Winnipeg Regional Health Authority

Professional Practice Model Implementation Evaluation

Final Report (April 2018)

HEALTH in COMMON

Thanks to the PPM Evaluation Team and administrative support colleagues for their thoughts, guidance and commitment to the evaluation.

Evaluation Team
Kate Dubberley
Lenore Finnson
Darlene Girard
Julie Halipchuk
Hanna Moffatt
Lea Mutch
Debbie Nowicki
Carolyn Perchuk
Judy Saltel-Olsen
Carol Styles
Krista Wilkinson

Administrative Support
Nadene Coutu
Susan Rodgers
Pauline Karlenzig

HEALTH in COMMON
200–141 Bannatyne Avenue
Winnipeg, MB
204.946.1888 / 1.800.731.1792

Table of Contents

Foreword

I am very pleased to present the WRHA Public Health Nursing Professional Practice Model Implementation Evaluation Report. This report provides Public Health Nurses, the Population and Public Health Program and regional community leadership with key learnings focused around four objectives:

1. Describe how PHNs are practicing in accordance with the Professional Practice Model (PPM)
2. Identify, assess and describe PPM key performance indicators
3. Examine facilitators and barriers related to the PPM, including learning opportunities and next steps
4. Establish knowledge mobilization processes for evaluation findings

The report is organized by theme; implementation readiness (awareness, knowledge, skills, and attitudes), facilitators, challenges and opportunities for improvement. Throughout the report, selected quotes are included to add both richness and truth to the findings.

Public Health Nursing has a rich history in Winnipeg, Manitoba and Canada. Public Health Nurses continue to work passionately every day to promote and protect the health of the population, and to advocate for equitable health outcomes. Public health nursing works proactively, shifting and adjusting based on the needs of the community, as well as current research and guiding principles of public health theory. The PPM is an articulation of our knowledge and understanding at this point in time. It drives us toward a consistent, professional, informed approach to achieve the best possible outcomes from the resources available. We seek to identify effective interventions while being challenged to measure outcomes in a meaningful way. It takes time and persistent effort to build trust and to establish meaningful relationships with individuals, families and communities.

Public Health Nursing practice is evolving. Through their everyday work and this evaluation process, PHNs have provided examples of the PPM in action. We need to celebrate and share these examples. While many aspects of the PPM have been readily incorporated into practice, there are areas for development and improvement. This will require ongoing collaboration and growth across our system. It is clear from the progress to date that together, across centralized and community area teams, we have the ability and drive to continue successfully progress and achieve the desired results.

Thank you to each of you for your ongoing dedication and commitment to the health and wellbeing of our communities and the population. This has not been a journey without challenges and it is a tribute to the strength and commitment of all involved that that has led to the successes to date. We continue to learn and improve. Thank you to the PPM Evaluation Team and all who participated for their collaboration in completing this evaluation to help guide our success as we move forward.

Sincerely,

Carolyn Perchuk, RN MN IBCLC
Program Director
Population & Public Health

Executive Summary

In 2014, the Population and Public Health (PPH) program at the Winnipeg Regional Health Authority (WRHA) established the Professional Practice Model (PPM). The model was developed to promote population health and health equity, and align Public Health Nursing (PHN) practice with PHN competencies. The PPM was informed by public health and nursing literature, service delivery models, WRHA nursing leadership, and nursing standards (national and provincial). It offers a framework and "common language to articulate the PHN role, while clarifying roles and responsibilities at organization and system levels."[1] In June 2016, the PPM was implemented across all twelve community areas.

An evaluation of the PPM implementation, launched by the PPH program in March 2017, included four key objectives:

- Describe how PHNs are practicing in accordance with the Professional Practice Model (PPM)
- Identify, assess and describe PPM key performance indicators
- Examine facilitators and barriers related to the PPM, including learning Opportunities and next steps
- Establish knowledge mobilization processes for evaluation findings

Led by a multi-disciplinary team, the evaluation included three key components:

- Two rounds of surveys completed by PHNs (December 2015, n= 48 / June 2017, n=73)
- Six focus groups with PHNs, Team Managers, and Clinical Nurse Specialists (n=36)
- Review of key performance indicators from the Healthy Parenting and Early Childhood Development database.

PHN voices were instrumental in the evaluation; providing input on the PPM implementation process, including PHN practice relative to the model and areas where WRHA systems can be strengthened.

[1] WRHA (2014). Public Health Nurse Professional Practice Model.

Recommendations for Consideration

Grounded in evaluation findings, recommendations are provided for consideration and discussion to inform PHN practice within the PPM. Recommendations focus on building on identified strengths and areas for improvement.

Moving forward, ongoing dialogue between PHNs, the PPH program, and community area leadership will inform priority next steps. It will also be important to consider the recommendations previously received from PHN Practice Council working groups.

Supporting PHN practice within the PPM

Evolution of PHN practice

- Define the understanding of and support working to "full scope of practice"
- Continue to work across our system to facilitate role clarity to ensure PHNs are focusing on PPH work.
- Support balancing and prioritizing within practice to meet community needs (e.g. learn from success stories of PPM implementation across areas of practice).
- Review practice changes (e.g., 48 hours to contact, 7 days to home visit, decreased weekend staff, decreased time with advantaged clients) which should have resulted in additional time for full scope of practice.
- Identify implementation successes and challenges of local teams and support as needed.
- Clarify and communicate expectations regarding community level work, including community development. Reinforce the long term nature of this work and its natural ebb and flow.
- Reinforce the value of collaboration and partnership at the community level; acknowledging the value of relationship-based work over time.
- Strengthen existing collaboration between PHNs and centralized program staff.
- Clarify and support the PHN role in healthy public policy and built and social environment work.
- Acknowledge the challenges faced by PHNs and all staff due to implementing the model at the same time vacancy management was implemented as a budget strategy.
- Implement plan to review allocation upon completion of current process; using updated data.

Continued Professional Development

- Support PHNs to balance and prioritize within their practice, including opportunities for ongoing professional development, both self-directed and program supported, e.g., literature, peer supports, staff development and other educational opportunities.

- Strengthen PHN capacity to complete community health assessments and to use population and public health data to inform practice (e.g. support PHN capacity to use NETS).
- Enhance PHN capacity for epidemiological literacy).
- Support awareness of existing data sources to inform public health practice.
- Increase capacity to understand the concept of working upstream and how this is implemented at various levels, from service delivery to policy interventions.
- Engage PHNs and community area leadership in program strategic planning.

Enhancing Recognition

- Build shared understanding of the PHN role and practice among PHNs and PPH leadership.
- Celebrate the evolution of the PHN practice since model implementation, including alignment with practice standards.
- Celebrate PHNs ability to build relationships with communities
- Celebrate progress toward an equity focus, prioritizing disadvantaged populations.
- Utilize existing mechanisms (e.g. program and regional newsletters) to acknowledge work to date.
- Encourage PHNs to share and learn from each others' successes and challenges, focusing on how PHNs are prioritizing their work, within and across the various domains of practice

Communication and Technology

- Identify opportunities to improve communication between PHNs, program, and community area leadership, including a review of current mechanisms for sharing information (e.g., newsletters, committees, and practice councils).
- Enhance reach, repetition and consistency of messaging from leadership.
- Leverage existing technology and platforms (e.g., PPH website) to promote optimal use of PPH information systems to sharing knowledge and tips.
- Acknowledge concerns regarding communication technology that strengthens practice (e.g. smart phones, electronic health records), communicate efforts to advocate for improved public health information systems.
- Work to improve efficiency to the extent feasible within the current state, (e.g., decrease unnecessary data entry over time).

Monitoring and Measurement

- Explore opportunities to measure and monitor practice evolution and successes, acknowledging the long-term nature and multiple factors impacting population health.
- Support a culture shift toward outcome measurement.
- Identify realistic and meaningful outcome indicators.
- Develop and implement methods to monitor and report on progress.

Highlights

Readiness

- PHNs have a high awareness of the Professional Practice Model (PPM). Most survey respondents read the PPM in the year prior to completing the survey (97.9%, Dec 2015; 89%, June 2017).
- Over 75% of PHNs report a good or very good confidence level in ability to apply the PPM in practice.
- While all ten of the Strategic Approaches are at work in Public Health Nurse (PHN) practice, some are applied more often – and others very rarely. Most examples of implementation described by focus group participants related to collaboration and partnership, outreach, and public health clinical practice.
- Although a key area of discussion, focus group participants pointed to gaps in community development implementation, as well as a lack of shared understanding of the concept, and lack of specific supports for community-based work, such as funds for food to incentivize gatherings.
- Areas of highest self-rated knowledge in the 2015 and 2017 surveys (including strategic approaches and public health concepts) are often the areas PHNs feel most confident applying skills to practice.
- PHNs have positive attitudes regarding the PPM. Over 65% of survey respondents expressed excitement about working to full scope of practice. 69% in Dec 2015 and 71% in June 2017 looked forward to "a new way of doing work."
- PHNs expressed strong agreement with public health concepts (such as harm reduction and health equity), and upstream investment (e.g., early childhood development), which underscores acceptance of the model.

Facilitators

- Many successes related to outreach and community development are the result of working alongside colleagues in other program areas and other service providers (related to PHNs playing a "facilitator" or coordination role).
- Co-location or proximity to other service providers supports collaboration and building coalitions.
- Proximity of PHNs to populations being served ensures barriers to services are reduced, and increases PHNs ability to engage with clients in their own setting.
- Wide variety of partners (e.g., Healthy Baby) support PHN daily practice.
- Cohesive and supportive colleagues ensure PHNs can dedicate time and energy to various PPM strategic approaches – such as outreach or community development.
- Participation on coalitions and PHN Practice Council enhance understanding of PHN practice and opportunities to hear and learn from others.
- Leadership with experience in public health nursing practice, and work done with staff to ensure best use of available information such as data and resources, support PHN knowledge, skill development and practice.

- Community data supports PHN practice by providing neighborhood information on population demographics and challenges.

Challenges

- Lack of understanding and skills in some areas present implementation challenges, specifically with healthy built and social environments, applied public health research, and healthy public policy.
- Almost half (46%) of PHNs feel they have control over what they can stop doing in order to work to the full scope of practice (35% disagree, 11% strongly disagree); another 21% are uncertain (June 2017).
- Some participants noted a failure to recognize the value of PHN work and an inadequate understanding of the PHN role – both within public health and by the broader public.
- Recognition of PHN work is directly connected to the ability to measure success – finding ways to adequately capture the work being done by PHNs is a challenge.
- Desire for ongoing, two-way communication between staff and leadership, and staff and centralized program resources.
- Desire for leadership to identify a clear vision and strategic direction (e.g., ensuring resources are in place to support implementation).
- Tension remains in balancing daily demands of referral-driven care and practicing the PPM to its full scope of practice.
- Shifting PHN work culture and moving away from a narrow clinical focus to embrace values of health equity and social justice is a challenge for some. For others, this scope of practice is not new – "this is the job".
- On whether they know where to find answers on change management, over half of survey respondents agree (38%) or strongly agree (15%), another third (36%) are uncertain and – 10% disagree (June 2017).
- PHNs identified some management decisions were inconsistent with the values and guiding principles of the model, and spoke about relocating teams away from target client populations, and a vacancy management process that PHN's perceive reduces clients' access to PHN services.

Opportunities for Improvement

Opportunities below summarize ideas for improvement presented by respondents, and reflect a diversity of voices. Opportunities are not prioritized, or assessed for feasibility; some opportunities may not align.

Organizational Structure and Leadership

- Developing a vision that embraces the PPM model and engages PHNs and leadership.
- Engaging leadership and managers in discussions of what it means to work to full scope.

Responsive PPM implementation

- Implementing the PPM model in a way that responds to unique community areas.

Using resources strategically

- Ongoing PHN engagement and training with surveillance data; bringing forward current data when available.
- Drawing on existing centralized program expertise and supports such as Program Specialists, Initiative Leads, CNSs, Epidemiologists, as well as colleagues and partners working to address community needs.
- Dedicating resources within a community area team as leads on strategic approach areas (e.g., Healthy Public Policy, Healthy Built and Social Environment).
- Identifying and excluding tasks from PHN home visits (e.g., vital signs, blood work).

Resourcing the shift in practice

- Staffing teams, CNS and managers at full level to support PPM implementation.
- Ensuring availability of technology to connect PHNs reliably with community members (e.g., smart cell phones, ipads to share information visually with clients).

Enhancing learning and knowledge transfer

- Focusing training and professional development on areas where PHNs have identified less understanding and confidence, such as the role of the PHN in community development; public health research; healthy public policy; healthy built and social environment.
- Enhancing peer-based learning, including shadowing colleagues and community area exchanges.
- Ongoing orientation to the PPM model that focuses on foundational concepts (e.g., community development, health equity).
- Enhancing role clarity for those within the WRHA who contribute to success of the model, including engaging with other service providers outside the WRHA to enhance understanding of the PHN role.

Enhancing recognition

- Enhancing two-way communication between staff and leadership, and staff and program resources such as centralized program positions.
- Sharing knowledge among teams, within community areas, and with leadership on practicing to full scope (e.g., providing examples of managing responsibilities).
- Ensuring staff and colleagues are recognized for their valued contributions, including Families First Home Visitors, Interpreters and PHNs.

Measuring what counts

- Enhancing current efforts to measure PHN work and population health outcomes.
- Updating reporting platforms to reduce input duplication.
- Engaging with the allocation model to ensure data is current and capturing PHN input to inform how community areas can best be served.
- Ensuring data available to PHNs is current.

Introduction

In 2014, the Winnipeg Regional Health Authority (WRHA) Population and Public Health (PPH) program developed the Professional Practice Model (PPM) to promote population health and equity, and support the alignment of Public Health Nursing (PHN) practice with PHN competencies. The PPM, implemented in June 2016, was informed by public health and nursing literature, WRHA Nursing Practice Council, PHNs, and PPH program staff.

Grounded in eight guiding principles, the PPM consists of five components (see Figure 1, page 16). A key component, Delivery Structure and Process, outlines 10 Strategic Approaches intended to inform the PHN role.

Efforts to evaluate the implementation of the model, led by the WRHA Population and Public Health Program, began in 2017. Phase One evaluation activities included a follow-up PHN survey (Dec 2015 and June 2017), focus groups (September-October 2017), and ongoing work related to key performance indicators derived from the Healthy Parenting and Early Childhood Database (HPECD). Phase One evaluation goals were to:

- describe how PHNs are practicing in accordance with the PPM
- identify, assess, and describe PPM key performance indicators
- examine facilitators and barriers related to the PPM
- identify learning opportunities
- establish knowledge mobilization processes for evaluation findings

Operating Environment

PPM implementation coincided with:

- adoption of the provincial Public Health Standards for Prenatal, Postpartum and Early Childhood;
- continued work to reallocate PHN positions through attrition (1.5 positions were reallocated in 2017/18);
- vacancy management, with some PPH teams managing work with reduced capacity (e.g., positions held open for three-month periods, reduced CNS program resources); and
- consolidation of paired community area offices (two teams relocated in the summer of 2017).

Timeline

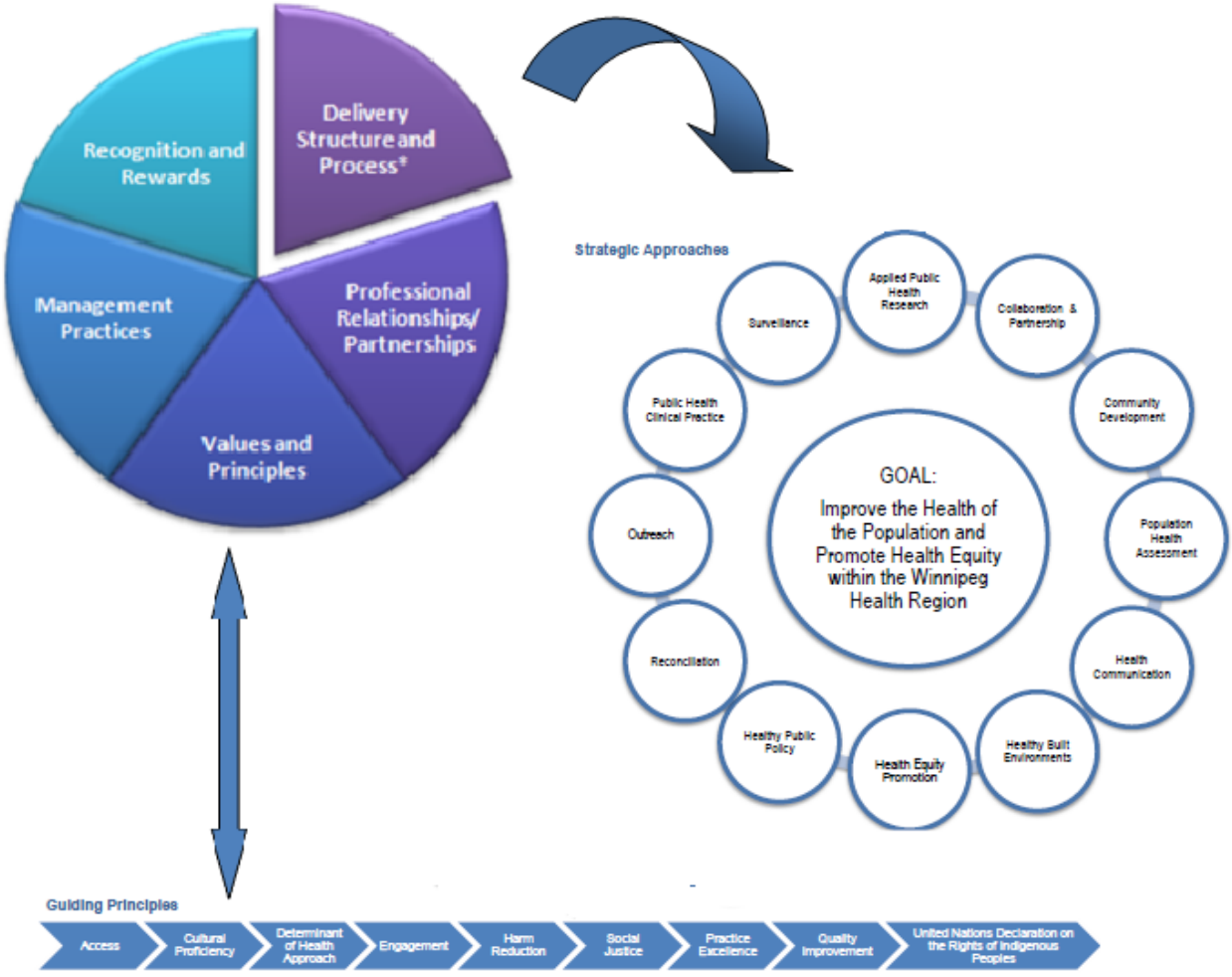
Environmental context, model development and implementation, professional development and evaluation initiatives to support model implementation are reflected in the timeline.

Model Development
Model Implementation
Environmental Context

Year	Evolution of the PPM
October 2008	Best Practice Issue Paper submitted to PHN Practice Council (PHN PC) *What is the best way to meet community needs and demand for service given limited resources, diversity of communities, and ever-increasing load of multiple programs?*
2010	PHN PC established in response to October 2008 Best Practice Issue Paper Development of Appreciative Inquiry process to inform PHN service delivery model
June 2010	Appreciative Inquiry presentation at staff development sessions
2011	Competency-based PHN position description statement developed based on Community Health Nurses of Canada documents Planning for working group to explore development of a service delivery model within PhD research study
February 2012	Working group re-established
February 2012 – Dec 2013	Professional Practice Model (PPM) developed
December 2013	PPM published, printed and distributed
May 2013 – December 2015	*Provincial Public Health Nursing Standards: Prenatal, Postpartum, and Early Childhood* completed, published and distributed. These were implemented at the same time as the PPM.
Fall 2015	New Allocation model developed for PHN positions (see Appendix B)
December 2015	*The Professional Practice Change Readiness Survey* ("PHN survey")
January 2016	Reallocation of PHN positions to support implementation of the PPM PhD dissertation on research associated with the PPM published Canadian Journal of Nursing Research 2017, Vol. 49(1) 16–27; *Reorienting Public Health Nurses' Practice With a Professional Practice Model*
May – June 2016	PPM workshops completed (all PHNs, TMs, some central staff) Implementation memo released (Director, Public Health)
Summer 2016	NETS tool rolled out at PPM workshops and training occurred throughout summer
October 2016	Issue paper resolved
Nov 2016 – January 2017	Logic Model for evaluation of PPM Implementation finalized

December-February 2017	Sites/programs identify initiatives to eliminate deficits (2017-18 fiscal)
March 2017	PPM Evaluation Team established PPM Phase One evaluation framework developed, distributed to PPH leadership and PHNs Manage to budget initiatives, Population and Public Health (PPH) Program for 2017/18 fiscal year: Stop filling vacant shifts; all positions vacancy managed for three months
April 2017	Weekend practice changed to support population based PHN practice in community areas throughout the week
May 2017	Community-level tracking tool developed by PHN PC/ CNS
June 2017	*Professional Practice Change Readiness Survey* (PHN survey #2) Community-level tracking tool piloted
July 2017	WRHA announces manage to budget initiatives including office moves St. Vital PPH office moves to Access St. Boniface from Youville Centre
September 2017	Focus groups with PHNs, Team Managers and CNS conducted by to gather input from PHNs regarding PPM implementation
September 2017	River Heights PPH office moves from Corydon Avenue to Access Fort Garry
Fall 2017	Data extracted from HPECD Database to assess key performance indicators for Phase one of PPM evaluation
October 2017	Community-level tracking tool pilot re-launched
Ongoing work	PHN PC working groups submitted documents with recommendations to NPC/CNSs (communicable disease, community development, documentation tools) Reallocation of PHN positions through attrition Staff professional development remains a priority, including but not limited to: • webinars (2) on healthy built environment and community development • monthly conversations regarding health equity, Indigenous health promotion, and harm reduction • in person staff development sessions • regular communication and newsletters

Figure 1- PPM Model WRHA PHN Professional Practice Model Summary:



Methodology

Survey

Two voluntary surveys were conducted by the WRHA PPH Program in December 2015 (n=48) and June 2017 (n=73). The survey goals were to:

- assess the extent PHNs understand the WRHA PHN Professional Practice Model; and
- explore the extent that PHNs believe they possess the knowledge, skills, and attitudes to apply the model and move forward with a practice based on principles of population/public health and equity.

Both surveys were completed by community area PHNs, most of whom were full-time practitioners, and having worked 6 - 15 years (Figure 2). Based on the number of respondents (December 2015, n=48; June 2017, n=71) and the overall number of community area PHNs (n=121 EFTs), these findings are considered representative of the WRHA general practice PHN population.

Figure 2 – Survey respondents by EFT status (full-time, 0.5)

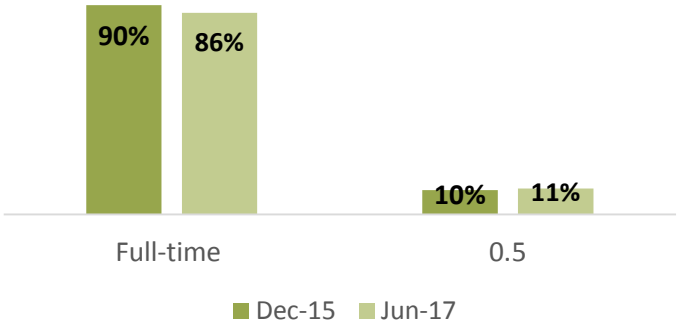
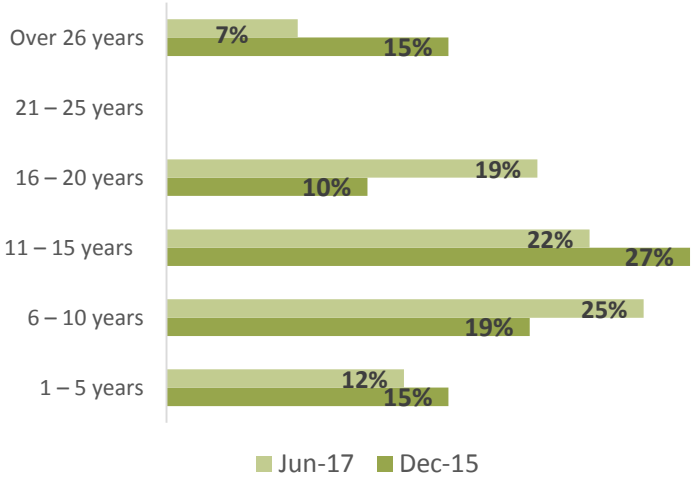


Figure 3 - Survey respondents' years of PHN experience



Data management and analysis

Quantitative data: Implementation of both surveys was managed using SurveyMonkey and extracted for analysis in Statistical Package for the Social Sciences (SPSS, version 20, IBM Corp. Released 2011. IBM SPSS Statistics for Windows, Version 20.0. Armonk, NY: IBM Corp.). Percentages do not equal 100% as answers with less than five respondents were excluded. The survey data were checked for duplicates, and illegal values and fields; none were found. All surveys for which consent was provided were retained for analysis. A small number (n=8) of central services PHNs completed the June 2017 survey. As the PPM had not yet been fully implemented centrally at the time of the evaluation, these responses were filtered out of the analysis.

Qualitative data: Several of the survey questions included a narrative, i.e., qualitative component. While attempts were made to analyze themes from these data, this was

challenged by a high variability in the content. In addition, the nature of the responses did not lend to assessment of the directionality of the responses, i.e., it was not possible to assign a negative or positive value to the comments. In other words, we could not tell whether a comment was negative or positive in nature. However, a small number of quotes are provided within the text of this report for added context.

Limitations

Quantitative survey data were summarized using descriptive analyses (frequencies and proportions). Numbers smaller than five were suppressed in the analysis and are indicated by a dash ("-") in the tables that follow.

Comparative survey analysis is limited as these were cross-sectional surveys (December 2015, n=48; June 2017, n=71). Although participants were drawn from the same population of PHNs, these were not paired groups, i.e., there were different numbers and likely individuals who responded to each survey. Statistical comparisons were not deemed to be appropriate.

Not all survey participants responded to every question, resulting in missing and/or unknown records for one or more variables of interest. Therefore, the sub-totals for each question may not equal the total sample sizes for the 2015 and 2017 survey, respectively.

Given that comparisons between surveys are limited, evaluation findings often highlight the most recent survey findings (June 2017); these being the closest in date to the focus groups conducted in September 2017.

Focus groups

Six focus groups with Public Health Nurses, Clinical Nurse Specialists and Team Managers were conducted as part of PPM evaluation. Following a focus group pilot with members of the evaluation committee, and adaptations to the focus group discussion guide, PHNs from all Community Areas (CAs) were invited to indicate interest in participating; participation was confirmed via email. Each focus group included participants representing different CAs with a range of years of PHN experience and EFTs. To encourage participation and to support anonymity, focus group invite management and facilitation was conducted by an external evaluator. Facilitated focus groups were supported by a discussion guide, audio recorded and transcribed for analysis.

Data management and analysis

Focus Group Stakeholders and Data Collection	
PHN	4 focus groups (n=26)
CNS	1focus groups (n=5)
Team Managers	1focus group (n=5)

Focus group participant (n=36) consent was obtained verbally or via print consent forms. Focus groups were recorded and transcribed verbatim; identifying information (e.g., specific community area references, names) was redacted from transcripts.

Data was themed using Dedoose software[2] (version 8.0.35) for mixed-methods research. Initial codes were identified by evaluators. Codes were further revised; two evaluators themed the data, with coding compared to ensure inter-rater reliability.

Primary codes aligned with the PPM elements (Recognition and Rewards, Delivery, Structure, and Process, Professional Relationships/Partnerships, Values and Principles, Management Principles) and evaluation questions (PPM implementation, supports, barriers, opportunities). Secondary codes emerged from thematic textual analysis. Weighted code application was used to differentiate negative, neutral and positive sentiments (-1, 0, 1). Code co-occurrence tables identified concurrent themes (refer to Appendix D).

Positive, neutral and negative values (sentient weighting; -1, negative; 0, neutral; 1, positive) were applied to primary codes as well as each Strategic Approach to support understanding of degree of PPM implementation.

Quotes illustrate themes presented as well as the diversity of ideas shared, and do not reflect majority opinion, weighting or a prioritization exercise.

Limitations

Focus group findings capture a diversity of voices yet are not inclusive of all stakeholder input. While efforts were made to ensure PHN representation from all community areas for focus group participation, some areas had greater representation than others (Table 1).

Table 1- PHN participation by paired Community Area

Area 1	11
Area 2	5
Area 3	4
Area 4	2
Area 5	1
Area 6	3

Focus group and survey participation was voluntary and may represent those most motivated and interested in the PPM, resulting in a self-selection bias.

Qualitative coding and sentient weighting is based on evaluators' subjective assessments.

Key Performance Indicators

Key Performance Indicators were obtained from the Healthy Parenting and Early Childhood Development (HPECD) database.

Four main questions were identified and corresponding data were extracted from the HPECD database and analyzed to answer:

1. Does PHN practice provide more direct service time to families with FFS positive results as compared to FFS negative results?
2. Are PHNs meeting the Public Health prenatal contact standards? Has there been a shift in practice towards providing more prenatal service?

[2] Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC

3. For families with a postpartum referral, are PHNs completing the Parent Survey for all families with a positive Families First screen?
4. Are PHNs meeting the Public Health standards related to universal contact/home visit and timeliness of initial postpartum contact and visit?

Results describe individuals with a permanent Winnipeg address that had either a prenatal or postpartum referral during the two periods of analysis studied; Period 1 covered the interval between June 1, 2014 and June 30, 2016 and Period 2 covered the interval between July 1, 2016 and June 30, 2017. Outcomes by families with Families First Screen (FFS) positive results (FFS score greater than or equal to 3) and families with Parent Survey positive results (parent survey score greater or equal to 25) were reviewed. Clinical positive screen and survey results were also included in the positive groups.

Limitations

Data used in this report reflect information recorded in the HPECD database at the time of data extraction. Although an established data quality process exists, underlying errors will persist and may impact estimates. Despite this limitation, the KPIs provide objective data and facilitate insight into practice.

Data Sources and Organization of Evaluation Inputs

Evaluation data are organized by four evaluation objectives, and draw from three data sources.

	Surveys (Dec 2015 & June 2017)	Focus Groups	KPI Tracking Data
1. How is PPM being Implemented?			
• Awareness of Model	✓	✓	
• PPM in Action		✓	✓ Increased time with structurally disadvantaged clients[3] ✓ Meeting Post-Partum Standards (referrals)
• Knowledge	✓		
• Skills	✓		
• Attitudes	✓	✓	✓ Meeting standards
2. What are the facilitators to implementation?	✓	✓	
3. What are the barriers to implementation		✓	✓ Challenges with KPI data collection
4. What opportunities exist?	✓	✓	✓ Use and dissemination of KPI data

[3] As identified by Families First and Parent Survey scores

What We Heard

I. Readiness

Highlights

- PHNs have a high awareness of the Professional Practice Model (PPM). Most survey respondents read the PPM in the year prior to completing the survey (97.9%, Dec 2015; 89%, June 2017).
- Over 75% of PHNs report a good or very good confidence level in ability to apply the PPM in practice.
- While all ten of the Strategic Approaches are at work in Public Health Nurse (PHN) practice, some are applied more often – and others very rarely. Most examples of implementation described by focus group participants related to collaboration and partnership, outreach, and public health clinical practice.
- Although a key area of discussion, focus group participants pointed to gaps in community development implementation, as well as a lack of shared understanding of the concept, and lack of specific supports for community-based work, such as funds for food to incentivize gatherings.
- Areas of highest self-rated knowledge in the 2015 and 2017 surveys (including strategic approaches and public health concepts) are often the areas PHNs feel most confident applying skills to practice.
- PHNs have positive attitudes regarding the PPM. Over 65% of survey respondents expressed excitement about working to full scope of practice. 69% in Dec 2015 and 71% in June 2017 looked forward to "a new way of doing work."
- PHNs expressed strong agreement with public health concepts (such as harm reduction and health equity), and upstream investment (e.g., early childhood development), which underscores acceptance of the model.

Awareness

High awareness of PPM

Most survey respondents said they had read the PPM in the year prior to completing the survey (97.9%, Dec 2015; 89% June 2017). For many focus group participants, the PPM strategic approaches articulate a public health nursing practice that is long-standing, familiar, and rooted in PHN practice standards and clinical practice guidelines. Focus groups noted PHN practice is reflective of PPM guiding principles, such as Health Equity and Accessibility.

Full scope of practice

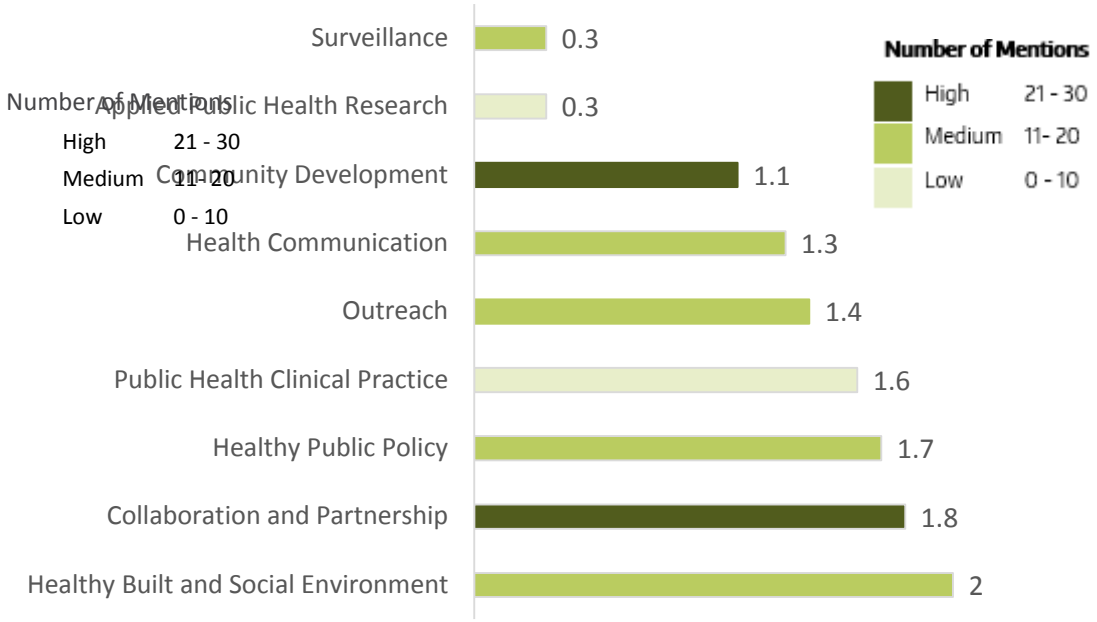
Focus group participants spoke of tension between daily demands of referral-driven care and practicing the PPM to its full scope of practice. Teams experience tension as colleagues dedicate time to work outside of clinical practice (e.g., referrals) – unsure of how to balance these demands as a team. For example, participants spoke of being challenged to spend ¾ of a day per week on community development as estimated by program in PPM implementation discussions.

Focus group and PPM survey (December 2015, June 2017) findings indicate a high understanding and comfort with clinical practice, outreach, and collaboration and partnership. While PHNs engaged often in discussions related to community development, they expressed uncertainty regarding shared understanding and indicated that there are gaps in implementation.

Focus group participants rarely discussed applied public health research or population health assessment – and offered very positive but limited examples of Healthy Built and Social Environment (HBSE).

While all ten of the Strategic Approaches are at work in PHN practice, focus group respondents noted some are implemented more often – and others very rarely (see fig. 4, highest numbers of mention). Most examples of PPM in action provided by PHN focus group participants related to collaboration and partnership, healthy public policy, and public health clinical practice.

Figure 4 – Examples of strategic approaches "at work", focus group participants mostly focused on Collaboration & Partnership, HPP and Clinical Practice at work. Higher numbers indicate a more positive description of implementation (between 0-2; 2 indicates more positive response)



Areas that PHNs spoke most often and positively of in focus group discussion were areas where they had higher self-assessed understanding: clinical practice, outreach, and collaboration and partnership (Table 2).

Table 2 - Areas of self-rated understanding; categories (strongly agree/agree; uncertain; strongly disagree/disagree) with greatest numbers of respondents indicated by darker green.

Understanding	Dec 2015 (%)			June 2017 (%)		
	Strongly/ Disagree	Uncertain	Strongly/ Agree	Strongly /Disagree	Uncertain	Strongly/ Agree
Role of the PHN in public health clinical practice	-	14.6	77.1	-	10.8	89.3
Role of the PHN in outreach	12.5	22.9	64.6	-	18.5	78.4
Role of the PHN in healthy public policy	22.9	39.6	33.3	10.8	36.9	50.7
Role of the PHN in healthy built and social environments	16.7	45.8	31.1	9.2	41.5	41.5
Role of the PHN in population health assessment	10.4	31.3	58.3	20.5	20.5	63.0
Role of the PHN in community development	12.5	29.2	56.3	-	26.2	67.7
Role of the PHN in collaboration and partnership	33.0	25.0	68.7	-	11.0	73.9
Role of the PHN in applied public health research	14.6	43.8	31.3	13.8	50.8	33.8
Role of the PHN in surveillance	10.4	47.9	41.7	9.2	29.2	61.6

Focus group participants spoke positively about **collaboration and partnerships** that support and streamline program and service delivery, including sharing resources with other service providers, maintaining open lines of communication, and participation on various local committees.[4] Many examples of successful PPM implementation related to PHNs working alongside colleagues from other program areas and other service providers –

> "My involvement on the Parent Child Coalition..prior to that our community facilitator used to attend and bring back info but it was hard to appreciate and to feel like we were connected with the community by having our facilitator do it. I attend monthly and bring back info to our team." – Focus group participant

[4] Participants offered very positive but limited examples of Healthy Built and Social Environment.

playing a "facilitator" or coordination role.

Collaboration and partnerships allow PHNs to engage in a range of public health-related areas without necessarily leading initiatives. Collaboration with service providers is critical to practicing to the full scope of the model; nurses drawing on knowledge and supports from other areas, as opposed to leading on each aspect of the model. Nearly three-quarters rate their understanding of collaboration and partnership as described in the PPM as very good

> "I'm seeing, for myself and my coworkers, more collaboration. There will be a family that has some crisis issues, maybe CFS is involved. There are more meetings, more than there used to be, where Public Health is there and maybe asking for the meeting where as before we didn't. Seeing more of that." – Focus group participant

(Table 3).

Table 3 – Understanding of PHN role in collaboration and partnership

		Dec 2015 (n=48)	*June 2017 (n=64)*
Role of the PHN in collaboration and partnership	Very good	22.9%	26.0%
	Good	45.8%	47.9%
	Fair	25.0%	11.0%
	Poor	-	-
	Not at all	-	-

Collaborating with key partners – such as Employment Insurance Assistance (EIA), schools, primary care, or newcomer serving agencies – supports PHN's ability to respond to emerging issues and engage hard to reach audiences; providing opportunities to apply a preventative, "upstream" health approach. Similarly, more than three-quarters of 2017 survey respondents indicated very good (25%) or good (56.7%) skills for creating and maintaining diverse partnerships (Table 5). The PHNs ability to work as members of inter-professional teams is also positively rated.

A core area of practice for PHNs, **clinical practice** is clearly understood, "straightforward," and "easy to operationalize." Survey responses indicate a strong understanding (>80%) of the PHN role in clinical practice, as described in the PPM (Table 6).

> "I think clinical practice is the 'easiest' part of our job to understand because we have such clear guidelines that we follow."
> – Focus group participant

Table 4 – Ability to work as a team member

		Dec 2015 (n=48)	*June 2017 (n=65)*
Ability to work as a member of an inter-professional team	Very good	58.3%	61.7%
	Good	39.6%	36.7%

Table 5 – Ability to create and maintain partnerships

		Dec 2015 (n=47)	*June 2017 (n=60)*
Ability to create and maintain partnerships with diverse community partners and agencies	Very good	16.7%	25.0%
	Good	54.2%	56.7%
	Fair	29.2%	18.3%
	Poor	-	-

Table 6 -

		Dec 2015 (n=48)	*June 2017 (n=65)*
Role of the PHN in public health clinical practice	Very good	25.0%	30.8%
	Good	52.1%	58.5%
	Fair	14.6%	10.8%
	Poor	-	-
	Not at all	-	-

Understanding of PHN role in clinical practice in PPM

Effective tools for equity focus

PHN's spoke about the important role equity plays in their jobs and the need for PHN's to

> "The program has taken this new perspective, looking at it like well if you don't score a 3, you really should be limiting your services."
>
> "Working around the SDoH and with families that need more support is the job. If you don't like the job, you have to find another job because this ***is*** the job. – Focus group participant

practice these values.

Current screening tools support the equity focus important to many PHNs. Over 80% of survey respondents (2017) agreed that the Families First Survey and Parent Survey are effective tools to identify individuals or families at risk for negative outcomes (Table 7). Close to 70% agreed that individuals or families with no identified risks should be referred to primary care and other community resources for ongoing follow up and support (36% strongly agreed, 34% agreed, Table 9).

Table 7 – Effectiveness of Families First screen and survey tool

		Dec 2015 (n=48)	*June 2017 (n=57)*
The Families First (FF) screen and survey are effective tools to identify individuals/families at risk for negative outcomes.	Strongly agree	37.5%	33.3%
	Agree	33.3%	45.6%
	No opinion or uncertain	14.6%	13.7%
	Disagree	-	-
	Strongly disagree	-	-

Table 8 – Focusing efforts on individuals/families at risk

		Dec 2015 (n=48)	*June 2017 (n=57)*
PHN services should focus efforts on individuals/families identified at risk for negative outcomes based on the FF screen and parent survey results.	Strongly agree	25%	31.6%
	Agree	41.7%	54.4%
	No opinion or uncertain	18.8%	8.8%
	Disagree	10.4%	-
	Strongly disagree	-	-

Table 9 - Those with no identified risks should be referred to other resources

		Dec 2015 (n=48)	*June 2017 (n=57)*
Those individuals/families that have no identified risks should be referred to primary care and other community resources for ongoing follow up and support.	Strongly agree	25.0	35.7
	Agree	31.3	33.9
	No opinion or uncertain	18.8	21.4
	Disagree	20.8	8.9
	Strongly disagree	-	-

PHN practice aligns with equity focus

PHN practice provides more direct service time to families with Families First positive and Parent Survey positive results, as compared to Families First negative results – demonstrating PHN's daily practice aligns with an equity focus (Table 10). Over 80% of PHNs agree they should focus efforts on individuals/families identified as at risk (Table 11). Focus group participants spoke of this shift in approach, noting how survey results inform a "new perspective" on how to direct service.

Table 10 - Service intensity by Families First status, WRHA residents, November 1, 2016 to October 31, 2017[5]

	Minutes	*(Min/Max)*
Postpartum referrals		
Median PHN minutes per family		
FFS positive	115	(1/1075)
FFS negative	80	(1/850)
Parent Survey positive	133	(5/850)
Parent Survey negative	95	(1/477)
Median PHN contacts per family		
FFS positive	4	(1/33)
FFS negative	3	(1/27)
Parent Survey positive	5	(1/33)
Parent Survey negative	3	(1/20)
Prenatal referrals		
Median PHN minutes per family		
FFS positive	130	(1/927)
FFS negative	85	(5/767)
Parent Survey positive	145	(3/927)
Parent Survey negative	113	(5/760)
Median PHN contacts per family		
FFS positive	5	(1/42)
FFS negative	3	(1/29)
Parent Survey positive	6	(1/42)
Parent Survey negative	5	(1/34)

[5] These data are from the *Service Intensity by Families First Status* report (HPECD database). Results are for individuals with a permanent Winnipeg address that had either a prenatal or a postpartum referral between November 1, 2016 and October 31, 2017. Direct service time includes both phone and home visits.

Table 11–Focus of PHN services on individuals/families identified as at risk

		Dec 2015 (n=48)	*June 2017 (n=57)*
PHN services should focus efforts on individuals/families identified at risk for negative outcomes based on the FF screen and Parent Survey results.	Strongly agree	25.0%	31.6%
	Agree	41.7%	54.4%
	No opinion or uncertain	18.8%	8.8%
	Disagree	10.4%	-
	Strongly disagree	-	-

Nurses continue to meet provincial standards

The Provincial PHN Practice Standards for Prenatal, Postpartum and Early Childhood (2015) allow flexibility in managing referrals, and hence support practice within the PPM. PHNs continue to meet prenatal contact standards for first contact, with 62% being contacted and meeting the standard in Period 1 (June 1, 2014 – June 30, 2016) and 60% contacted and meeting the standard in Period 2 (July 1, 2016 – June 30, 2017) (Table 11). In addition, for families with a postpartum referral, the percentage of families screening positive on the Families First screen has remained stable; almost 90% of screen positive families have a Parent Survey initiated and survey completion rate has not changed over time.

Some focus group participants noted that along with post-partum visits and "getting to know families," population health assessment (PHA) is part of this "regular day to day practice." Just over half of survey respondents (June 2017) reported a very good or good understanding of the PHN role in population health assessment – with 20.5% indicating a fair understanding (Table 12). Survey comments (2017) noted that communication and encouragement related to PHA could be improved.

Table 12 - Understanding of PHN role in Population Health Assessment

		Dec 2015 (n=48)	*June 2017 (n=65)*
Role of the PHN in population health assessment (PHA)	Very good	12.5%	17.8%
	Good	45.8%	45.2%
	Fair	31.3%	20.5%
	Poor	10.4%	-
	Not at all	-	-

> "A better job could be done by sharing population health assessment data with workers at the front line." – 2017 survey respondent
>
> "I do not feel encouraged to do any broad Public Health Assessment." – 2017 survey respondent

Following clinical practice, outreach was the area rated most positively in terms of understanding. Over 75% of June 2017 survey respondents indicated a good (53.8%) or very good understanding of the outreach role (Table 13). When conducting outreach, PHNs described examples of daily relationship-building: meeting with community members who are "more hidden than out front;" engaging target audiences by changing the program location; offering services with translation support; and targeting home visits for those identified as needing support (i.e. +3) on Families First Screen. Relationships that are built by PHN's daily interactions with community members help to increase awareness and uptake of resources.

Table 13 - Understanding PHN role in outreach

		Dec 2015 (n=48)	*June 2017 (n=65)*
Role of the PHN in outreach	Very good	25%	24.6%
	Good	39.6%	53.8%
	Fair	22.9%	18.5%
	Poor	12.5%	-
	Not at all	-	-

> "Our team is a result of the "new way of doing business". It has allowed them the opportunity to begin outreach. For example, we recently went into one of our junior high schools on a Parent / Teacher evening. They had tables for anxiety and stress for students. It went extremely well. Parents were so delighted that we were there, the nurses were thrilled, the principal. It's going to be expanding out."
> – Focus group participant
>
> "Developed really good relationships with the people in that community."
> – Focus group participant

Although a key area of discussion, focus group participants often pointed to gaps in community development implementation. Others spoke about whether PHNs are actively engaging with this area of work, degree of team support, lack of shared understanding of the concept, and lack of tangible supports (e.g., funds for food to incentivize gatherings). Some focus group participants noted community development is a "shift" in practice; others said that it was a long-standing element of PHN practice. Close to 70% of PHNs reported a very good (18.5%) or good understanding of their role in community development – and just over a quarter said their understanding was fair (Table 14).

Table 14 – Understanding PHN role in community development

		Dec 2015 (n=48)	*June 2017 (n=65)*
Role of the PHN in community development	Very good	16.7%	18.5%
	Good	39.6%	49.2%
	Fair	29.2%	26.2%
	Poor	12.5%	-
	Not at all	-	-

In terms of **healthy public policy**, a few focus group respondents described PHNs playing an advocacy role and finding opportunities to influence processes and policies, as one said "an unfair practice or something in another area like income assistance..we've been able to take it forward to their Community Area Director (CAD) and then have had things change."

Focus group participants rarely discussed **applied public health research** or population health assessment – and offered very positive but limited examples of healthy built and social environment (HBSE). Some respondents noted that Families First screening information is used in "all kinds of research in Manitoba." A few focus group participants spoke about the **healthy built and social environment (HBSE)** – a "newer" strategic approach for some. Survey findings are similar; PHN's understanding of their role related to public health research and HBSE as described in the PPM is lower than other areas (Tables 15 & 16).

Table 15 – Understanding PHN role in applied Public Health Research

		Dec 2015 (n=48)	*June 2017 (n=65)*
Role of the PHN in applied public health research	Very good	-	9.2%
	Good	31.3%	24.6%
	Fair	43.8%	50.8%
	Poor	14.6%	13.8%
	Not at all	-	

Table 16 - Understanding PHN role in HBSE

		Dec 2015 (n=48)	*June 2017 (n=65)*
Role of the PHN in healthy built and social environments	Very good	31.1%	41.5%
	Good	45.8%	41.5%
	Fair	16.7%	9.2%
	Poor	-	-
	Not at all	-	-

Focus group participants spoke about the value of **surveillance** data; "it's helpful, surveillance wise, when we hear the data coming back…." Some were unsure how information is used (e.g., for research, to demonstrate outcomes, for monitoring), or were at times unclear about the purpose of collecting surveillance data. A number of participants said NETS (Neighbourhood Explorer Tool Set) is a useful tool that supports community assessments. Others said using NETS is time-consuming, "not up to date," and inaccurate. While over 60% indicated their understanding was very good (23%) or good (39%), a third of 2017 survey respondents rated understanding of their surveillance role as fair (Table 17).

Table 17 - Understanding PHN role in surveillance

		Dec 2015 (n=48)	*June 2017 (n=65)*
Role of the PHN in surveillance	Very good	14.6%	23.1%
	Good	27.1%	38.5%
	Fair	47.9%	29.2%
	Poor	10.4%	9.2%
	Not at all	-	-

Knowledge

Survey respondents assessed their understanding of foundational public health concepts, social determinants of health and health equity promotion the highest (over 90%, very good / good, Tables 18, 19, 20).

Table 18 - PHN's self-rated understanding of social determinants of health is highest among public health concepts (2017)

		Dec 2015 (n=48)	*June 2017 (n=65)*
Social determinants of health	Very good	39.6%	59.4%
	Good	25%	37.5%
	Fair	-	-
	Poor	-	-
	Not at all	-	-

Table 19 – Understanding health equity promotion

		Dec 2015 (n=48)	*June 2017 (n=65)*
Health equity promotion	Very good	31.3%	44.6%
	Good	43.8%	49.2%
	Fair	22.7%	-
	Poor	-	-
	Not at all	-	-

Table 20 – Understanding social justice

		Dec 2015 (n=48)	*June 2017 (n=65)*
Social justice	Very good	16.7%	18.5%
	Good	41.7%	55.4%
	Fair	31.3%	23.1%
	Poor	10.4%	3.1%
	Not at all	-	-

Survey respondents indicated a very good (9%) or good (62%) understanding of the change management process, noting change management communications are received by PHNs. Many participants discussed management decisions that challenge PHNs ability to practice to full scope, such as relocating teams away from target client populations, and a vacancy management process that is perceived to hinder clients' access to PHN services. Some PHNs noted the gap between the values described in the PPM and management decisions.

In June 2017, 81.5% of survey respondents indicated a very good (27.7%) or good (53.8%) understanding of Indigenous health promotion (Table 21). Survey comments were diverse, and included mentions related to knowledge levels – such as wanting more clarity on the PHN role in healthy public policy, and more communication with Indigenous people and communities, "more education on how to support disadvantaged families," needing practice in population health assessment; and "learning about [the healthy built and social environment] concept."

Table 21– Understanding Indigenous health promotion

		Dec 2015 (n=48)	*June 2017 (n=65)*
Indigenous health promotion	Very good	14.6	27.7
	Good	25	53.8
	Fair	60.4	16.9
	Poor	-	-
	Not at all	-	-

> "Need information on how to work effectively with urban indigenous people and communities." – 2017 survey respondent

Skills

Applying public health concepts

Among the public health concepts assessed (Fig. 5), PHNs felt most confident in their ability to address the social determinants of health (22% very good, 68% good), apply health equity promotion (58% very good, 28% good) and apply a harm reduction approach (19% very good, 68% good).

Figure 6 – Public health concepts assessed in survey

PHNs were asked to rate their understanding and confidence related to a range of public health concepts:

- Health equity promotion
- Social determinants of health
- Harm reduction
- Indigenous health promotion
- Structural disadvantage
- Social justice
- Cultural proficiency / safety

Knowledge transfer

PHNs reported a high level of skill in the area of knowledge transfer, including the ability to describe health equity and the relationship between poverty and health (see Table 22). Limited (<5) respondents rated these skills as fair or poor (June 2017). The ability to facilitate groups was also highly rated (over 80%, June 2017).

Table 22 – Knowledge transfer abilities

		Dec 2015 (n=48)	*June 2017 (n=60)*
Ability to describe the concept of health equity to others	Very good	31.3%	43.3%
	Good	56.3%	53.3%
	Fair	12.5%	-
	Poor	-	-
Ability to communicate the relationship between poverty and health	Very good	41.7%	50%
	Good	54.2%	46.7%
	Fair	-	-
	Poor	-	-
Ability to facilitate groups	Very good	-	51.7%
	Good	47.9%	43.3%
	Fair	43.9%	5%
	Poor	-	-

Evidence-based practice

Most PHNs reported a good/very good ability to review, understand and apply PH and nursing research evidence (over 70%), and interpret surveillance data (65%) (Table 23).

Table 23 – Ability to apply evidence-based practice

		Dec 2015 (n=48)	*June 2017 (n=60)*
Ability to appraise and apply research evidence from public health and nursing sciences	Very good	-	16.9%
	Good	56.3%	55.9%
	Fair	35.4%	25.4%
	Poor	-	-
Ability to interpret surveillance data	Very good	-	15%
	Good	47.9%	50%
	Fair	43.9%	33.3%
	Poor	-	-

Outreach & Community Development

Almost 100% of PHNs reported very good (47%) or good (50%) ability to create relationships and build trust with disadvantaged populations – one of the highest areas of self-rated understanding (Table 24).

Table 24 – PHNs report very good skills building relationships and trust (<5 responded Fair, Poor, Not at all)

		Dec 2015 (n=48)	*June 2017 (n=60)*
Ability to create relationships and built trust with disadvantaged populations	Very good	43.8%	46.7%
	Good	50%	50%

PHNs positively rated their own ability (i.e., good or very good) to facilitate access to resources and health services for those more vulnerable, and plan and deliver responsive programs and services (Table 25).

Table 25 – Abilities related to delivery and advocacy for disadvantaged groups

		Dec 2015 (n=48)	*June 2017 (n=60)*
Ability to facilitate access to resources and health services for disadvantaged populations	Very good	27.1%	30%
	Good	50%	60%
	Fair	22.9%	8.3%
	Poor	-	-
Ability to plan and deliver programs/services specifically for disadvantaged populations	Very good	23.4%	20%
	Good	36.2%	63.3%
	Fair	36.2%	16.7%
	Poor	-	-
Ability to engage in advocacy with, or on behalf of, disadvantaged groups	Very good	23.4%	20%
	Good	36.2%	63.3%
	Fair	36.2%	16.7%
	Poor	-	-

Understanding is generally consistent with confidence to apply skills

Generally, there is agreement with PHNs' very good or good understanding of the strategic approaches and self-confidence in applying the strategic approach to daily practice (Table 26).

Table 26 – Comparing very good or good *UNDERSTANDING* vs *CONFIDENCE*

	Understanding of PHN role	*Confidence in ability to apply*
Role of the PHN in public health clinical practice	89.4%	95.5%
Role of the PHN in outreach	78.4%	80%
Role of the PHN in population health assessment	63%	57.5%
Role of the PHN in community development	67.7%	62.7%
Role of the PHN in collaboration and partnership	73.9%	85.5%
Role of the PHN in surveillance	616%	60%

Where PHNs have a lower (fair or poor) self-rated understanding of the strategic approach, there is also agreement in lower confidence to apply the strategic approach to their practice. Where about half of respondents indicated an understanding of their role in healthy public policy (and focus group participants noted examples of development and implementation), a lower number of survey respondents feel confident in their ability to undertake healthy public policy work (Table 27).

Table 27 - Comparing very good or good *UNDERSTANDING* vs *CONFIDENCE*

	Understanding of PHN role	Confidence in ability to apply
Role of the PHN in healthy public policy	50.7%	35.6%
Role of the PHN in healthy built and social environments	41.5%	33.3%
Role of the PHN in applied public health research	33.8%	40%

Attitudes

Focus group participants spoke passionately about their commitment to public health, enthusiastically described interactions with community members, and shared stories of connecting clients to knowledge and services. Over 75% of PHNs reported a very good or good confidence level about their ability to apply the PPM in their practice (Table 28).

Table 28 - Confidence to apply PPM model

		Dec 2015 (n=48)	*June 2017 (n=60)*
PPM Professional Practice Model	Very good	18.8%	25.0%
	Good	43.8%	50.0%
	Fair	25.0%	23.3%
	Poor	12.5%	-
	Not at all	-	-

Survey respondents indicated same; over 65% of survey respondents expressed excitement to work to full scope of practice (Table 29) – and 69% (Dec 2015) and 71% (June 2017) looked forward to "a new way of doing work" (Table 30) (see Appendix D – Personal Readiness Questions).

Table 29 – Excited about work based on PPM

		Dec 2015 (n=48)	*June 2017 (n=56)*
I am excited about basing my practice on the Professional Practice Model (ie. working to the full scope of the PHN role)	Strongly agree	33.3%	28.6%
	Agree	35.4%	39.3%
	Uncertain	25%	30.4%
	Disagree	-	-
	Strongly disagree	-	-

Table 30 – Looking forward to new way of working

		Dec 2015 (n=48)	*June 2017 (n=56)*
I look forward to a new way of doing my work	Strongly agree	29.2%	26.8%
	Agree	39.6%	44.6%
	Uncertain	22.9%	28.6%
	Disagree	-	-
	Strongly disagree	-	-

Strong commitment to PH concepts

PHNs indicate a strong belief and commitment to principles of health equity and population health. Survey respondents identified hopes about changing practice. Many comments related to meeting the needs of clients (improving the health of the population), contributing to the health of the population, and seeing a positive change (n=55, June 2017). Over 80% of survey respondents agreed that PHNs are well positioned to support individuals and families disadvantaged by issues such as poverty, mental illness, racism, lack of education and lack of ability to access resources (June 2017, Table 32).

While most PHNs agree (12.5% strongly, 41% agree) that PHNs are well positioned to work upstream to address system issues that cause health inequities, close to a third are uncertain they agree or have no opinion, and approximately 15% disagree (June 2017, Table 31). PHNs report a strong agreement that early investments in childhood have positive effects on population health outcomes (Table 32).

Table 31– Well-positioned for equity work

		Dec 2015 (n=47)	*June 2017 (n=57)*
PHNs are well positioned to work upstream and tackle the inequitable distribution of power, money and resources that cause health inequities.	Strongly agree	14.6%	12.5%
	Agree	31.3%	41.1%
	No opinion or uncertain	29.2%	28.6%
	Disagree	22.9%	16.1%
	Strongly disagree	-	-

Table 32 – Agreement with upstream investment (e.g., childhood)

		Dec 2015 (n=48)	*June 2017 (n=57)*
Investments in early childhood have the greatest opportunity to improve one's life course and contribute to population health outcomes	Strongly agree	77.1%	75.4%
	Agree	22.9%	21.1%
	No opinion or uncertain	-	-
	Disagree	-	-
	Strongly disagree	-	-

Aware (and optimistic) about shifting culture of work

As noted, focus group participants described tensions between daily demands of referral-driven care and practicing the PPM to its full scope of practice. Although most survey respondents do not feel they can control their own daily practice (Table 33), more agree than disagree they will shift their daily practice (Table 34) – indicating a positive attitude toward change.

Table 33 – Control over what work can be stopped

		Dec 2015 (n=48)	*June 2017 (n=56)*
I feel that I have control over what I can stop doing in order to be able to work to the full scope of my practice	Strongly agree	-	8.9%
	Agree	12.5%	25%
	Uncertain	29.2%	21.4%
	Disagree	41.7%	33.9%
	Strongly disagree	-	10.7%

Table 34 - More agreement than uncertainty or disagreement in one's intention to work to full scope

		Dec 2015 (n=48)	*June 2017 (n=56)*
I believe that I will allow myself to stop doing some of the things I am currently doing in my practice in order to work to the full scope of my practice	Strongly agree	14.6%	14.3%
	Agree	39.6%	53.6%
	Uncertain	33.3%	25%
	Disagree	12.5%	-
	Strongly disagree	-	-

Focus group participants noted challenges shifting the culture of PHN work from a narrow clinical focus. A few participants said some colleagues appear to be challenged to acknowledge and incorporate values of health equity and social justice. Half of survey respondents (Table 35, June 2017) agreed that colleagues have a good understanding of full

> "Recognizing past practice seemed to be getting your desk clean. Getting your referrals done and everything squared away before the end of the day. The new model means there's always going to be work at the end of the day. It is a big culture shift…In terms of approach…it's hard."– Focus group participant

scope of practice – and the remainder are uncertain (21.4%) or disagree (19.6%) (Table 36).

Table 35 – PHNs' understanding about full scope of practice

		Dec 2015 (n=48)	*June 2017 (n=55)*
I believe that my PHN colleagues have a good understanding of what it means to work to the full scope of their practice.	Strongly agree	-	8.9%
	Agree	37.5%	42.9%
	Uncertain	37.5%	21.4%
	Disagree	16.7%	19.6%
	Strongly disagree	-	-

II. Facilitators

Highlights

- Many successes related to outreach and community development are the result of working alongside colleagues in other program areas and other service providers (related to PHNs playing a "facilitator" or coordination role).
- Co-location or proximity to other service providers supports collaboration and building coalitions.
- Proximity of PHNs to populations being served ensures barriers to services are reduced, and increases PHNs ability to engage with clients in their own setting.
- Wide variety of partners (e.g., Healthy Baby) support PHN daily practice.
- Cohesive and supportive colleagues ensure PHNs can dedicate time and energy to various PPM strategic approaches – such as outreach or community development.
- Participation on coalitions and PHN Practice Council enhance understanding of PHN practice and opportunities to hear and learn from others.
- Leadership with experience in public health nursing practice, and work done with staff to ensure best use of available information such as data and resources, support PHN knowledge, skill development and practice.
- Community data supports PHN practice by providing neighborhood information on population demographics and challenges.

Location

Proximity to partners supports PHNs' ability to directly engage service providers; as one said, "Physical location made a huge difference. Even [colleagues] like EIA..you see them in the coffee room" Co-location with other services connects community members to PHN services in a timely way – contributing to strengthened relationships with community members. For some, co-location allows PHNs to focus on clinical work, while community partners focus on other elements of the PPM model (e.g., outreach).

> "Yes, so you can go around the corner and see the EIA worker or CFS worker or you can bump into a client downstairs when they're coming for EIA services. [Clients] ask for us because they know we're in the building." – Focus group participant

Co-location or proximity supports but does not determine a high level of collaboration among service providers. As one focus group participant said, "It isn't about the proximity because I also work in an Access Centre and we don't have that going on." Participants identified that relationship building is critical.

Colleagues' support facilitates practicing to fuller scope of practice. Focus group participants described picking up colleagues' referral work, operating "fluid as a team," and the importance of this support to team cohesiveness.

Most survey respondents agreed they have the support of direct managers to work to full scope (Table 36).

> "Facilitators of our practice are our team members." – Focus group participant
>
> "In the sense that if you're going to commit for half a day somewhere, that you have the team support if you get referrals that day..that they support you. It doesn't build animosity or frustration." – Focus group participant
>
> "We're also really good resources for each other. And our manager is very supportive that we're talking to each other. Really encourages us to brainstorm off each other." – Focus group participant

Table 36 – Manager support to work to full scope

		Dec 2015 (n=48)	*June 2017 (n=55)*
I believe that I will be supported by my manager to stop doing some of the activities I am currently doing in order to work to the full scope of my practice	Strongly agree	14.6%	9.1%
	Agree	66.7%	56.4%
	Uncertain	14.6%	29.1%
	Disagree	-	-
	Strongly disagree	-	-

In addition to support from colleagues and direct managers, some participants spoke positively about the initial training on the PPM model. Learning and professional development encourages PHNs, as one respondent said:

> "What I've found helpful is that every two months, we did a focused professional development piece within our teams. It's required by all teams. Last one we did was on cultural awareness. That was from this model, developed to encourage and support us with learning and understanding. Those are helpful." – Focus group participant

Collaboration and Relationships

Collaboration with service providers is critical to practicing to the full scope of the model; allowing nurses to draw on knowledge and supports from other areas, as opposed to leading on each aspect of the model. Participants spoke often about colleagues who support PH practice, such as, the "invaluable" work of Families First Home Visitors, and interpreters.

> "I'm seeing, for myself and my coworkers, more collaboration. There will be a family that has some crisis issues, maybe CFS is involved. There are more meetings, more than there used to be, where Public Health is there and maybe asking for the meeting where as before we didn't. Seeing more of that." – Focus group participant
>
> "We have great Home Visitors, they stay with families a long time if they can..[Families First] itself is a really good program." – Focus group participant
>
> "When centralized programs like Injury Prevention do communicate to the teams it's super helpful." – Focus group participant

PHNs noted that the support of interpreters increases access to some target audiences.

Data and Measurement

Community data supports PHN practice – providing neighbourhood information on population demographics and challenges. Data also helps PHNs understand that "we actually have a role there."

> "I think a real facilitator is getting data that is rich and with some sort of targets with that particular data to help drive some of the activity" – Focus group participant
>
> "with the NETS tool, I just recently printed off a map with the low-income housing, FF screens, MB housing…we've used this map to show the concentrated need of resources. The data is so valuable." – Focus group participant
>
> "One things that has supported the practice a little bit, the change in community development or understanding the needs of the community is the NETS. Giving [PHNs] maps of what some of the needs of..communities are, [what] the population statistics are..That's been a support in my experience." – Focus group participant

For some, the allocation model supports PPM implementation by resourcing areas of higher need, and ensuring an equity approach to public health. Focus group participants also identified that PHNs have clear practice guidelines that are consistent with the PPM – and "make the [PPM] model come alive." Additional supports include committees (HPP, HBE) that include PHNs and the Families First program, as well as outreach guidelines.

> "For delivery, structure and process, the way we are supposed to deliver our services is very clearly outlined by our Clinical Practice Guidelines."
> – Focus group participant

III. Challenges

Highlights

- Lack of understanding and skills in some areas present implementation challenges, specifically with healthy built and social environments, applied public health research, and healthy public policy.
- Almost half (46%) of PHNs feel they have control over what they can stop doing in order to work to the full scope of practice (35% disagree, 11% strongly disagree); another 21% are uncertain (June 2017).
- Some participants noted a failure to recognize the value of PHN work and an inadequate understanding of the PHN role – both within public health and by the broader public.
- Recognition of PHN work is directly connected to the ability to measure success – finding ways to adequately capture the work being done by PHNs is a challenge.
- Desire for ongoing, two-way communication between staff and leadership, and staff and centralized program resources.
- Desire for leadership to identify a clear vision and strategic direction (e.g., ensuring resources are in place to support implementation).
- Tension remains in balancing daily demands of referral-driven care and practicing the PPM to its full scope of practice.
- Shifting PHN work culture and moving away from a narrow clinical focus to embrace values of health equity and social justice is a challenge for some. For others, this scope of practice is not new – "this is the job".
- On whether they know where to find answers on change management, over half of survey respondents agree (38%) or strongly agree (15%), another third (36%) are uncertain and – 10% disagree (June 2017).
- PHNs identified some management decisions were inconsistent with the values and guiding principles of the model, and spoke about relocating teams away from target client populations, and a vacancy management process that PHN's perceive reduces clients' access to PHN services.

Respondents identified barriers to PPM implementation that intersect with the PPM Components and Strategic Approaches, with most referring to: inadequate resources (staff, time) for individuals to practice to full scope of PPM model; lack of shared understanding of the PHN role among PHNs, public, and management; desire for leadership (e.g., collaborative leadership, providing guidance on implementation); challenges measuring progress toward PHN outcomes; and communication.

Focus group participants juxtaposed elements of the PPM model (such as community development and healthy public policy) with daily clinical work; and reported feeling tension between working to full scope and focusing on equity-based work, and responding to requests for home visits.

Resources

Respondents stressed the negative impact of vacant positions and working on teams with less than the full staff complement. Some noted that practicing to full scope requires a supportive team setting, which relies on available staff. In addition to vacancy management, managing personal and medical leaves is difficult for teams; "it's hard to operationalize the model if I don't have the staff," as one respondent said.

> "My experience of doing community development, to get people to come you have to feed them or have some incentive/draw. The WRHA gives us zero funding to do that work." – Focus group participant
>
> "A barrier for us in our area has been staffing. When you're really, chronically, short staffed - and we were short staffed for a long year before they implemented the vacancy management." – Focus group participant
>
> "No staff allocation for community development." – 2017 survey respondent

Lack of resources is a barrier - "community resources are full – there's nowhere to send [families]." Many spoke about longstanding waits for Families First programming, as well as the lack of funding for PPM implementation (particularly community development). Many respondents said additional tasks and concepts have been taken on, without additional resources.

Focus group participants spoke about the need to fully resource the PPM model, supporting full scope of practice, as well as tools to support PHNs shifting focus of their work (e.g., adapted care map). In 2015 and 2017, more than half of survey respondents were uncertain or disagreed they have access to the tools, resources and support required to work to full scope of practice; 18% agreed in 2015, 32% in 2017 (Table 37). In addition, challenges accessing data collection and data not being current present further issues for PHNs

> "Don't take something away without giving us something in return. Give us other resources, give us a list of where these families can go, or websites where they can do prenatal classes online." – Focus group participant

seeking a good understanding of their neighbourhood areas.

Table 37 – Access to tools and support for full scope of practice

		Dec 2015 (n=48)	June 2017 (n=55)
I will have access to the tools, resources and support required to work to the full scope of my practice.	Strongly agree	-	-
	Agree	18.8%	32.1%
	Uncertain	64.6%	41.1%
	Disagree	-	17.9%
	Strongly disagree	-	-

Communicating with clients is hampered by "not having proper resources for our clients" and technology that doesn't adequately support information sharing. Respondents indicated the need for technologies that help share information (e.g., an ipad to show a health video), updated web-based information, and support maintaining contact with clients (e.g., updated, smart cell phones that maintain connection, with headset capability).

PHN Role

Participants noted a failure to recognize the value of PHN work and an inadequate understanding of the PHN role. For many, recognition is directly connected to the ability to measure and account for successes achieved – finding ways to adequately capture the work being done by PHNs.

Some PHNs noted a struggle to adapt practice to reflect the full breadth of the PPM model. Respondents described the increased emphasis on equity-based work as a "hard change for some people." PHNs seek to strengthen partnerships with other community-focused positions (such as a Community Facilitators), while avoiding duplication.

> "PHN role in PH is hard to understand. People don't get it. Really, the goal of PH is population health. Whereas the rest of health care is all individual. It's hard to make that shift. Even if you're a nurse." – Focus group participant
>
> "That's been a difficult role for lots of areas to figure out what that job is and how we work together." – Focus group participant

Team and Manager Support

Most survey respondents agreed they have the support of direct managers to work to full scope (see Table 36, page 42). Fewer respondents felt the same about receiving support from organizational leadership (i.e., Community Area Director, Clinical Nurse Specialists); almost 50% reported being uncertain that the organization's leaders will provide support (June 2017, Table 38).

Table 38 – Leaders' support to PHNs

		Dec 2015 (n=48)	June 2017 (n=55)
I believe the leaders in my organization (Director PPH, CNSs, Coordinators) will support me through this change	Strongly agree	-	-
	Agree	43.8%	27.3%
	Uncertain	39.6%	49.1%
	Disagree	-	12.7%
	Strongly disagree	-	-

Measurement

A number of respondents said that PHN recognition is directly connected to the ability to measure and account for the work and successes being achieved (e.g., how time-consuming outreach work can translate into connecting a family accessing a health resource). Some mentioned that it is challenging to understand impact of PHN work when many public health outcomes are so long term. Recently, efforts have been made to gather data on community level practice via the recently piloted community level tracking tool. While some respondents spoke about work being done to capture some areas of PHN practice measures (e.g., Families First screening assessments inputted to the HPECD database), many respondents pointed to a lack of measures and user-friendly tools that adequately capture and document the results of PHNs' day-to-day work; this makes it challenging for PHNs to

> "What we count is what people feel accountable to. If you don't count these kinds of things then there's no recognition that you're actually doing it." – Focus Group Participant

communicate successes and contributions.

Data that is no longer current, and difficulty accessing information from existing databases frustrates respondents. As one said, "everything that we do needs to be evidence-based, [but] it comes as bit of a road block when we don't have the data to show that…" Databases that require repetitive entry, and gaps in WRHA technologies present further challenges.

> "Stats were so far off because we have so many new [housing] developments in our area so the stats from 2011 and 2014…they were so far off because no one lived there and now they're huge areas."
> – Focus group participant
>
> "Our allocation was based on 2014. It's 2017, the team is stressed but we can't see how this year is different from three years ago."
> – Focus group participant
>
> "The other thing that's been added to our work load is the entering of data. The Healthy Parenting ECD database is slow, cumbersome, and repetitive."
> – Focus group participant

Management Practices

PHNs are critical of management decisions to move PHNs out of areas, and away from the communities they serve. For many, this challenges values of equity-based practice, and increases barriers facing clients (e.g., access to health resources, or transportation challenges).

> "Our move is based financially. Last year when we were moving, we were asked if we wanted to go..and we all said no – it was a team decision because we wanted to be in the community. And now we're not. Whether our CAD or manager really supports being in the community it doesn't really matter." – Focus group participant
>
> "When you read it they profess to communicate and addressing the Social Determinants of Health (SDoH) but not reflected in management and how they're working with us." – Focus group participant

All respondent groups spoke about the importance of PHN independence and autonomy in nursing practice. Some reported they find the management structure a challenge, as PHN's report to Team Managers and Community Area Directors who may not have "education or experience" to provide relevant PHN practice guidance. Others recognized the value of program supports to practice, indicating a desire for more support (e.g., the CNS role which provides leadership to practice).

Model Implementation

Some focus group participants said the allocation model supports PPM implementation, aligning resources with an equity focus. Others said the allocation of resources does not adequately meet neighbourhood need; creating additional challenges (e.g., not capturing families in an area's high need, or not placing PHNs in close proximity to target populations). Some respondents want CAs to be able to structure pods and allocate staff to respond to

> "..We really should be looking at the model and over laying it on our community...working as that group with the epidemiologists, with these program specialists to say "your area is the area we do need to target support for single moms." – Focus group participant
>
> "Allowing teams to work according to how they think it needs to happen." – Focus group participant

community needs as they experience them.

Organizational Structure and Leadership

A small number of PHNs identified the need for a clear vision of PHN practice, and consistent strategic direction. Developing a vision that embraces the PPM model, engaging input from PHNs and leadership – uniting those working to implement the PPM model.

Some PHNs called for leadership in the form of direction, resourcing PPM implementation, (e.g., ensuring programming is available for Families First clients, staffing vacant positions), supporting teams with experienced team managers, and providing information on community data trends.

Half of survey respondents agree (38% strongly agree, 15% agree) they know where to get answers to questions about PPM; approximately a third of survey respondents are uncertain (Table 39). Some focus group participants said they want more clarity, and dialogue with leadership; "People can only adapt to the extent to which they can describe the change. The description has not been super clear."

> "There has to be a really clear-cut plan on how these changes role out, where your resources are, who's going to use them, how are they going to be used. But it's been little bits of dribs and drabs…"
>
> "Consistent mission, vision and understanding of that vision. That has been one of the main challenges." – Focus group participant

Table 39 – Getting answers about PPM change initiative

		Dec 2015 (n=48)	*June 2017 (n=55)*
I know where to go to get answers to my questions related to this change initiative	Strongly agree	14.9%	14.5%
	Agree	29.8%	38.2%
	Uncertain	38.3%	36.4%
	Disagree	10.6%	10.9%
	Strongly disagree	-	-

IV: Opportunities for Improvement

Opportunities reflect the diversity of respondents' voices and ideas. Opportunities are not prioritized, or assessed for feasibility; some opportunities may not align.

While maintaining current supports to PPM implementation, respondents identified opportunities to strengthen the model. This includes: embracing a vision; strategically resourcing the shift in practice; enhancing learning and training (particularly in areas where PHNs identified gaps through the PPM survey); ongoing measurement and evaluation; enhancing PHN recognition management practices; and model implementation responsive

What we heard

Organizational structure and leadership

- Developing a vision that embraces the PPM model and engages PHNs and leadership.
- Engaging leadership and managers in discussions of what it means to work to full scope.

Responsive PPM implementation

- Implementing the PPM model in a way that responds to unique community areas.

Using resources strategically

- Ongoing PHN engagement and training with surveillance data; bringing forward current data when available.
- Drawing on existing centralized program expertise and supports such as Program Specialists, Initiative Leads, CNSs, Epidemiologists, as well as colleagues and partners working to address community needs.
- Dedicating resources within a community area team to lead on strategic approach areas (e.g., Healthy Public Policy, Healthy Built and Social Environment).
- Identifying and excluding tasks from home visits (e.g., vital signs, blood work).

Resourcing the shift in practice

- Staffing teams, CNS and managers at full level to support PPM implementation.
- Ensuring availability of technology to connect PHNs reliably with community members (e.g., smart cell phones, ipads to share information visually with clients).

to communities.

What we heard (cont.)

Enhancing learning and knowledge transfer

- Focusing training and professional development on areas where PHNs have identified less understanding and confidence, such as the role of the PHN in community development; public health research; healthy public policy; healthy built and social environment.
- Enhancing peer-based learning, including shadowing colleagues and community area exchanges.
- Ongoing orientation to the PPM model that focuses on foundational concepts (e.g., community development, health equity).
- Enhancing role clarity for those within the WRHA who contribute to successful PPM implementation, including engaging with other service providers to enhance understanding of the PHN role.

Enhancing recognition

- Enhancing two-way communication between staff and leadership, and staff and centralized program positions.
- Sharing knowledge among teams, within community areas and with leadership on practicing to full scope (e.g., providing examples of managing responsibilities).
- Ensuring staff and colleagues are recognized for their valued contributions, including Families First Home Visitors, Interpreters and PHNs.

Measuring what counts

- Enhancing current efforts to measure PHN work and population health outcomes.
- Updating reporting platforms to reduce input duplication.
- Engaging with the allocation model to ensure data is current and capturing PHN input to inform how community areas can best be served.
- Ensuring data available to PHNs is current.

Embracing a Vision

Developing a vision that embraces the PPM model, engaging input from PHNs and leadership, and uniting those working to implement the PPM model can provide direction across PPH, while helping to address PHN's uncertainties regarding managers' and leaders' support for full scope of practice.

Communicating what it means to practice to full scope (e.g., providing examples of managing responsibilities) can strengthen the shared understanding of PPM implementation, for PHNs, managers, and leadership.

Using Resources Strategically

To better meet the full scope of practice, focus group participants see opportunities to draw on existing program expertise and supports as well as colleagues and partners working to support communities; "build on the partners. CNS is one, that's [epidemiologist] another one." Others suggested dedicated resources that would allow PHNs to lead on some strategic approach areas, as well as centralizing resources; "we're a fairly small city and a lot of the policy work, the built environment work, I actually feel does belong better in centralized."

PHNs acknowledge that resources are limited; as one example, one survey respondent cautioned that delivering the FF screen and survey "introduces scope creep." Identifying what tasks can be excluded from home visits (e.g., taking vital signs for babies well within normal range), or done by other professionals may also allow PHNs to engage more fully across the scope of practice. Examples included applying more stringent screening at hospitals to reduce the number of home visits, visiting only those that meet criteria, and referring other mothers to local PHN run group or clinic (e.g., breastfeeding buddies).

> "Lab tech is less expensive than a PHN…[PHNs often take blood from babies at home visits. "travelling lab" but isn't a good use of their time.]"
> – Focus group participant

Resourcing the Shift in Practice

Noting numerous challenges balancing workload, focus groups noted that ensuring teams are at full staffing levels would support PPM implementation; this includes ensuring the technology and tools are available for PHNs to engage directly with community members, with limited barriers.

Respondents pointed to how some areas of the model have progressed as a result of dedicated resources (e.g., staff dedicated to health communication). Others noted that teams could similarly strengthen model implementation by dedicating some PHNs (fully or in part) to specific Strategic Approaches – while their colleagues focus on daily clinical public

> "People specifically dedicated to work on Healthy Public Policy, someone who worked on Healthy Built and Social Environment. Because they specifically work on that, they were really able to take things further and including PHN[s] in that…That's really been a support."
> – Focus group participant

health practice and "pick up the slack."

Enhancing Learning and Knowledge Transfer

Respondents value opportunities to learn from peers, and spoke about shadowing colleagues, and doing exchanges with other CAs. Ongoing orientation to the PPM is a further opportunity to deepen understanding of concepts foundational to PHN practice; for example, a third of PHNs are uncertain they agree they are well-positioned to work upstream, and others identified a need to better understand how to undertake community development.

> "As I'm listening to everybody speak, I get this feeling that this is what's been missing for incorporating this into our work – it's a chance to sit around and talk to other nurses." – Focus group participant

Enhancing role clarity of those within the WRHA expected to contribute to the PPM, including how to successfully engage partners, could be included in the PPM orientation.

In the 2015 and 2017 surveys, PHNs identified elements of the PPM where they have a lower understanding and confidence to apply skills or concepts. Training may target these areas – such as HBSE, applied public health research, and Indigenous health promotion.

Measuring What Counts

A number of respondents said that PHN recognition is directly connected to the ability to measure and account for the work and successes being achieved (e.g., how time-consuming outreach work can translate into connecting a family accessing a health resource). Recently, efforts have been made to gather information on PHN community-level practice, such as the community-level tracking tool recently piloted.

> "What we count is what people feel accountable to. If you don't count these kinds of things then there's no recognition that you're actually doing it." – Focus Group Participant

> "Aside from Families First, we're doing a great job but we're not capturing the successes that we're having in the community. There's no database that's allowing us to catch an idea of how many times outreach efforts are required in order to actually get a family who has had a mother with her baby apprehended and actually get her to a point where she has her kids returned." – Focus group participant

Enhancing efforts to measure of the work of PHNs and related outcomes, while finding ways to value PHN engagement with the various strategic approaches is an opportunity. This would create a better understanding of the time required for outreach efforts, and coalition work, and contribute to a better understanding of the PHN role.

Responsive PPM Implementation

Implementing the PPM to ensure it is responsive to unique community areas includes; engaging with the allocation model, ensuring the timeliness of data, incorporating PHN knowledge and reviewing how community areas can best be served by the PPM.

> "I agree that we all have different community areas with different needs. We need to have the ability to make it work for our respective community areas."
> – Focus group participant

All focus groups spoke about the importance of PHN independence and autonomy in nursing practice. Others noted that management decisions at times disregard PHN input; others called for improved dialogue and understanding between program and operations, and clear understanding of roles. For some, the management structure is a challenge, as PHN's report to Team Managers and Community Area Directors who may not have "education or experience" to provide relevant PHN practice guidance.

Enhancing Recognition

Focus groups noted current examples of intra-team recognition, including weekly acknowledgements of staff efforts. Building on best practices shared at Nursing Practice Council and in the quarterly PHN newsletter, other modes of recognition included: more system-wide strategies within teams and across the WRHA, and scheduling staff recognition events so they into account "what might work best" for the day-to-day PHN schedule (e.g., less busy time of year).

Awareness of the PHN role can be strengthened through partnerships with the general public, and professional union.

> "So I'm just thinking that we're lacking with relationships and partnerships with public in general. And the awareness of what we do."
> – Focus group participant

> "Some of the gaps that we're missing is the relationship with our union as well. You see every commercial on T.V., it's just clinical, hospital, stethoscope. Our union completely [doesn't] involve PH nursing in any commercial. Maybe the hand washing one." – Focus group participant

Some respondents identified the need for the WRHA to provide or identify alternate resources when programming is cancelled (e.g., provide information upon cancellation of lactation consultants). Others wish to see support systems – such as centralized program resources – further developed, and described challenges accessing the timely support of

program and practice supports (e.g., Program Specialists, Initiative Leads, Clinical Nurse Specialists). A number of PHNs recognize the expertise of Clinical Nurse Specialists, and look for more engagement with CNS expertise across different areas – surveillance, measurement and evaluation, and clinical knowledge.

Appendix A – Program Evaluation Framework

Evaluation Questions	Indicators	Data Sources	Method
How are PHNs practicing in accordance with the PPM?	• Examples of PPM implementation • Descriptions of positive / negative implementation	PHN4s CNS Team Managers Key Performance Indicator Data	Focus Groups Surveys Data review
What are the facilitators to implementation?	• Descriptions of facilitators		
What are the barriers to implementation?	• Description of barriers		
What supports do PHNs and Team Managers need?	• Description of supports		

Appendix B – PHN Allocation Methods

Fall 2015	Spring 2016
Actuarial Method	The Needs Based Method (TNBM)
PHNs allocated ACROSS CAs based on consideration of 18 workload factors	PHNs allocated WITHIN CAs to neighbourhood based on assessment of population health need

Appendix C– Personal Readiness Questions

Table 40 - Survey respondents' personal readiness responses tend toward agreement – indicating support for working to full scope of the PHN role. Challenges to personal readiness include balancing demands at work, and a sense of control over what to stop in order to practice to full scope

	Dec-15			Jun-17		
	Strongly/ Disagree	Uncertain	Strongly/ Agree	Strongly /Disagree	Uncertain	Strongly/ Agree
I am excited about basing my practice on the Professional Practice Model (ie. working to the full scope of the PHN role)	-	25	68.7	-	30.4	67.9
I look forward to a new way of doing my work	-	22.9	68.8	-	28.6	71.4
I feel that I have a good understanding of what I should stop doing in my practice in order to have the time to work to the full scope of my practice	43.8	29.2	43.8	11.1	14.8	72.3
I feel that I have control over what I can stop doing in order to be able to work to the full scope of my practice	41.7	29.2	12.5	33.9	21.4	33.9
I believe that I will allow myself to stop doing some of the things I am currently doing in my practice in order to work to the full scope of my practice	12.5	33.3	54.2	-	25.0	67.9
I believe it is possible for PHNs in the WRHA to work to the full scope of their practice	-	22.9	72.9	19.7	28.6	51.8
I know where to go to get answers to my questions related to this change initiative	10.6	38.3	44.7	10.9	36.4	52.7

Appendix D – Focus Group Report

Professional Practice Model Evaluation Focus Group Findings Report

Appendix E – PHN Survey Data Tables

PHN Survey Data Tables

Appendix F – Key Performance Indicators Report

Key Performance Indicators Report