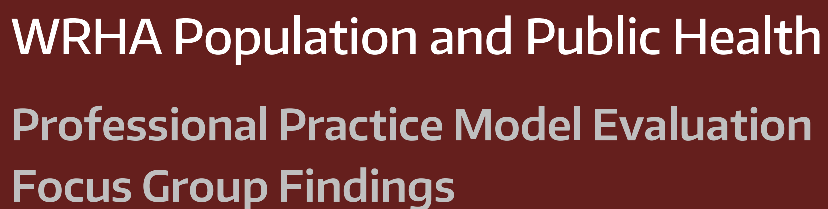


WRHA Population and Public Health

Professional Practice Model Evaluation
Focus Group Findings

Final Report

(November 2017)

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

Revised April 19th, 2018

HEALTH in COMMON

200–141 Bannatyne Avenue
Winnipeg, MB
204.946.1888 / 1.800.731.1792

Table of Contents

Executive Summary 4
Findings 5
Introduction 9
Scope and purpose 9
Methodology 10
1. PPM in Action 13
Delivery Structure and Process 14
Management Practices 22
Recognition and Rewards 23
Professional Relationships / Partnerships 24
Values and Principles 24
2. Supports 26
3. Barriers 31
4. Opportunities 37
Appendix A – PPM Focus Group Evaluation Framework 41
Appendix B – Code Application 42
Appendix C – PPM Elements: Code Counts, Weighting 44

Executive Summary

Developed by the WRHA Population and Public Health Program (PPH Program) in 2014, the *Professional Practice Model (PPM) to Promote Population Health and Equity* was developed to support Public Health Nursing (PHN) practice, in alignment with the national Standards and Competencies.

Efforts to evaluate implementation of the PPM began with the first PHN survey in 2015. This survey was intended to assess readiness to practice according to the PPM. In 2017, the PPH Program undertook a multi-phased evaluation to assess PPM implementation, to: describe how Public Health Nurses (PHNs) are practicing in accordance with the PPM; identify, assess, and describe PPM key performance indicators, examine facilitators and barriers related to the PPM; define learning opportunities and next steps; and establish knowledge mobilization processes for evaluation findings.

As part of the evaluation, six focus groups (n=36) were conducted between September 11 – October 2, 2017. Discussions with PHNs, Clinical Nurse Specialists (CNS) and Managers from the region's 12 Community Areas focused on the five elements of the PPM framework: Delivery Structure and Processes; Management Practices; Recognition and Rewards; Professional Relationships and Partnerships; and Values and Principles. PHN functions are outlined in 10 Strategic Approaches embedded in Delivery Structure and Process.

Findings align with questions identified by the WRHA PPM Evaluation Committee:

	Question	Findings
1	How are PHNs practicing in accordance with the PPM?	PPM in Action
2	What are the facilitators to implementation?	Supports
3	What are the barriers to implementation?	Barriers
4	What supports do PHNs and Team Managers need?	Opportunities

Findings

1. PPM in Action	
Delivery Structure & Process	- While all ten of the Strategic Approaches are at work in PHN practice, some are applied more often – and others very rarely. Most examples provided related to collaboration and partnership, healthy public policy, and public health clinical practice. - Although a key area of discussion, respondents often pointed to gaps in Community Development implementation, as well as a lack of shared understanding of the concept, and lack of specific supports such as funds for food to incentivize gatherings.
Management Practices	- PHNs commented that some management practices challenge values and guiding principles espoused in the model (e.g., relocating teams away from target client populations, vacancy management that PHNs feel hinders clients' access). - Respondents seek ongoing, two-way communication between staff and leadership, staff and centralized program staff; "collaborative", "unified" leadership; a clear vision and strategic direction.
Recognition and Rewards	- Many respondents feel there is a failure to recognize the value of PHN work, as well as adequately understand the 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. - Respondents identified the contributions of colleagues such as Home Visitors and Interpreters to public health practice, and call for greater recognition of "unbelievably valuable" frontline colleagues.
Professional Relationships / Partnerships	- While most discussion focused on the similar area of Collaboration and Partnership (one of the 10 Strategic Approaches), respondents also spoke about the wide variety of PPH program supports available to PHNs. - Respondents want to work more closely with areas of specialty to strengthen PHN practice (e.g., epidemiology, CNS). - Many successes working alongside other service providers relate to PHNs playing a "facilitator" or coordination role.

Values and Principles	- Many respondents reported tensions between daily demands of referral-driven care and practicing the PPM to its full scope of practice – and described a gap between the values described in the PPM and management decisions and practices. - Shifting PHN work culture means moving away from a narrow clinical focus. - For many, the strategic approaches articulate a public health nursing practice that is long-standing, familiar, and has roots both nationally and internationally. - PHN practice is reflective of PPM guiding principles such as Health Equity and Accessibility.
2. Supports	
Location	- Co-location or proximity to service providers supports collaboration and building coalitions. - Proximity to target population ensures barriers to health services are reduced, and increases PHNs ability to engage with clients in their own setting.
Team and Manager Support	- Cohesive and supportive colleagues ensure PHNs can dedicate time and energy to various strategic approaches. - PHNs value nursing leadership to practice, working to support best use available resources, supporting PHN knowledge and skill development.
Education and training	- For some, initial orientation to the PPM improved their knowledge and awareness of the framework; others found it "too clinical." - Participation on coalitions and Nursing Practice Council enhance understanding of PHN practice and opportunities to hear and learn from others.
Collaboration and Relationships	- Relationship development with community members supports increased familiarity with PHNs and available resources. - Relationships with service providers ensure PHNs have broader reach to target audiences; PHNs partner with others to fulfil a broader scope of practice. - Colleagues provide invaluable program services (e.g., Home Visitors, interpreters). - Availability of program resources (e.g., Healthy Baby material, Injury Prevention) helps to share information with clients.

Data and measurement	- Community data supports PHN practice – providing neighbourhood information on population demographics and need. - Additional supports include committees (Healthy Public Policy, Healthy Built and Social Environment) that include PHNs and Families First (FF) program, standards documents from the PHN Practice Council working groups (and PHN practice standards and clinical practice guidelines), and outreach guidelines.
3. Barriers	
Resources	- Vacancy management was identified as negatively impacting PHNs' ability to practice to full scope, as PHNs manage daily referrals and balance workload. - Building on existing professional relationships and partnerships, greater engagement with Clinical Nurse Specialists and centralized Population and Public Health Program staff is desired.
PHN role	- The shift in practice is a challenge for some PHNs; deeper understanding of the PPM model, and clarity of PHN role internally and among partners is needed.
Data and measurement	- There is a lack of measures and tools to adequately capture daily PHN work and document results, creating challenges to communicate PHN successes and contributions. - Some data platforms are not user-friendly (e.g., repetitive data entry, error messages in HPECD) – and NETs data is not current.
Model implementation	- For some respondents, the allocation formula does not adequately reflect neighbourhood need – creating additional challenges for those of greatest vulnerability.
Communication	- Information technology used by PHNs is inadequate, and creates barriers to communicate and maintain contact with clients (e.g., phones that drop client calls). - PHNs lack web-based, electronic and print resources to share with clients, hampering outreach, and health communication.
Structure and Leadership	- Respondents look for unified, collaborative leadership, with dialogue between positions and program areas. - Clarity on the desired change (e.g., strategic indicators, goals), and clear vision. - A few identified a conflict inherent in a population health model based on individual health measures (Families First Screening data).

4. Opportunities	
Using resources strategically	- Draw on existing expertise (e.g., centralized program staff), as well as colleagues and partners working to address community needs. - Dedicating resources to lead on areas of strategic approach (e.g., Healthy Public Policy, Healthy Built and Social Environment). - Identifying and excluding tasks from home visits (e.g., vital signs, blood work).
Supporting 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. - Ensuring Families First Home Visitors and Interpreters are recognized for their valued services
Enhancing learning and knowledge transfer	- Enhancing peer-based learning, including shadowing colleagues, and Community Area (CA) exchanges. - Ongoing orientation to the PPM model, focusing on foundational concepts (e.g., community development, health equity). - Enhancing role clarity of those within the WRHA who contribute to PPM implementation – as well as how to engage with colleagues and partners.
Measuring what counts	- Enhancing current efforts to identify and capture indicators related to PHN practice and outcomes. - Updating data platforms to reduce duplication of input (e.g., HPECD, Panorama, Breast Feeding Initiative surveillance) and also expending PHN time on making data corrections.
Responsive PPM implementation	- Engaging with the allocation model, enhancing timeliness of data, and capturing PHN input to inform how community areas can best be served. - Implementing the PPM model in a manner responsive to unique community areas.

Introduction

In 2014, the WRHA Population and Public Health Program developed the Professional Practice Model (PPM) to Promote Population Health and Equity to support Public Health Nursing practice and alignment with the provincial and national standards and competencies. The PPM was informed by the public health and nursing literature, WRHA PPH Nursing Practice Council, PHNs working in PPH community area and centralized service teams. The model was formally implemented in June of 2016.

The PPM, grounded in eight guiding principles, consists of five components (see Figure 1, page 11). A key component, Delivery Structure and Process, outlines 10 Strategic Approaches intended to inform PHN functions.

A multi-stage evaluation, led by Population and Public Health, 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; and
- establish knowledge mobilization processes for evaluation findings

This report reflects the focus groups facilitated with staff and managers by an external evaluator, as part of phase one of the evaluation.

Scope and purpose

Six focus groups were conducted with PHNs, Clinical Nurse Specialists (CNS) and Team Managers to:

- Identify to what extent PHN practice is consistent with the PPM and PHN practice standards
- Identify facilitators and barriers to implementation
- Identify learning opportunities and next steps
- Identify supports needed by PHNs and Team Managers

Methodology

Six focus groups with Public Health Nurses, Clinical Nurse Specialists and Team Managers were conducted as part of the ongoing multi-phased 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. 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. Each focus group included participants with a range of experience and EFTs and represented different CAs. Facilitated focus groups were supported by a discussion guide, audio recorded and transcribed for analysis.

Data collection

Focus group participants' (n=36) consent was obtained verbally or via print consent forms. All community areas were represented (Table 1). Focus groups were recorded and transcribed verbatim; identifying information (e.g., public health office, community area name, PHN name, or other geographic locating information) was redacted from transcripts.

Table 1 - PHN participation by paired Community Area

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

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

Data analysis

Data was themed using Dedoose, software for mixed-methods research. Initial codes were identified by evaluation team members. Codes were further revised; two evaluators themed the data, with coding compared to ensure inter-rater reliability.

Primary codes aligned with the PPM elements and evaluation questions (PPM in action, 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 (see Appendices B, C, D, E).

Sentient weighting (-1, negative; 0, neutral; 1, positive) was 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

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

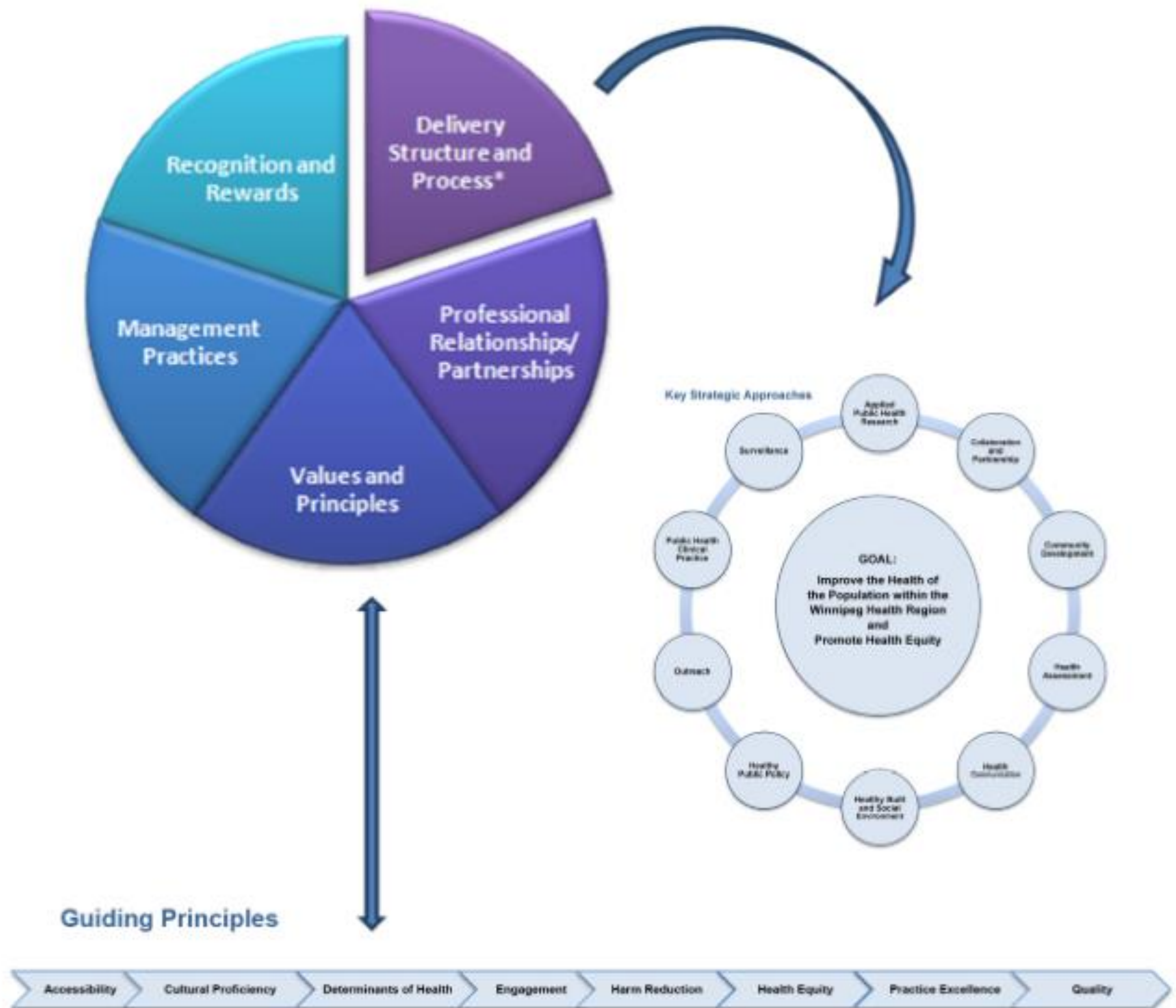
Focus group participation was voluntary and may represent those most motivated and interested in the PPM; resulting in a self-selection bias.

Findings reflect a diversity of voices yet are not inclusive of all stakeholder input. While efforts were made in ensure PHN representation from all community areas, some areas had greater representation than others (Table 1).

Figure 1 - PPM Model

WRHA PHN Professional Practice Model Summary

WRHA PHN Professional Practice Model to Promote Population Health and Equity



What We Heard

1. PPM in Action

Highlights:

- While all ten of the Strategic Approaches are at work in PHN practice, some are applied more often – and others very rarely. Most examples provided related to collaboration and partnership, healthy public policy, and public health clinical practice.
- Although a key area of discussion, respondents often pointed to gaps in community development implementation, as well as a lack of shared understanding of the concept, and lack of specific supports (e.g., funds for food to incentivize gatherings).
- PHNs commented that some management practices appeared to challenge values and guiding principles espoused in the model (e.g., relocating teams away from target client populations, vacancy management that PHNs felt hinders client access).
- Respondents seek ongoing, two-way communication between staff and leadership, staffing and program resources, unified leadership, and a clear vision and strategic direction.
- Many respondents feel there is a failure to recognize the value of PHN work, as well as adequately understand the 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.
- Respondents identified the contributions of colleagues such as Home Visitors and Interpreters to public health practice, and call for greater recognition of "unbelievably valuable" frontline colleagues.
- While most discussion focused on the similar area of Collaboration and Partnership (one of the 10 Strategic Approaches), respondents also spoke about the wide variety of program resources available to PHNs.
- Respondents want to work more closely with areas of specialty to strengthen PHN practice (e.g., epidemiology, CNS).
- Many successes working alongside other service providers relate to PHNs playing a "facilitator" or coordination role.
- Many respondents reported tensions between daily demands of referral-driven care and practicing the PPM to its full scope of practice – and described a gap between the values described in the PPM and management decisions and practices.

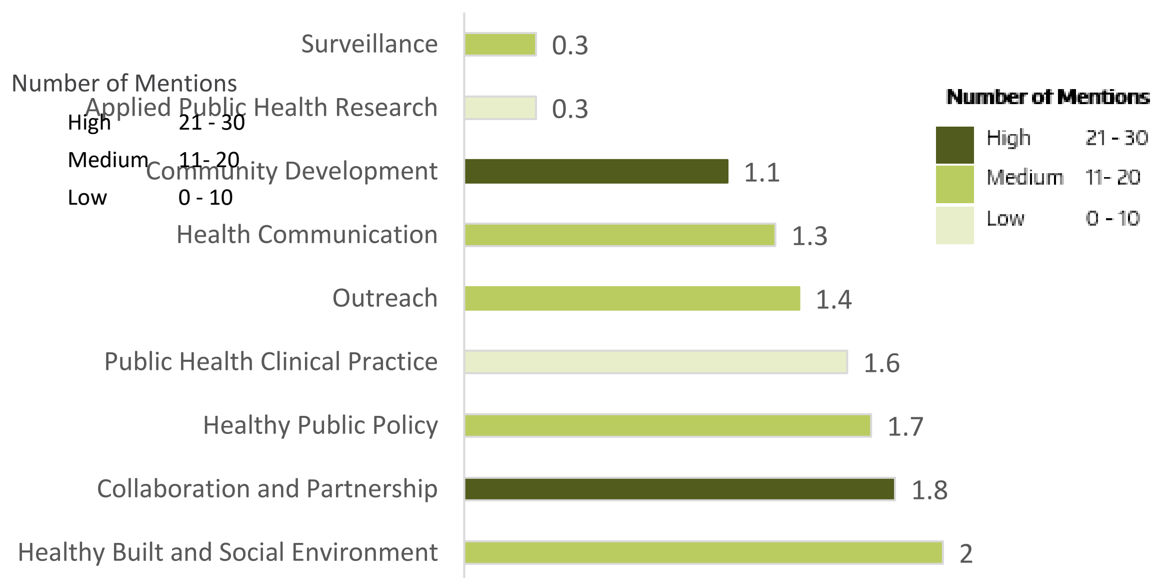
Highlights, (cont):

- Shifting PHN work culture means moving away from a narrow clinical focus. Some commented they perceived colleagues are challenged to embrace values of health equity and social justice.
- For many, the strategic approaches articulate a public health nursing practice that is long-standing, familiar, and has roots both nationally and internationally.
- PHN practice is reflective of PPM guiding principles such as Health Equity and Accessibility.

Delivery Structure and Process

Respondents mentioned all 10 Strategic Approaches (SA) when discussing Delivery Structure and Process (see Appendix B – Code Application), speaking most about collaboration and partnership, healthy public policy, and public health clinical practice.[1] Respondents spoke more positively about public health clinical practice, healthy public policy, collaboration and partnership, and healthy built and social environment (average weighting > 1.5). Collaboration and partnership had the highest number of mentions (21 – 30).

Figure 2 – When asked for examples of strategic approaches "at work", focus group participants talked most about 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)



[1] Weighting was applied based on degree of positivity. Adjusted scores (0 = negative, 1 = neutral, 2 = positive) were averaged to quantify how respondents felt about the topic.

Collaboration & Partnerships

Respondents spoke positively about collaboration that supports and streamlines program and service delivery, including sharing resources with other service providers, maintaining open lines of communication, and participation on various local committees.[2]

> "My Involvement on the Parent Child Coalition. Been on that for about [redacted] years. 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."

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, engage hard to reach audiences; providing opportunities to apply a preventative, "upstream" health approach. For instance, working with schools connects PHNs to children and families. Respondents noted that a lack of services in a geographic area negatively impacts the ability to work with other service providers, and connect clients with needed services. Collaboration and partnerships allows PHNs to engage in a range of public health-related areas without necessarily leading initiatives.

> "...this past summer we had to move locations and we were able to partner with [a local resource centre]...the turnout has been amazing. We're getting the right population – we're getting seven or more people consistently. It feels so valuable to be there and the partnership with [the centre]..."

Outreach

Respondents described daily relationship-building with community members who are "more hidden than out front;" engaging target audiences by changing the program location; offering services with translation support; and targeted home visits for those identified as needing support (i.e. +3) on Families First Screen. The support of interpreters increases access to some target audiences.

---

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

> "We work collaboratively with them. At the food centre we have a youth mental health group. So, we could now all work together because we're all dealing with the teens, do[ing] different events. And not necessarily doing all of the work but collaborating with them to support health promotion and prevention."
>
> "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."
>
> "A nurse in our office is frequenting this place at lunch and found a pregnant immigrant woman there and started talking to her and gave her some information. Got connected with her....a lot of our prenatal moms, we can't necessarily connect with if they're working. She hadn't been referred to us but it was just sort of a case finding/outreach."
>
> "I really love the in-home interpreters. Love that as part of our outreach...we need a lot of females because women prefer females to talk about their bodies, of course. Sometimes it's hard, we wait two weeks to get an interpreter. But...I haven't met one that isn't extremely professional...We couldn't do our work without them."

Relationships that are built daily help to increase awareness and uptake of PHN resources, particularly for populations that face challenges, such as travelling to health providers. One manager said PHNs "struggle" to understand outreach – and defined it as relationship-building. One respondent said that targeted outreach can be more effective if conducted when families are better able to absorb information – such as early school age of children.

> "Developed really good relationships with the people in that community. I was the only nurse that really visited in that community. I joined the ...Board and then they had a steering committee for that area so I was a rep on that for health needs."
>
> "Outreach to me should be in brackets as really relationship building...Offering your presence and an ability to dialogue to know what that agency does or how they see themselves in the community so that, as time goes on, you build that relationship [and] when opportunity presents for you to partner with them for something you have that relationship established."

Public Health Clinical Practice

A core area of practice for PHNs, clinical practice is clearly understood, “straightforward,” and “easy to operationalize.” Respondents often spoke positively about this strategic approach, while also noting the unpredictable demands of daily practice - including referrals and home visits - and the challenge of balancing these demands with the broadened scope of the PPM.

> “I think clinical practice is the ‘easiest’ part of our job to understand because we have such clear guidelines that we follow.”
>
> “On a day to day, public health clinical practice and Health Assessment, that’s our regular day to day practice; with post-partum visits, getting to know families, building good relationships.”
>
> “There are certainly elements of practice where outreach is happening, community networking and working with agencies in our area…[but] a lot of my time is spent dealing with the work that comes in on a day to day basis.”
>
> “Actually, it says targeted home visiting, it says vulnerable populations but we are, by program standards, having to meet with everyone. Everyone who would like us to. So I’m not really sure how that’s feasible to complete anything other than outreach [from among the Strategic Approaches].”

Healthy Public Policy (HPP)

On a daily basis, PHNs encounter clients facing inequities created or reinforced by public policy practices, including barriers to accessing resources intended to support healthy communities. PHNs play an advocacy role, 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.” Collaboration with partners supports PHN’s participation in the development and implementation of healthy public policy. Some acknowledged that HPP is hard to “operationalize.”

> "In our day to day practice, if we come across something that we see that seems to be discriminating against people, then we can take that to our policy committee that we have in Public Health. It's a new committee that they've struck."
>
> "Yeah. Looking at policies that continue to create gaps for the population that they're serving. They have a strong advocacy role and what can they do shift policy or change policy to be able to make health changes and change population health."
>
> "Primary care relationships – built a streamline process for applying for them to get them into the clinic. From there it's opened up more of a collaboration with primary care."
>
> "But, as a whole I really struggle because, as PHN we have key insights to our clients and community areas and yet we don't really get a place to feed in our thoughts on what could make good HPP.
> I feel like there's a big disjoint."

Health Communication

In addition to a dedicated PHN role, health communication is supported by leveraging stakeholder connections with community members and resources developed by organizations (e.g., Healthy Baby / Healthy Child Manitoba). PHNs work with stakeholders to identify and address health needs, including how to best communicate the information.

> "Never making assumptions. That communication takes a lot of time. With bigger players like the schools, you figure out how best to communicate; who's their key contact person? Is emailing ok? The school population – maybe put an article in the newsletter or in the neighbourhood for flu. Trying to figure out how best to communicate with the population."

Respondents noted a lack of broad public health messaging.

> "I think we do a lot of communication individually or at a bigger level with schools or groups but I think often public health falls silent… more of mass communications. I reflect on Healthy Sexuality and Harm Reduction has done award winning campaigns in regards to STI reductions… why can't PH get similar funding to do a breast feeding campaign or something to support that? I feel like for sending out mass messaging for the public, we fall short. We don't do that except for maybe around flu."

Healthy Built and Social Environment

A "newer" strategic approach for some PHNs, working alongside community-led built environment initiatives, such as community gardens and street infrastructure (e.g., pedestrian crosswalk) were mentioned. Other respondents spoke about adapting approaches and programming to social environments and networks. As one respondent described, "we run a lot of groups…. And they all have a bit of a different flavor."

> "I personally see the initiatives going that PHNs participate as a part of a broader team to address issues. We have a couple new groups that are trying to formulate a wellness centre in their catchment. As an example we had an evening BBQ that ties in bicycle safety, helmets, teachings of that nature… very innovative."
>
> "What I do for one group over here, I tweak/adjust for another group. Not cookie cutter. I have to go with the group and where I know they're coming from and be prepared to listen to needs."

Surveillance

Unsure how information will be used (e.g., for research, to demonstrate outcomes, for monitoring), PHNs are at times unclear about the purpose of collecting surveillance data.

> "It's helpful, surveillance wise, when we hear the data coming back. If we're dealing with moms in all different communities, it's really great when we get the surveillance back to say this is what's happening and let's keep going with it. That kind of data is always really good. It would be good if we could get it fed back."

A number of respondents described NETS (Neighbourhood Explorer Tool Set) as a useful tool, supporting community assessments. Others said using NETS is time-consuming, and inaccurate.

> "I know you talked about NETS and I found it really helpful. I have a fairly new school, it opened in January. The communications is very good there [NETS]. [Name] from NETS is really helpful. She is our neighbourhood tool and is inputting data and keeping us up to date with that. Getting the data from the database into the NETS. Nice to have that tool."
>
> "I don't use it because it's not accurate. Not up to date. If you're in [community area], we have a lot of clients on assistance, really struggling there. But because they're so close to a flourishing area, it doesn't show up on the map. So, the map I find useless in that sense."

Community Development

Some respondents noted Community Development is a "shift" in practice; others said that it was a long-standing element of PHN practice. For many, community development is rooted in relationship building with communities and service providers; allowing communities to lead on local issues that are important to them, and focusing beyond individual needs.

> "I've had the privilege since I've been at the school more than five years now of connecting with the parents on a monthly basis. Initially the outreach worker said to me, 'well, you can do anything you want.' But it's really not about what I want, it's what they want to talk about [or] hear."
>
> "We also find it very beneficial to invite the key community organizations in our area to our patient meetings to just present about what they do. That some organizations that we know provide services to the same population group mothers, children, that we also target. But we don't really know details about what they do so we talk about how we can collaborate if we need to. That's been very helpful to make those connections."

Respondents report varied levels of understanding and implementation of community development. Teams experience tensions as colleagues dedicate time to work outside of clinical practice (e.g., referrals) – unsure of how to balance these demands as a team. Some spoke of struggling to spend ¾ of a day per week on community development as estimated by program in PPM implementation discussions.

> "Community development keeps making the agenda and getting bumped off. Either you're a lone wolf doing your own thing…but then don't have time to work as a team."
>
> "Some of the same things though; tension of being referral-driven and understanding the essence of PH practice is based on relationships in the community."
>
> "Community development can take a long time. It's about building relationships, getting to know your community and what their needs are. I tell people, community development can look like I'm sitting at my desk on the phone or emailing with people. But what does that look like to somebody walking by? Probably like I'm just sitting there doing nothing. Community development can look that way cause you're working, understanding your community and making connection. Can take months or it could take years to develop something in your community."
>
> "…there are program standards, not just for post-partum but for community development. It is that we're supposed to be spending ¾ of a day every week - at least, not just – in community development, more specifically targeted at youth (ages 6-17 y.o.). I don't feel like we do that at all in my area. Our involvement in schools is minimal and now that we are moving out of the elementary schools I don't really know how we're going to be there or what our place is there."

Applied Public Health Research

Respondents spoke little about applied public health research. Some respondents noted that Families First screening information is used in "all kinds of research in Manitoba."

Management Practices

Following discussion of Delivery Structure and Process, respondents addressed the remaining four elements of the PPM model; speaking most about Management Practices informing PPM implementation (See Appendix C – PPM Elements).

PHNs are critical of management decisions 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."
>
> "When you read it they profess to communicate and addressing the Structural Determinants of Health (SDoH) but not reflected in management

All respondent 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, working within the matrix management structure is challenging (e.g., how to navigate information sharing, and receiving direction from both areas of leadership — program and community area).

> "I think that CA managers should recognize the strength of our autonomy. We've done exactly what we need to, like you say. And when that happens, as long as we have enough reason to back it…"
>
> "Health care is hierarchical. You have a program who sets the program and then it's up to us to make it happen. When we go back to program to say, 'hey, this is what's good, this is what's not so good, this isn't really working.' [program says], 'There's nothing we can do about that, this is what we want you to do. Go back and do it.' Okay…but it's not working. So what happens is people stop talking to program about things that aren't working. People go underground and do the best that they can."

Respondents 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).

> "How do we really change practice if our documentation is still chaining a lot of nurses into doing physical assessments rather than family social assessments? A year ago to now, that [Care Map] has not changed."
>
> "There needs to be political will for some significant changes in staffing health services; from implementation of midwifery to changes in the roles and responsibilities of CADs and managers, to the dedication of resources to complete the implementation process for the PPM."

Recognition and Rewards

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 collect data on PHN community-level work. The community-level tracking tool piloted recently was specifically mentioned by participants as positive.

> "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."

Respondents noted some 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), respondents' ideas for 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).

> "I think that's a component that we're not the strongest in, in terms of recognizing and rewarding our own practice. Maybe we just need some strategies on how we can do that as a team level and how we can do that at a regional level…We talk in our team, everybody has to talk about a success story. Maybe that's it but I would like to see more strategies to support other people."

Respondents identified the contributions of Families First Home Visitors to public health practice, and indicated the need for greater recognition of "unbelievably valuable" frontline workers – whether through increased pay or recognizing the services Families First Home Visitors provide.

Professional Relationships / Partnerships

Respondents identified a wide variety of program resources available to PHNs, and expressed a desire to work more closely with WRHA program staff to strengthen PHN practice (e.g., epidemiologists, health equity, falls prevention). Many respondents indicating the need to strengthen connections between each Community Area and centralized program resources – and better understand how to use specialized program knowledge of colleagues.

Respondents described more "people wanting to be part of [community development]" than in earlier years, and stressed the importance of negotiating the PHN's role within in this area of work. Many spoke of successes working in partnership where PHNs played a "facilitator" or coordination role. One identified a challenge where a Community Facilitator's area of focus did not overlap with PHN work.

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."
>
> "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."

Values and Principles

Some respondents noted that PHN practice is reflective of PPM guiding principles such as Health Equity and Accessibility.[3]

> "I'm seeing a shift in our practice that we're trying to get more resources to families that have more barriers. We are offering less support to families who are well off financially and have other resources."

Respondents noted challenges shifting the culture of PHN work from a narrow clinical focus. A few observed that some colleagues are challenged to acknowledge and incorporate values of health equity and social justice.

[3] Eight principles underlie the PPM model; accessibility, cultural proficiency, determinants of health, engagement, harm reduction, health equity, practice excellence, and quality.

Some respondents feel a disconnect between the PPM values and principles and management messages and practices. Many reported the tension between the daily demands of referral-driven care and practicing the PPM to its full scope of practice.

> "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."
>
> "That was a surprise for me that people don't have those fundamental beliefs that you should have in PH like equity and social justice."
>
> "Values and principles are wonderful but I don't think our standard for offering care to families matches those values and principles. Our leader said, "I want every family assessed."
>
> "When you read it they profess to communicate and addressing the SDoH but not reflected in management and how they're working with us."

2. Supports

Highlights:

- Co-location or proximity to service providers supports collaboration and building coalitions.
- Proximity to target population ensures barriers to health services are reduced, and increases PHNs ability to engage with clients in their own setting.
- Cohesive and supportive colleagues ensure PHNs can dedicate time and energy to various strategic approaches.
- PHNs value nursing leadership to practice, and working to optimize available resources, supporting PHN knowledge and skill development.
- For some, initial PPM orientation and training facilitated knowledge and awareness of PPM; others found it "too clinical."
- Participation on coalitions and Nursing Practice Council enhance understanding of PHN practice and opportunities to hear and learn from others.
- Relationship development with community members supports increased familiarity with PHNs and available resources.
- Relationships with service providers ensure PHNs have broader reach to target audiences; PHNs can partner with others to fulfil a broader scope of practice.
- Colleagues provide invaluable services (e.g., Home Visitors, interpreters).
- Availability of program resources (e.g., Healthy Baby material, Injury Prevention) helps to share information with clients.
- Community data supports PHN practice – providing neighbourhood information on population demographics and need.
- Additional supports include committees (HPP, HBE) that include PHNs and Families First (FF) program, standards documents from the PHN Practice Council working groups (and PHN practice standards and clinical practice guidelines), and outreach guidelines.

In addition to the PPM's alignment with national standards, PPM implementation is facilitated by the proximity of PHNs to clients and partners (location), cohesive and supportive teams and managers, collaborative relationships with providers and centralized programs, and data and measurement that allows PHNs to conduct surveillance and assess community need.

Location

Proximity to partners was identified by PHNs as a support to their 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."

Several commented that the decision to move PHNs from a location easily accessed by community residents was detrimental to community-based work, and can erode the "established footing" of nurses in a community; as one PHN said, "community development and partnerships have been completely destroyed by moving them out of that building." For instance, Families First clients may be away from needed services. Co-location or proximity does not ensure a high level of collaboration among service providers. Respondents identified that relationship building is critical.

Team and Manager Support

Team members who support colleagues engaging with strategic approaches facilitates PPM implementation. Respondents described picking up colleagues' referral work, operating "fluid as a team," and the importance of this support to team cohesiveness.

> "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."
>
> "Facilitators of our practice are our team members."
>
> "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."

Respondents noted that teams could strengthen model implementation by dedicating some PHNs (fully or in part) to some Strategic Approaches – while their colleagues focus on daily clinical public health practice.

> "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."
>
> "We need to work more a as a system to recognize that when one nurse does this in a team, it supports ALL of us. So maybe more of her work is in the applied PH research realm or in the HPP realm, so the rest of us can pick up the slack."

Respondents value managers that are knowledgeable about PH nursing and offer strong leadership and encouragement. Managers' abilities to communicate the PPM model, balance the competing interests of daily referrals and broader scope of practice, and support PHN autonomy were also identified as supports. Some mentioned that it is important for PHNs and Managers to engage directly with leaders to inform decisions (e.g., management meetings, NPC), and that PHNs and teams adapt the model to best meet community need.

> "I feel very privileged to work with managers who have that belief of the importance of servicing this population."
>
> "I have a very vibrant and collaborative team – that's very helpful. And [I have] an extremely supportive and active CAD. That's very, very helpful."

In addition to support from colleagues, some respondents 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."

Collaboration and Relationships

As one respondent said, "everything seems to be based on relationships." Building relationships with community members helps to connect them with information and resources, and at times ensures that resources and materials provided are used.

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. As one respondent noted, formalizing regular meetings can help collaboration.

> "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."

Respondents spoke often about colleagues who support PH practice, such as, the "invaluable" work of Families First Home Visitors, and interpreters.

> "We have great Home Visitors, they stay with families a long time if they can...[Families First] itself is a really good program."
>
> "Collaboration – we use that language interpreter services quite a bit now. We are constantly in contact with them. We're reaching a population that we wouldn't reach otherwise. That's another really important collaboration."
>
> "When centralized programs like Injury Prevention do communicate to the teams it's super helpful. You get resources like bike helmets, car seats. It's just not enough. It's not very often that we get these updates but when they do it's great."

Data and Measurement

Community data supports PHN practice – providing neighbourhood information on population demographics and need. 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"
>
> "with the NETS tool, I just recently printed off a map with the low income housing, FF screens, MB housing, and used it to submit… for our community area. Based on the info, the actual visual, we've taken it to presentations at the school and we've used this map to show the concentrated need of resources. The data is so valuable."
>
> "One thing 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."

For some, the allocation model supports PPM implementation by resourcing areas of higher need, and ensuring an equity approach to public health. Respondents 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."

3. Barriers

Highlights:

- PHNs feel that vacancy management negatively impacts ability to practice to full scope, as PHNs manage daily referrals and balance workload.
- Building on existing professional relationships and partnerships, greater engagement with Clinical Nurse Specialists and program resources is desired.
- The shift in practice is a challenge for some PHNs; deeper understanding of the PPM model, and clarity of PHN role internally and among partners is needed.
- There is a lack of measures and tools to adequately capture daily PHN work and document results, creating creates challenges to communicate PHN successes and contributions.
- Some data platforms are not user-friendly (e.g., repetitive data entry, error messages in HPECD) – and NETs data is not current.
- For some respondents, the allocation formula does not adequately reflect neighbourhood need – creating additional challenges for those of greatest vulnerability.
- Information technology used by PHNs is inadequate, and creates barriers to communicate and maintain contact with clients.
- PHNs lack web-based, electronic and print resources to share with clients, hampering outreach, and health communication.
- A handful of respondents said a lack of vision for the model creates confusion for staff.
- A handful identified a conflict inherent in a population health model based on individual health measures (Families First Screening data).
- Respondents look for unified, collaborative leadership, with dialogue between levels and program areas.

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; perception of limited leadership; challenges measuring progress toward PHN outcomes; and communication.

Respondents often 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.

> "Our outreach had been fairly limited in the past, partly because of time constraints. We still haven't moved past that idea that we do have the time do this."
>
> "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."
>
> "In the whole work load of the key service areas, if you were a PHN and you had to prioritize because there is no staff, you cannot do everything. There has to be something that you can slow down. You don't give it up and say, "I'm not doing it." But you need to prioritize accordingly."
>
> "...quite a push now to do community development. -3/4 of a day a week, you should be out doing things. The actual reality for our team has been that we can barely get through the referrals that come in and provide those clients with any semblance of decent care... that's been a big, big, big, pressure. We haven't been able to develop our contacts within the community, that's a pressure."

Lack of resource availability was identified as 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.

> "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."
>
> "I've been at [community area] since... and haven't gotten a single client into our Families First program. All of those clients now are my responsibility to case manage and it's exhausting."

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 – to be further developed, and described challenges accessing the timely support of program staff such as Program Specialists, Initiative Leads, Clinical Nurse Specialists, Epidemiologists. A number of PHNs call for more engagement with Clinical Nurse Specialists, and better use of their expertise across different areas – surveillance, measurement and evaluation, and clinical knowledge.

> "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."
>
> "I know there's tools to measure community development pieces/outcomes... any other tools that we can provide for our teams to measure outcomes and successes would be beneficial. Maybe that's the role for CNS' as well too. How do you really measure collaboration and partnership."

PHN Role

The shifting role of PHNs poses challenges, as some struggle to adapt practice to reflect the full breadth of PPM model. Respondents described the increased emphasis on equity-based work as a "hard change for some people."

> "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."

Some pointed to a lack of shared understanding across levels and sectors of the PHN role, perceiving this contributes in part to PHNs being a "catch all" or "back up" for other sectors (e.g., mental health, domestic violence).

Alongside examples of partnerships, PHNs noted that implementing the full scope of the PHN role posed challenges when clarifying the role of the PHN with respect to other community based colleagues (such as a Community Facilitators).

> "We have the EIA worker that goes to the resource centre. We also have a Nurse Practitioner (NP) that goes to the resource centre and she has walk ins. She's from Primary Care. So, we meet at service providers for [community area]. We meet monthly or every other month …so we can share what's going on. plus, it's also promoting your programs so that the primary care or NP knows where to send her clients."
>
> "Just negotiating that, that's been a bit of a barrier that we've found. We don't want to step on each other's territory and we want to have that partnership but what is it and how does it not look like a duplication?"
>
> "That's been a difficult role for lots of areas to figure out what that job is and how we work together."
>
> "I hope that the directors and people who run PH have a clear role of what PHN do. I'm not sure anyone has a clear [picture] of what our role is."
>
> "PHN role is really complex – not always well understood by our partners and certainly within the medical field. We need to say to people, "this is what we do but I can refer you to somebody."
>
> "But I think still short of where we ought to be as a program and as management to guide this process. It's not all about adapting to change. People can only adapt to the extent to which they can describe the change. The description has not been super clear."

Measurement

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 communicate successes and contributions.

> "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. That's an important piece of your practice."

A few noted that some data (e.g., NETs) that is no longer current, and challenges working with 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, requiring more time to complete tasks.

> "Stats were so far off because we have so many new 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.
>
> "…do you know how hard it is to find out how many referrals you had this year? We should be able to go to this computer and print it all out. This is a computer program that we can't actually extract data from. When you're talking about NETS that's probably from 2014. 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."
>
> "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."

Communication

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) and support maintaining contact with clients (e.g., updated cell phones that maintain connection, with headset capability).

> "We need electronics. We need proper phones that we can actually talk to the clients, communicate properly with our clients."
>
> "We don't have anything to offer them. [Can't say,] 'go to the website, there's some good information…'"
>
> "Even getting us from paper charting to the real world, electronic charting."

Model Implementation

A small number of respondents identified that the allocation formula allocates resources to areas of greater need; for some, this supports PPM implementation and demonstrates an alignment of 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 community needs as they experience them.

> "…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."
>
> "Allowing teams to work according to how they think it needs to happen? Maybe a team will work together to do one particular community development project with one school, for example. And they're also going to be intentional about gathering research data to show the effectiveness, etc. But that the team can somehow determine the work."
>
> "To further that, it's almost like, as managers we need to be entrusted with the concepts and what are the goals. And then where are we, where do we want to go? Let us figure out how to get there."

Structure and Leadership

A few respondents identified the need for a clear vision of PHN practice, and consistent strategic direction. For some that entails clarity on the desired change (e.g., strategic indicators, goals) so PHNs can prioritize their work. Developing a vision that embraces the PPM model, engaging input from PHNs and leadership – uniting those working to implement the PPM model.

Others described challenges reporting within the matrix model of leadership (reporting to program while working alongside the Community Area leadership) and called for greater "collaborative leadership;" including greater dialogue across levels (e.g., managers and directors).

> "Consistent mission, vision and understanding of that vision. That has been one of the main challenges."
>
> "I do believe that a strong facilitator towards further operations, in terms of having consistent strategic direction, is having that dialogue with the program/director level."

4. Opportunities

Highlights:

- Draw on existing expertise of PPH program staff, colleagues and partners. and
- Dedicating resources to lead on areas of strategic approach (e.g., Healthy Public Policy, Healthy Built and Social Environment).
- Identifying and excluding tasks from home visits (e.g., vital signs, blood work).
- Staffing teams, CNS and managers at full level to support PPM implementation.
- Ensuring availability of technology to connect PHNs reliably with community members.
- Ensuring Families First Home Visitors and Interpreters are recognized for their valued contributions.
- Enhancing peer-based learning, including shadowing colleagues, and community area exchanges.
- Ongoing orientation to the PPM model, focusing on foundational concepts (e.g., community development, health equity).
- Enhancing role clarity of those within the WRHA who contribute to the PPM, as well as how to engage with other service provider partners.
- Enhancing current efforts to capture measures of PHN work and outcomes.
- Updating reporting platforms to reduce duplication of input.
- Engaging with the allocation model, enhancing timeliness of data, and capturing PHN input to inform how community areas can best be served.
- Implementing the PPM model in a manner responsive to unique community areas.

While maintaining current supports to PPM implementation, respondents identified opportunities to strengthen the model. This includes: resourcing the shift in practice; strategically using existing resources; enhancing learning and training; ongoing measurement and evaluation; and model implementation responsive to communities.

Using Resources Strategically

To better meet the full scope of practice, respondents see opportunities to draw on existing expertise (e.g., program specialists, Initiative Leads), as well as other service providers focusing on community need; "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.

> When there's only so much of us/so many resources… we need to figure out where we're going to get the most bang for our buck. We need to be able to prioritize and focus because we can't be everything to everybody."
>
> "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."

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.]"
>
> "For an equities population, seeing them right after having a baby is great. But I feel like going forward, we need either the FF screen or some type of screen done in hospital done by labor and delivery. That makes the most sense"

Resourcing the Shift in Practice

Noting numerous challenges balancing workload, 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.

> Real crisis of leadership, real crisis of appropriate management of those positions and management of vacancies. To me, we're really exploiting the people we're supposed to be helping.
>
> "Nothing has changed from an organizational point of view since this was implemented. We talk about it but structurally I don't think we've been given any real tools to help us."

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 (e.g., community development, health equity, working at a policy level to effect change).

> "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."

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.

> "I feel like, now in the community, there are so many people wanting to be part of community development; what is it, what's your role in it as a PHN, what do you contribute as a PHN in that role in community development. I know that part of the new practice is to give time to community development but the definition is very hard… I'm really not sure what's expected of that."
>
> "And to do a better job of articulating to nurses that this IS the job. 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."

Measuring What Counts

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.

> "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."
>
> "Getting the process in place that will support [clarity of role]. If we had infrastructure, like databases like an EMR, that would be one way to gather information as well as get information back. That could measure the full role."

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 diff community areas with different needs. We need to have the ability to make it work for our respective community areas."

Appendix A – PPM Focus Group 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	Focus Groups
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 – Code Application

Table 2 - Parent code applications (number of mentions) by focus group. Note: focus groups not presented in the order conducted.

	Focus Group						
Parent codes	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
Barriers	17	41	17	21	6	35	137
Delivery, Structure and Process	12	30	10	2	7	28	89
Supports	3	14	9	7	10	2	45
Opportunities	7	11	4	8	10	2	42
Management Practices	9	4	2	2	2	3	22
Recognition & Rewards		2	2		2	10	16
Professional Relationships/Partnerships	3	2	4	1	1	1	12
Values & Principles	2	1	4	1		2	10

Table 3 - Sub-code application of *Barriers* by focus group

Barriers (sub-codes)	**2**	**1**	**6**	**4**	**5**	**3**	**Total**
Resources	1	1	3	8	20	15	48
PHN Role & Practice	9	6		3	16	10	44
Leadership	7	9		3	1	6	26
Communication		7	2	2	2	8	21
Measurement	2	4	2	6	4	1	19
Staffing	3	3	1	4	7	1	19
PHN time constraints	3			3	7	1	14
Education/Training	2					2	4
Program			1	1	1		3

Table 4 - Sub-code application of *Delivery, Structure and Processes* by focus group

Sub-codes: Delivery, structure and processes	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
Community Development	2	3	5	3	6	10	29
Collaboration and Partnership	6	1	3		6	5	21
Health Communication	6	1		1	2	3	13
Outreach	3		1	4	2	2	12
Surveillance	5	1		1	1	4	12
Healthy Public Policy (HPP)	6	2				2	10
Public Health Clinical Practice		2	1	1	2	3	9
Healthy Built and Social Environment (BHSE)	3			1	2		6
Applied Public Health Research	1	1				1	3
Health Assessment				1	1		2

Table 5 - Sub-code application of *Supports* by focus group

Supports (sub-codes)	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
Location	1	1		1	6	4	13
Manager, Team support	1	3	4	2	3		13
Relationships	1	2	4	2		3	12
Measurement/data		2	1	1		2	6
Standards		2	2				4

Appendix C – PPM Elements: Code Counts, Weighting

Figure 4 - Number of mentions by PPM element

Figure 5 –Average Code Weighting, PPM Elements (0, low rating; 2 high rating)

	High	21 to 30
	Medium	11 to 20
	Low	0-10