FOR RECERTIFICATION. Please choose as many as apply to your organization.	37	11	48	77.1%
18. Below are some statements about the value of certification to you personally: The outcomes of nursing certification for me include...	45	3	48	93.8%
19. Below are some statements about the value of certification to me in my professional role: The value of nursing certification for me include...	45	3	48	93.8%

H. Survey Results: Members+ Group

TABLE 1.3 – Sex: CHNC Members+		
Sex:		
Answer Options	**Response Percent**	
Male	1.7%	
Female	98.3%	
	answered question	**172**
	skipped question	**5**

TABLE 1.4 – Age: CHNC Members+		
Age:		
Answer Options	**Response Percent**	
20-29	4.1%	
30-39	14.5%	
40-49	37.2%	
50-59	39.0%	
60-69	5.2%	
	answered question	**172**
	skipped question	**5**

TABLE 1.5 – Number of years in current position: CHNC Members+		
Number of years in your current position:		
Answer Options	**Response Percent**	
Less than 1 year	5.2%	
1 to 2 years experience	15.1%	
3 to 5 years experience	29.7%	
6 to 10 years experience	22.7%	
11 or more years experience	27.3%	
	answered question	**172**
	skipped question	**5**

TABLE 1.6 – Employment Status: CHNC Members+		
Employment status:		
Answer Options	**Response Percent**	
Full-time	80.2%	
Part-time	16.3%	
Casual full-time	0.6%	
Casual part-time	2.9%	
	answered question	**172**
	skipped question	**5**

TABLE 1.7 – Province/Territory of practice: CHNC Members+		
In which province/territory(s) do you practice:		
Answer Options	**Response Percent**	
Atlantic	18.0%	
QC/ON	33.7%	
MB/SK	17.4%	
AB/BC	29.1%	
YK/NT/NU	1.7%	
	answered question	**172**
	skipped question	**5**

TABLE 1.8 – Main area of practice: CHNC Members+		
What is the MAIN area of your practice? Please choose one:		
Answer Options	**Response Percent**	
Public health	58.5%	
Home care	13.5%	
Education institution	2.9%	
Parish nursing	0.0%	
Occupational health nursing	0.0%	
Community health nursing	14.6%	
Primary care/family practice nursing	1.8%	
Prison nursing	0.0%	
Telehealth	0.0%	
Nursing station (outpost or clinic)	0.6%	
Government	1.2%	
Other (please specify)	7.0%	
answered question		**173**
skipped question		**4**

TABLE 1.9 – Main focus of practice: CHNC Members+		
What is the MAIN focus of your practice? Please choose one:		
Answer Options	**Response Percent**	
Direct (clinical, front line)	63.3%	
Administration	18.9%	
Professional development or staff education	15.4%	
Educational institution	2.4%	
answered question		**171**
skipped question		**6**

TABLE 1.10 – No. yrs working in community health nursing: CHNC Members+		
How many years have you been working in community health nursing (direct practice, administration, staff education and teaching/research)? Please choose one:		
Answer Options	**Response Percent**	
Less than 1 year	0.6%	
1 to 2 years experience	0.6%	
3 to 5 years experience	10.6%	
6 to 10 years experience	23.5%	
11 or more years experience	64.7%	
answered question		**172**
skipped question		**5**

TABLE 1.11 – Organizational structure/size: CHNC Members+		
In what type of organizational structure/size do you practice? Please choose one:		
Answer Options	**Response Percent**	
Local/district public health unit/department	44.3%	
Regional health authority	37.1%	
Provincial/Territorial Government Agency	6.6%	
Public Health Association or Society	0.0%	
Primary Care	3.6%	
Private Agency	4.8%	
Not-for-profit agency (VON, St. Elizabeth)	3.6%	
answered question		**169**
skipped question		**8**

TABLE 1.12 – Other educational credentials: CHNC Members+	
Besides your RN, what educational credentials do you hold?	
Answer Options	**Response Percent**
Bachelor's degree in Nursing	75.2%
Bachelor's degree other than Nursing	13.0%
Master's degree in Nursing	7.5%
Master's degree other than Nursing	11.2%
Doctoral degree in Nursing	0.6%
Doctoral degree other than Nursing	0.6%
Other (please specify): • Certificate • Diploma Occupational Health Nursing • Business admin diploma • Presently working on my Masters of Nursing • CHN Certification • part way through masters in leadership • CCHN(c) • currently taking a master's degree in nursing • CCHN (C) • CNA Certification CHN • CHPCN, IIWCC • Spiritual Direction/Spiritual Formation (U. of Winnipeg) • Community Health Certificate • almost complete BN • Community Health Certificate • enrolled in Masters of Public Health nursing program to be completed in 2011 • IBCLC • 6 credit hours short of a BA degree • Nurse Continence Advisor Certificate • CCHN • Primary Health Care NP certificate • 2 other certifications • CVAA(C) CHPCN(C) CCHN(C) • currently taking Master's degree in Nursing • Certificate in Enterostomal Therapy • BA Psychology • CCHN (C) • CCHN & CHPCN • Health Care Administration Certificate • CDE, Adult Education Certificate	18.6%
answered question	**163**
skipped question	**14**

TABLE 1.13 – CCHNC certification: CHNC Members+		
Have you ever achieved CCHN(C) certification?		
Answer Options	**Response Percent**	
No	12.4%	
Yes	87.6%	
	answered question	**172**
	skipped question	**5**

TABLE 1.14 – Organizational response: CHNC Members+

Please indicate your response to each of the statements by choosing the option that best represents your opinion:

Our organization has...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Amended its job descriptions to fit the CCHN Standards	11.7% (19)	13.5% (22)	41.1% (67)	30.7% (50)	3.1% (5)
b. Amended its performance appraisal formats to fit the CCHN Standards	9.8% (16)	14.1% (23)	41.1% (67)	27.6% (45)	7.4% (12)
c. Changed the qualifications it seeks when hiring registered nurses	13.8% (22)	17.6% (28)	47.8% (76)	17.0% (27)	3.8% (6)
d. Adjusted pay scales to accommodate nurses with certification	4.3% (7)	50.0% (81)	33.3% (54)	9.3% (15)	3.1% (5)
e. Become more aware of its continuing education responsibilities for certified nurses	5.5% (9)	22.1% (36)	38.0% (62)	28.2% (46)	6.1% (10)
f. Offered more access to continuing education or professional development opportunities now than in the past	5.6% (9)	23.5% (38)	42.0% (68)	23.5% (38)	5.6% (9)
g. Provided recognition for nurses who become certified	4.3% (7)	19.6% (32)	24.5% (40)	38.7% (63)	12.9% (21)
h. Offered incentives for certification	4.3% (7)	28.2% (46)	38.7% (63)	20.9% (34)	8.0% (13)
i. Provided support for certification	4.9% (8)	11.1% (18)	17.3% (28)	46.9% (76)	19.8% (32)
j. Expressed desire that nurses who are currently certified maintain and renew their CCHN certification	14.8% (24)	19.1% (31)	32.1% (52)	24.1% (39)	9.9% (16)
k. Acted to reduce or eliminate obstacles they were made aware of	25.8% (42)	13.5% (22)	23.3% (38)	32.5% (53)	4.9% (8)
l. Informed the public that we have specialist nurses on staff	9.9% (16)	31.5% (51)	48.8% (79)	6.8% (11)	3.1% (5)
			answered question		**163**
			skipped question		**14**

TABLE 1.15 – Role of certified community health nurses: CHNC Members+

Please indicate your response to each of the statements by choosing the option that best represents your opinion:

Compared to non-certified community health nurses, certified nurses...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Work to a more full scope of practice	9.2% (15)	7.4% (12)	33.7% (55)	42.3% (69)	7.4% (12)
b. Are more up-to-date in their knowledge	6.7% (11)	3.1% (5)	14.1% (23)	57.7% (94)	18.4% (30)
c. Are noted by clients as credible specialists in their area of practice	17.8% (29)	9.2% (15)	47.2% (77)	20.9% (34)	4.9% (8)
d. Satisfy clients with the service provided	19.1% (31)	3.7% (6)	17.3% (28)	48.8% (79)	11.1% (18)
e. Are more credible in interprofessional/multidisciplinary contexts	12.9% (21)	5.5% (9)	19.6% (32)	50.3% (82)	11.7% (19)
f. Apply and talk about research in practice decisions	14.2% (23)	2.5% (4)	18.5% (30)	56.8% (92)	8.0% (13)
g. Are better prepared for positions of added responsibility	10.4% (17)	3.1% (5)	20.9% (34)	52.8% (86)	12.9% (21)
h. Are more likely to promote certification among colleagues	3.8% (6)	1.3% (2)	5.0% (8)	53.8% (86)	36.3% (58)
i. Are more likely to create tension among non-certified colleagues	9.2% (15)	28.2% (46)	57.1% (93)	4.9% (8)	0.6% (1)
			answered question		**163**
			skipped question		**14**

TABLE 1.16 – Barriers to certification: CHNC Members+	
Below are some BARRIERS to certification. Please choose as many as apply to your organization	
Answer Options	**Response Percent**
Lack of recognition of certified nurses within your organization	56.9%
Lack of support to prepare for examination	45.6%
Inability to increase compensation for certified nurses	81.9%
Inability to provide on-site professional development/continuing education	40.0%
Policy that continuing education is on the employee's personal time	33.8%
Lack of mentors	35.6%
Lack of on-site, easily accessible reference materials	40.6%
Other (please specify): • Perception about time commitment for certification • Lack of understanding from other community nurses, when I asked home and community care nurses (I work in Public Health) if I could observe a clinic or borrow some references they created all sorts of obstacles - I ended up going to my university and borrowing books from their library. • Other continuing education opportunities competing for time • Geography and cost for writing • D/t to budget decreases this year some of the financial incentives were taken away paid study time, reimbursement on exam • Managers generally clueless about certification process and exam. • Time • No one thinks this is important. I did it to get a public health job ie. Extra points on my resume • Lack of promotion of certification opportunity • Inability to compensate nurse for exam • Not enough compensation ~ certified nurses receive $3.83 per pay day above regular pay. Nurses have to pay for their own certification exam and costs associated with travelling to location and accommodations for the exam. • Time to prepare for the exam. Upfront cost of writing exam although many apply and receive financial compensation after writing the exam • Some of these barriers are in place in parts of AHS. • Managers do not recognize the value of supporting this • When I certified, I was well-supported by my organization. However, since then, budget restraints have drastically changed support nurse receive in obtaining certification. • Lack of awareness by admin and front-line nurses; lack of priority given to the role of certification • Geographic distances between nurses; demands of workload reduce the amount of time and energy available for studying • No work time preparation for course • Did not actively encourage and promote nurses to get certified. Seemed to want to keep it under the table. I think because if they drew attention to it, we nurses would be a liability by requesting increased compensation. • On site education is annual or longer between offerings • Lack of public awareness of certification • Would prefer a public health specific certification. Also front-line public health managers are not public health nurses/practitioners so may lack some understanding of certification and nursing in general. • No current external incentives to obtain certification • My current employer is a hospital and therefore not abreast of community nursing issues • Employers don't consider it important, necessary or valid. Other PHN's don't think it's worth the time or money to attempt because there is no support and takes a huge amount of time to achieve. • Non nurse leaders/directors etc • Education credits	17.5%
answered question	**160**
skipped question	**17**

TABLE 1.17 – Facilitators for certification: CHNC Members+	
Below are some FACILITATORS for certification. Please circle as many as apply to your organization	
Answer Options	**Response Percent**
It offers reimbursement for examination costs	53.1%
It provides work time for examination preparation	43.4%
It provides mentors for RNs wishing to become certified	33.1%
It has added reference materials in accessible locations for examination preparation purposes	44.1%
It provides on-site continuing education	29.7%
It keeps the standards in mind as we make continuing education decisions	34.5%
It recognizes certification in our pay scales	6.2%
It promotes certification as a benefit to our organization and its clients	27.6%
It recognizes certificate holders in some way	31.7%
It celebrates successful achievement of certification	47.6%
Other (please specify): • Facilitated access to online study group; flexing of work time to participate in study group • Reimbursement is not a given but has been provided in the past. • Immediate manager was aware of the preparation demands to write the exam however senior managers did not know that certification was all about. • Not enough compensation ~ certified nurses receive $3.83 per pay day above regular pay. Nurses have to pay for their own certification exam and costs associated with travelling to location and accommodations for the exam. • Offers a weekly on-site study group for 12 weeks as well as a debrief meeting post exam with evaluation of the study group process • Some of these facilitators WERE in place in former health regions, now AHS. They could be revitalized again (maybe). Also, for unionized CHNs, a pay rate is available for certification but it can't be combined with pay rate for BN so only applies for RNs without degree but with CCHN. • See above, as this no longer applies due to recent budget restraints. • I am not aware of seeing support being developed/offered for Home Care nurses to become certified, like there is for PH nurses. • was mentioned in orientation by director - I know that she holds it in high esteem, but not sure that front-line managers do • I had to REALLY assert (it took hours of time to beg for it) to have some reference materials acquired with organizational funds • WE GET AN EXTRA 7.65 PER PAY FOR BEING CERTIFIED • To clarify, when I wrote the exam 3 years ago, the organization supported us both financially and promoting time for exam preparation during work time. I am not sure the same opportunities exist at this time. • Work time is provided using your 3 allotted professional development days/year. • no one in our HR is certified or has attempted so really can't comment for sure	9.7%
answered question	**145**
skipped question	**32**

TABLE 1.18 – Intrinsic value of certification: CHNC Members+

Below are some statements about the value of certification to you personally. Please choose the option that best represents your opinion:

The outcomes of nursing certification for me could include...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Enhanced feelings of personal accomplishment	0.0% (0)	0.6% (1)	0.6% (1)	30.9% (50)	67.9% (110)
b. Personal satisfaction	1.2% (2)	0.6% (1)	0.0% (0)	34.2% (55)	64.0% (103)
c. Job satisfaction	4.4% (7)	3.1% (5)	18.9% (30)	47.8% (76)	25.8% (41)
d. Validation of specialized knowledge	3.1% (5)	1.9% (3)	0.6% (1)	43.5% (70)	50.9% (82)
e. Professional growth	1.2% (2)	1.2% (2)	1.2% (2)	34.8% (56)	61.5% (99)
f. Attainment of a practice standard/competency.	1.9% (3)	0.6% (1)	0.6% (1)	47.2% (75)	49.7% (79)
g. Evidence of professional commitment	0.0% (0)	0.6% (1)	1.3% (2)	40.3% (64)	57.9% (92)
h. Acceptance of professional challenge	0.6% (1)	0.0% (0)	1.9% (3)	38.4% (61)	59.1% (94)
i. Professional credibility	3.1% (5)	1.3% (2)	5.6% (9)	43.1% (69)	46.9% (75)
j. Enhanced personal confidence in clinical abilities	3.2% (5)	2.5% (4)	14.6% (23)	46.2% (73)	33.5% (53)
k. Higher level of clinical competence	3.8% (6)	2.5% (4)	14.6% (23)	50.0% (79)	29.1% (46)
l. Enhanced professional accountability	4.5% (7)	1.9% (3)	10.3% (16)	45.2% (70)	38.1% (59)
Other (please specify): • Motivating others to complete certification • broader and deeper understanding of nursing practice • Certification is definitely something you need to do for yourself. • Contributed to ability to obtain new position of increased responsibility and accountability and leading to increased job satisfaction. • MAKES ME FEEL COMPETANT WITH CONFIDENCE • it did not enhance my competency....I already had this knowledge. It just provided me with a clear demonstration of that fact. • can mentor and encourage others • Did it for my own personal satisfaction as health authority doesn't seem to support					8
answered question					**162**
skipped question					**15**

TABLE 1.19 – Extrinsic value of certification: CHNC Members+

Below are some statements about the value of certification to you in your professional role. Please choose the option that best represents your opinion:

The outcomes of nursing certification for me could include...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Enhanced managerial confidence in my clinical abilities	14.9% (24)	3.7% (6)	18.0% (29)	51.6% (83)	11.8% (19)
b. Increased marketability	7.5% (12)	1.9% (3)	11.8% (19)	58.4% (94)	20.5% (33)
c. Peer recognition of advanced status internally	3.8% (6)	3.8% (6)	25.5% (40)	52.2% (82)	14.6% (23)
d. External recognition of advanced status (e.g., professional association)	10.1% (16)	3.1% (5)	30.2% (48)	44.7% (71)	11.9% (19)
e. Improved recognition of advanced status from other health professionals/stakeholders	8.8% (14)	6.3% (10)	39.0% (62)	35.8% (57)	10.1% (16)
f. Better recognition of community health expertise	6.8% (11)	4.3% (7)	18.5% (30)	54.9% (89)	15.4% (25)
g. Increased client confidence	13.2% (21)	8.8% (14)	37.1% (59)	34.6% (55)	6.3% (10)
h. Increased client satisfaction	11.9% (19)	10.6% (17)	36.3% (58)	35.6% (57)	5.6% (9)
i. Increased salary	3.8% (6)	37.2% (58)	38.5% (60)	14.7% (23)	5.8% (9)
Other (please specify): • Not enough compensation ~ certified nurses receive $3.83 per pay day above regular pay. Nurses have to pay for their own certification exam and costs associated with travelling to location and accommodations for the exam. • Clients assume we are already competent. They gain nothing by viewing my certificate on the wall.					2
answered question					**163**
skipped question					**14**

I. Survey Results: Employers Group

TABLE 2.3 – Province/Territory of service provision: Employers of CHNs with CHNC(C)	
In which province/territory(s) does your organization provide service:	
Answer Options	**Response Percent**
Atlantic	14.3%
QC/ON	33.3%
MB/SK	23.8%
AB/BC	19.0%
YK/NT/NU	9.5%
answered question	**21**
skipped question	**10**

TABLE 2.4 – Main area of practice: Employers of CHNs with CHNC(C)	
What is your MAIN area of practice? Please choose one:	
Answer Options	**Response Percent**
Public health	77.8%
Home care	7.4%
Education institution	3.7%
Parish nursing	0.0%
Occupational health nursing	0.0%
Community health nursing	0.0%
Primary care/family practice nursing	0.0%
Prison nursing	0.0%
Telehealth	0.0%
Nursing station (outpost or clinic)	0.0%
Government	11.1%
Other (please specify)	0.0%
answered question	**27**
skipped question	**4**

TABLE 2.5 – Main focus of practice: Employers of CHNs with CHNC(C)	
What is the MAIN focus of your practice? Please choose one:	
Answer Options	**Response Percent**
Direct (clinical, front line)	10.7%
Administration	85.7%
Professional development or staff education	0.0%
Educational institution	3.6%
answered question	**28**
skipped question	**3**

TABLE 2.6 – Organization structure/size: Employers of CHNs with CHNC(C)	
How would you characterize your organization in terms of structure/size? Please choose one:	
Answer Options	**Response Percent**
Local/district public health unit/department	44.4%
Regional health authority	40.7%
Provincial/Territorial Government Agency	11.1%
Public Health Association or Society	3.7%
answered question	**27**
skipped question	**4**

TABLE 2.7 – Number of RNs employed with community health nursing certification: Employers of CHNs with CHNC(C)		
Approximately how many registered nurses with community health nursing certification do you employ?		
Answer Options	**Response Percent**	
Unknown	11.5%	
0	42.3%	
1-10	26.9%	
11-20	7.7%	
21-100	11.5%	
100+	0%	
answered question		**26**
skipped question		**5**

TABLE 2.8 – Number of RNs employed without community health nursing certification: Employers of CHNs with CHNC(C)		
Approximately how many registered nurses do you employ that do not have community health nursing certification?		
Answer Options	**Response Percent**	
Unknown	11.5%	
0	0%	
1-10	15.4%	
10-50	34.6%	
51-100	11.5%	
101-200	11.5%	
201+	15.4%	
answered question		**26**
skipped question		**5**

TABLE 2.9 – Organization response: Employers of CHNs with CHNC(C)

Please indicate your response to each of the statements by choosing the option that best represents your organization's opinion:

In our organization...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. We have amended our job descriptions to fit the CCHN Standards	13.6% (3)	13.6% (3)	27.3% (6)	40.9% (9)	4.5% (1)
b. We have amended our performance appraisal formats to fit the CCHN Standards	13.6% (3)	18.2% (4)	40.9% (9)	22.7% (5)	4.5% (1)
c. We have changed the qualifications we seek when hiring registered nurses	13.6% (3)	9.1% (2)	36.4% (8)	31.8% (7)	9.1% (2)
d. Our pay scales have been adjusted to accommodate nurses with certification	18.2% (4)	36.4% (8)	40.9% (9)	4.5% (1)	0.0% (0)
e. We are more aware of our continuing education responsibilities for certified nurses	13.6% (3)	9.1% (2)	36.4% (8)	40.9% (9)	0.0% (0)
f. We offer more access to continuing education or professional development opportunities now than in the past	9.1% (2)	18.2% (4)	31.8% (7)	31.8% (7)	9.1% (2)
g. We provide recognition for nurses who become certified	13.6% (3)	4.5% (1)	36.4% (8)	40.9% (9)	4.5% (1)
h. We offer incentives for certification	13.6% (3)	9.1% (2)	54.5% (12)	22.7% (5)	0.0% (0)
i. We provide support for certification	4.5% (1)	4.5% (1)	22.7% (5)	63.6% (14)	4.5% (1)
j. We want currently certified nurses to maintain and renew certification	27.3% (6)	4.5% (1)	13.6% (3)	45.5% (10)	9.1% (2)
k. When we hear about barriers or obstacles to certification we act to reduce or eliminate them	31.8% (7)	0.0% (0)	13.6% (3)	50.0% (11)	4.5% (1)
l. We inform the public that we have specialist nurses on staff	13.6% (3)	27.3% (6)	50.0% (11)	9.1% (2)	0.0% (0)
m. We have implemented more evidence-based practice guidelines	4.5% (1)	4.5% (1)	13.6% (3)	59.1% (13)	18.2% (4)
n. Our collaborative relationships within the organization have improved	36.4% (8)	9.1% (2)	22.7% (5)	22.7% (5)	9.1% (2)
o. Our collaborative relationships with other organizations have improved	33.3% (7)	9.5% (2)	28.6% (6)	19.0% (4)	9.5% (2)
p. Our collaborative relationships with other disciplines have improved	33.3% (7)	9.5% (2)	23.8% (5)	23.8% (5)	9.5% (2)
q. Client/patient care outcomes have improved	57.1% (12)	4.8% (1)	9.5% (2)	28.6% (6)	0.0% (0)
				answered question	**22**
				skipped question	**9**

TABLE 2.10 – Role of certified community health nurses: Employers of CHNs with CHNC(C)

Please indicate your response to each of the statements by choosing the option that best represents your organization's opinion:

Compared to non-certified community health nurses, certified nurses...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Work to a more full scope of practice	35.0% (7)	5.0% (1)	20.0% (4)	35.0% (7)	5.0% (1)
b. Are more up-to-date in their knowledge	25.0% (5)	5.0% (1)	15.0% (3)	50.0% (10)	5.0% (1)
c. Are noted by clients as credible specialists in their area of practice	50.0% (10)	5.0% (1)	35.0% (7)	10.0% (2)	0.0% (0)
d. Satisfy clients with the service provided	40.0% (8)	5.0% (1)	15.0% (3)	40.0% (8)	0.0% (0)
e. Provide higher quality services to clients	45.0% (9)	5.0% (1)	20.0% (4)	30.0% (6)	0.0% (0)
f. Are more credible in interprofessional/multidisciplinary contexts	30.0% (6)	0.0% (0)	25.0% (5)	45.0% (9)	0.0% (0)
g. Apply and talk about research in practice decisions	40.0% (8)	10.0% (2)	10.0% (2)	40.0% (8)	0.0% (0)
h. Are better prepared for positions of added responsibility	40.0% (8)	5.0% (1)	20.0% (4)	35.0% (7)	0.0% (0)
i. Are more likely to promote certification among colleagues	20.0% (4)	5.0% (1)	5.0% (1)	55.0% (11)	15.0% (3)
j. Are more likely to create tension among non-certified colleagues	30.0% (6)	0.0% (0)	65.0% (13)	5.0% (1)	0.0% (0)
k. Are more satisfied with their work	45.0% (9)	5.0% (1)	15.0% (3)	35.0% (7)	0.0% (0)
l. Are better able to collaborate with others	45.0% (9)	10.0% (2)	25.0% (5)	20.0% (4)	0.0% (0)
m. Work more autonomously	40.0% (8)	5.0% (1)	35.0% (7)	20.0% (4)	0.0% (0)
				answered question	**20**
				skipped question	**11**

TABLE 2.11 – Barriers to certification: Employers of CHNs with CHNC(C)	
Below are some BARRIERS to certification. Please choose as many as apply to your organization	
Answer Options	**Response Percent**
We do not offer recognition of certification in any way	45.0%
We do not provide support to prepare for examination	25.0%
We are unable to increase compensation for certified nurses	85.0%
We are unable to provide on-site professional development/continuing education	10.0%
We have a policy that continuing education is on the employee's personal time	0.0%
We have few mentors available	35.0%
We do not have easily accessible reference materials on-site	30.0%
Other (please specify): • PHNs have not expressed any interest • Only one nurse works for me so I'm not sure what CCHN is • Not a requirement for a faculty position • No desire from the organization • I would say any of these points do not provide/offer "enough" what is offered is very	25.0%
answered question	**20**
skipped question	**11**

TABLE 2.12 – Facilitators for certification: Employers of CHNs with CHNC(C)	
Below are some FACILITATORS for certification. Please choose as many as apply to your organization	
Answer Options	**Response Percent**
We offer reimbursement for examination costs	57.1%
We provide work time for examination preparation	47.6%
We provide mentors for RNs wishing to become certified/recertified	28.6%
We have added reference materials in accessible locations for examination preparation purposes	33.3%
We provide on-site continuing education	33.3%
We keep the standards in mind as we make continuing education decisions	42.9%
We recognize certification in our pay scales	4.8%
We promote certification as a benefit to our agency and its clients	33.3%
We recognize certificate holders in some way	28.6%
We celebrate successful achievement of certification	42.9%
Other (please specify): • We allow time off to write cert exam and cover costs of traveling to exam. • we have a professional dev fund that PHNs could access • as above • We have offered reimbursement for the exam cost up until last year. • allow flex time for staff to accommodate learning needs • links to external mentorship and educational sessions through study groups • Faculty can be reimbursed for the examination costs through their professional development expense account.	33.3%
answered question	**21**
skipped question	**10**

TABLE 2.13 – Outcomes of certification: Employers of CHNs with CHNC(C)

Below are some statements about the value of certification to an employer. Please choose the option which best represents your organization's opinion:

The outcomes of community health nursing certification for our organization include...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Enhanced feelings of personal accomplishment	20.0% (4)	0.0% (0)	5.0% (1)	55.0% (11)	20.0% (4)
b. Personal satisfaction among nursing staff	30.0% (6)	0.0% (0)	5.0% (1)	50.0% (10)	15.0% (3)
c. Validation of specialized knowledge	10.0% (2)	0.0% (0)	10.0% (2)	55.0% (11)	25.0% (5)
d. Professional growth	10.0% (2)	0.0% (0)	0.0% (0)	65.0% (13)	25.0% (5)
e. Attainment of a practice standard/competency.	10.0% (2)	0.0% (0)	5.0% (1)	65.0% (13)	20.0% (4)
f. Evidence of professional commitment	15.0% (3)	0.0% (0)	0.0% (0)	65.0% (13)	20.0% (4)
g. Acceptance of professional challenge	10.0% (2)	0.0% (0)	5.0% (1)	60.0% (12)	25.0% (5)
h. Professional credibility	10.0% (2)	0.0% (0)	5.0% (1)	75.0% (15)	10.0% (2)
i. Enhanced personal confidence in clinical abilities	15.0% (3)	0.0% (0)	5.0% (1)	60.0% (12)	20.0% (4)
j. Indication of higher level of clinical competence for our staff	15.0% (3)	0.0% (0)	20.0% (4)	60.0% (12)	5.0% (1)
k. Evidence of accountability	25.0% (5)	0.0% (0)	20.0% (4)	45.0% (9)	10.0% (2)
l. Enhanced professional accountability	15.0% (3)	0.0% (0)	15.0% (3)	60.0% (12)	10.0% (2)
m. Enhanced managerial confidence in certified nurses' clinical abilities	30.0% (6)	0.0% (0)	25.0% (5)	35.0% (7)	10.0% (2)
n. Improved collaboration internally	35.0% (7)	0.0% (0)	40.0% (8)	25.0% (5)	0.0% (0)
o. Increased marketability of our services	35.0% (7)	0.0% (0)	40.0% (8)	25.0% (5)	0.0% (0)
p. Peer recognition of advanced status internally	25.0% (5)	0.0% (0)	10.0% (2)	60.0% (12)	5.0% (1)
q. External recognition of advanced status (e.g., professional association)	25.0% (5)	0.0% (0)	30.0% (6)	45.0% (9)	0.0% (0)
r. Improved recognition of advanced status from other health professionals/stakeholders	50.0% (10)	0.0% (0)	25.0% (5)	25.0% (5)	0.0% (0)
s. Improved collaboration with external stakeholders	30.0% (6)	0.0% (0)	35.0% (7)	35.0% (7)	0.0% (0)
t. Better recognition of community health nurses within our organization	30.0% (6)	0.0% (0)	45.0% (9)	20.0% (4)	5.0% (1)
u. Increased client confidence	50.0% (10)	5.0% (1)	25.0% (5)	20.0% (4)	0.0% (0)
v. Increased client satisfaction	50.0% (10)	5.0% (1)	25.0% (5)	20.0% (4)	0.0% (0)
w. Increased salary	20.0% (4)	30.0% (6)	45.0% (9)	5.0% (1)	0.0% (0)
Other (please specify): • as above • N/A • Questions are based on opinion, not application					
				answered question	**20**
				skipped question	**11**

J. Survey Results: First Cohort Group

TABLE 3.3 – Sex: First Cohort		
Sex		
Answer Options	**Response Percent**	
Male	2.1%	
Female	97.9%	
	answered question	**47**
	skipped question	**1**

TABLE 3.4 – Age: First Cohort		
Age		
Answer Options	**Response Percent**	
20-29	0.0%	
30-39	12.8%	
40-49	34.0%	
50-59	46.8%	
60-69	6.4%	
	answered question	**47**
	skipped question	**1**

TABLE 3.5 – Number of years in current position: First Cohort		
Number of years in your current position:		
Answer Options	**Response Percent**	
Less than 1 year	2.2%	
1 to 2 years experience	15.2%	
3 to 5 years experience	21.7%	
6 to 10 years experience	34.7%	
11 or more years experience	26.1%	
	answered question	**46**
	skipped question	**2**

TABLE 3.6 – Employment Status: First Cohort		
Employment Status:		
Answer Options	**Response Percent**	
Full-time	83.0%	
Part-time	10.6%	
Casual full-time	0.0%	
Casual part-time	6.4%	
	answered question	**47**
	skipped question	**1**

TABLE 3.7 – Province/Territory of practice: First Cohort		
In which province/territory(s) do you practice:		
Answer Options	**Response Percent**	
Atlantic	17.4%	
QC/ON	45.7%	
MB/SK	8.7%	
AB/BC	26.1%	
YK/NT/NU	2.1%	
	answered question	**46**
	skipped question	**2**

TABLE 3.8 – Main area of practice: First Cohort	
What is your MAIN area of practice? Please choose one:	
Answer Options	**Response Percent**
Public health	46.8%
Home care	27.7%
Education institution	4.3%
Parish nursing	0.0%
Occupational health nursing	0.0%
Community health nursing	8.5%
Primary care/family practice nursing	6.4%
Prison nursing	0.0%
Telehealth	0.0%
Nursing station (outpost or clinic)	0.0%
Government	2.1%
Other (please specify): • Nursing Policy & Procedure Coordinator for Horizon Health Network, Zone 3 • manager Primary Health Care	4.3%
answered question	**47**
skipped question	**1**

TABLE 3.9 – Main focus of practice: First Cohort	
What is the MAIN focus of your practice? Please choose one:	
Answer Options	**Response Percent**
Direct (clinical, front line)	37.8%
Administration	46.7%
Professional development or staff education	15.6%
answered question	**45**
skipped question	**3**

TABLE 3.10 – Number of years working in community health nursing: First Cohort	
How many years have you been working in community health nursing (direct practice, administration, staff education and teaching/research)? Please choose one:	
Answer Options	**Response Percent**
Less than 1 year	0.0%
1 to 2 years experience	0.0%
3 to 5 years experience	0.0%
6 to 10 years experience	6.5%
11 or more years experience	93.5%
answered question	**46**
skipped question	**2**

TABLE 3.11 – Organizational structure/size: First Cohort	
In what type of organizational structure/size do you practice? Please choose one:	
Answer Options	**Response Percent**
Local/district public health unit/department	38.1%
Regional health authority	38.1%
Provincial/Territorial Government Agency	19.0%
Public Health Association or Society	4.8%
answered question	**42**
skipped question	**6**

TABLE 3.12 – Other educational credentials: First Cohort	
Besides your RN, what educational credentials do you hold? Please check as many as apply	
Answer Options	**Response Percent**
Bachelor's degree in Nursing	77.3%
Bachelor's degree other than Nursing	9.1%
Master's degree in Nursing	27.3%
Master's degree other than Nursing	13.6%
Doctoral degree in Nursing	0.0%
Doctoral degree other than Nursing	2.3%
Other (please specify): • International Board Certified Lactation Consultant • Diploma in Nursing Informatics • certified diabetes educator • currently working on Master's in Nursing • masters candidate MHSc • Certificate in infant mental health • CVAA(C) CHPCN(C) CCHN(C) • MSN: FNP in progress	18.2%
answered question	**44**
skipped question	**4**

TABLE 3.13 – Intent to renew certification: First Cohort	
Do you intend to renew your certification when it becomes due? Please choose one	
Answer Options	**Response Percent**
No	6.4%
Yes	80.9%
Unsure	12.8%
answered question	**47**
skipped question	**1**

TABLE 3.14 – Organization response: First Cohort

Please indicate your response to each of the statements:

As a result of completing CCHN-certification our organization has...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Amended its job descriptions to fit the CCHN Standards	4.4% (2)	17.8% (8)	42.2% (19)	28.9% (13)	6.7% (3)
b. Amended its performance appraisal formats to fit the CCHN Standards	2.2% (1)	20.0% (9)	35.6% (16)	33.3% (15)	8.9% (4)
c. Changed the qualifications it seeks when hiring registered nurses	4.4% (2)	20.0% (9)	51.1% (23)	20.0% (9)	4.4% (2)
d. Adjusted pay scales to accommodate nurses with certification	0.0% (0)	46.7% (21)	37.8% (17)	11.1% (5)	4.4% (2)
e. Become more aware of its continuing education responsibilities for certified nurses	8.9% (4)	15.6% (7)	48.9% (22)	24.4% (11)	2.2% (1)
f. Offered more access to continuing education or professional development opportunities now than in the past	6.7% (3)	24.4% (11)	42.2% (19)	24.4% (11)	2.2% (1)
g. Provided recognition for nurses who become certified	0.0% (0)	20.0% (9)	22.2% (10)	48.9% (22)	8.9% (4)
h. Offered incentives for certification	2.2% (1)	24.4% (11)	35.6% (16)	26.7% (12)	11.1% (5)
i. Provided support for certification	0.0% (0)	15.6% (7)	11.1% (5)	51.1% (23)	22.2% (10)
j. Expressed desire that nurses who are currently certified maintain and renew their CCHN certification	11.1% (5)	15.6% (7)	40.0% (18)	28.9% (13)	4.4% (2)
k. Acted to reduce or eliminate obstacles to certification	8.9% (4)	13.3% (6)	31.1% (14)	40.0% (18)	6.7% (3)
l. Informed the public that we have specialist nurses on staff	6.7% (3)	28.9% (13)	46.7% (21)	15.6% (7)	2.2% (1)
				answered question	**45**
				skipped question	**3**

TABLE 3.15 – Response to certification: First Cohort

Please indicate your response to each of the statements by choosing the number that best represents your opinion:

As a result of completing CCHN-certification...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. I have initiated discussions to change our job descriptions to fit the CCHN Standards	8.9% (4)	11.1% (5)	26.7% (12)	35.6% (16)	17.8% (8)
b. I have initiated discussions to modify our performance appraisal formats to fit the CCHN Standards	8.9% (4)	11.1% (5)	33.3% (15)	26.7% (12)	20.0% (9)
c. I am better able to establish collaborative relationships within the organization	8.9% (4)	4.4% (2)	33.3% (15)	48.9% (22)	4.4% (2)
d. I am better able to establish collaborative relationships with other organizations	8.9% (4)	6.7% (3)	37.8% (17)	37.8% (17)	8.9% (4)
e. I am better able to establish collaborative relationships with other disciplines	8.9% (4)	4.4% (2)	42.2% (19)	35.6% (16)	8.9% (4)
f. I work to a more full scope of practice	6.7% (3)	6.7% (3)	31.1% (14)	40.0% (18)	15.6% (7)
g. I stay more up-to-date with emerging knowledge in community health	6.7% (3)	0.0% (0)	15.6% (7)	46.7% (21)	31.1% (14)
h. I have clients who recognize my specialized knowledge	15.9% (7)	11.4% (5)	34.1% (15)	31.8% (14)	6.8% (3)
i. My clients are more satisfied with the service provided	33.3% (15)	11.1% (5)	31.1% (14)	17.8% (8)	6.7% (3)
j. I provide higher quality services to clients	13.3% (6)	6.7% (3)	28.9% (13)	40.0% (18)	11.1% (5)
k. I am more credible in interprofessional/multidisciplinary contexts	6.7% (3)	4.4% (2)	20.0% (9)	57.8% (26)	11.1% (5)
l. I apply and talk about research in practice decisions	2.2% (1)	2.2% (1)	13.3% (6)	66.7% (30)	15.6% (7)
m. I am better prepared for positions of added responsibility	2.2% (1)	4.4% (2)	33.3% (15)	37.8% (17)	22.2% (10)
n. I am more likely to promote certification among colleagues	4.4% (2)	2.2% (1)	2.2% (1)	37.8% (17)	53.3% (24)
o. I am more satisfied with my work	0.0% (0)	4.4% (2)	37.8% (17)	48.9% (22)	8.9% (4)
p. I am better able to collaborate with others	6.7% (3)	6.7% (3)	42.2% (19)	35.6% (16)	8.9% (4)
q. I feel more empowered to work autonomously	6.7% (3)	6.7% (3)	40.0% (18)	37.8% (17)	8.9% (4)
r. I use the PHAC Skill Enhancements program more	13.3% (6)	15.6% (7)	40.0% (18)	31.1% (14)	0.0% (0)
				answered question	**45**
				skipped question	**3**

TABLE 3.16 – Role of certified community health nurses: First Cohort					
Please indicate your response to each of the statements: **Compared to non-certified community health nurses, certified nurses...**					
Answer Options	**No Opinion**	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
a. Work to a more full scope of practice	4.4% (2)	4.4% (2)	33.3% (15)	55.6% (25)	2.2% (1)
b. Are more up-to-date in their knowledge	4.4% (2)	2.2% (1)	17.8% (8)	64.4% (29)	11.1% (5)
c. Are noted by clients as credible specialists in their area of practice	13.3% (6)	13.3% (6)	51.1% (23)	20.0% (9)	2.2% (1)
d. Satisfy clients with the service provided	20.0% (9)	6.7% (3)	28.9% (13)	40.0% (18)	4.4% (2)
e. Are more credible in interprofessional/multidisciplinary contexts	11.1% (5)	8.9% (4)	20.0% (9)	51.1% (23)	8.9% (4)
f. Apply and talk about research in practice decisions	17.8% (8)	2.2% (1)	24.4% (11)	51.1% (23)	4.4% (2)
g. Are better prepared for positions of added responsibility	11.4% (5)	2.3% (1)	25.0% (11)	50.0% (22)	11.4% (5)
h. Are less likely to promote certification among colleagues	6.7% (3)	33.3% (15)	42.2% (19)	15.6% (7)	2.2% (1)
i. Are more likely to create tension among non-certified colleagues	4.4% (2)	40.0% (18)	53.3% (24)	2.2% (1)	0.0% (0)
j. Are more satisfied with their work	8.9% (4)	4.4% (2)	20.0% (9)	60.0% (27)	6.7% (3)
k. Are better able to collaborate with others	11.1% (5)	4.4% (2)	33.3% (15)	48.9% (22)	2.2% (1)
l. Work more autonomously	8.9% (4)	4.4% (2)	35.6% (16)	46.7% (21)	4.4% (2)
m. Are more empowered	6.7% (3)	4.4% (2)	20.0% (9)	64.4% (29)	4.4% (2)
				answered question	**45**
				skipped question	**3**

TABLE 3.17 – Barriers to recertification: First Cohort	
Below are some BARRIERS TO RECERTIFICATION. Please choose as many as apply to your organization	
Answer Options	**Response Percent**
Lack of recognition of certified nurse	59.1%
Lack of support to prepare for recertification	50.0%
No increase in compensation for certified nurses	84.1%
Lack of on-site professional development/continuing education	40.9%
Policy that continuing education is on the employee's personal time	25.0%
Lack of accessible mentors in the organization	29.5%
Lack of on-site, easily accessible reference materials	31.8%
Other (please specify): • No value attached to certification - i.e considered an asset on job posters, • Cost; depending on the prof dev't it is on own time; this certification is seen as irrelevant; studying for exam and exam content too diverse and much is not directly applicable to public health -- it's good for nurses working in the community • time on or off work hours • not enough of a critical mass of certified nurses to make any difference in addressing recertification • financial assistance by employer has been drastically reduced	11.4%
answered question	**44**
skipped question	**4**

TABLE 3.18 – Facilitators for recertification: First Cohort	
Below are some FACILITATORS FOR RECERTIFICATION. Please choose as many as apply to your organization	
Answer Options	**Response Percent**
There is reimbursement for recertification costs	43.2%
There is work time for recertification preparation	40.5%
There are accessible mentors for RNs wishing to become certified	67.6%
There are added reference materials in accessible locations for examination preparation purposes	54.1%
There is on-site continuing education	48.6%
The Standards are used to make continuing education decisions	35.1%
Certification is recognized in the pay scales	13.5%
Certification is promoted as a benefit to the organization and its clients	37.8%
Certificate holders are recognized in some way	40.5%
Successful achievement of certification is celebrated in our organization	51.4%
Other (please specify): • Up until this past year there was full reimbursement of cost with writing the CNA Exam • have to apply to a fund to reimburse certification costs partial funding only • There was an afternoon recognition coffee but nothing after that as way of recognition.	8.1%
answered question	**37**
skipped question	**11**

TABLE 3.19 – Intrinsic value of certification: First Cohort

Below are some statements about the value of certification to you personally:

The outcomes of nursing certification for me include...

Answer Options	No Opinion	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Enhanced feelings of personal accomplishment	0.0% (0)	0.0% (0)	2.2% (1)	40.0% (18)	57.8% (26)
b. Higher personal satisfaction	0.0% (0)	0.0% (0)	2.2% (1)	46.7% (21)	51.1% (23)
c. Improved job satisfaction	6.7% (3)	2.2% (1)	31.1% (14)	44.4% (20)	15.6% (7)
d. Validation of specialized knowledge	2.2% (1)	0.0% (0)	6.7% (3)	33.3% (15)	57.8% (26)
e. Better professional growth	4.4% (2)	0.0% (0)	15.6% (7)	37.8% (17)	42.2% (19)
f. Attainment of a practice standard/competency	0.0% (0)	0.0% (0)	2.2% (1)	57.8% (26)	40.0% (18)
g. Evidence of professional commitment	2.2% (1)	0.0% (0)	0.0% (0)	40.0% (18)	57.8% (26)
h. Acceptance of professional challenge	2.2% (1)	0.0% (0)	0.0% (0)	44.4% (20)	53.3% (24)
i. Professional credibility	0.0% (0)	0.0% (0)	13.3% (6)	42.2% (19)	44.4% (20)
j. Enhanced personal confidence in clinical abilities	4.4% (2)	0.0% (0)	20.0% (9)	55.6% (25)	20.0% (9)
k. Improved quality of communication with colleagues	8.9% (4)	2.2% (1)	42.2% (19)	33.3% (15)	13.3% (6)
l. Different work assignments than non-certified colleagues	4.4% (2)	13.3% (6)	71.1% (32)	8.9% (4)	2.2% (1)
m. More autonomy in my practice	6.7% (3)	11.1% (5)	53.3% (24)	22.2% (10)	6.7% (3)
n. Enhanced managerial confidence in my clinical abilities	8.9% (4)	8.9% (4)	26.7% (12)	40.0% (18)	15.6% (7)
o. Higher level of clinical competence	11.1% (5)	2.2% (1)	24.4% (11)	48.9% (22)	13.3% (6)
p. Enhanced professional accountability	2.2% (1)	2.2% (1)	22.2% (10)	46.7% (21)	26.7% (12)
q. Enhanced empowerment for my practice	8.9% (4)	4.4% (2)	22.2% (10)	35.6% (16)	28.9% (13)
Other (please specify): • Validation of the knowledge I gained from practice. • Advocate within the organization to offer support to nurses to write the CNA Exam • role model to team members of commitment to continuing education • increased confidence in supporting new nurses and students • more likely to be considered for advancement, and opportunities to represent our organization at external tables					5
answered question					**45**
skipped question					**3**

TABLE 3.20 – Extrinsic value of certification: First Cohort					
Below are some statements about the value of certification to me in my professional role: The value of nursing certification for me include...					
Answer Options	**No Opinion**	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
a. Increased marketability	8.9% (4)	2.2% (1)	11.1% (5)	55.6% (25)	22.2% (10)
b. Peer recognition of advanced status internally	4.4% (2)	6.7% (3)	17.8% (8)	53.3% (24)	17.8% (8)
c. External recognition of advanced status (e.g., professional association)	11.1% (5)	11.1% (5)	22.2% (10)	44.4% (20)	11.1% (5)
d. Improved recognition of advanced status from other health professionals/stakeholders	6.7% (3)	11.1% (5)	37.8% (17)	42.2% (19)	2.2% (1)
e. Better recognition of my community health expertise	6.7% (3)	11.1% (5)	20.0% (9)	44.4% (20)	17.8% (8)
f. Increased client confidence	26.7% (12)	8.9% (4)	44.4% (20)	17.8% (8)	2.2% (1)
g. Increased client satisfaction	26.7% (12)	8.9% (4)	42.2% (19)	20.0% (9)	2.2% (1)
h. Increased salary	2.3% (1)	40.9% (18)	47.7% (21)	9.1% (4)	0.0% (0)
Other (please specify): • Confidence in the knowledge I have and this knowledge is valid • very small pay increase, extra $7.65 per pay • This is my reality, not my preference of what it should be					3
answered question					**45**
skipped question					**3**