Winnipeg Regional Health Authority,
Population & Public Health

Public Health Nurse Professional Practice Model

Winnipeg Regional Health Authority
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December 2013

Acknowledgements

The development of this professional practice model was possible as the result of the efforts of the working group, the nursing practice council, and public health nurses (PHNs) in the Winnipeg Regional Health Authority (WRHA). The response from PHNs was exceptional, with the consistent message that PHNs want to function to the full scope of their PHN Nurse IV role and position description.

Preliminary work began in the winter of 2012, to explore interest in reconvening a nursing practice council working group to address the outstanding issue of PHN service delivery. A participatory action research study was completed as a component of my PhD dissertation. Data was collected during 7 working group meetings that took place from November 2012 to July 2013, which were audio taped and transcribed verbatim. The audio tapes and transcriptions were summarized and the working group reviewed, discussed, and provided feedback. The working group strived to capture the feedback of the nursing practice council, as well as input from teams of PHNs working in community areas and centralized programs, leading to the development of the professional practice model and this document.

The working group deserves special recognition and thanks for their professionalism, commitment, collaboration, and passion. Preparation for the meetings involved not only collating PHN and team feedback, but also reviewing literature and other documents. The group was always prepared, provided leadership, and contributed with vigour and enthusiasm. The working group and co-authors of the document are:

- Anne Sikora
- Leanne O'Keefe
- Lenore Finnson (co-chair of working group)
- Lori Ann Laramee (co-chair of working group)
- Vicki Charski
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Sincerely,

Cheryl Cusack, RN PhD (C)

Table of Contents

Background:

This document outlines a professional practice model for Public Health Nurses (PHNs) in the Winnipeg Regional Health Authority (WRHA). Professional practice models have been identified as key organizational tools to support nursing practice [1-3], by identifying activities that nurses have direct control and responsibility for [1], and articulating a nursing philosophy based on specific knowledge, skills, and competencies for autonomous practice [4-6]. Professional practice models assist nurses with practice decisions and change [6], as well as promote nursing excellence, innovation, and quality client care [7].

A professional practice model has been conceptualized as a rope, which is strongest when the individual strands are woven together [8].

The following essential components have been identified [2, 8]:

1. **Values and Principles** – Form the collective belief system and foundation for PHN practice and professional development. The values and principles create focus for the other four components of the model, and assist with prioritization.

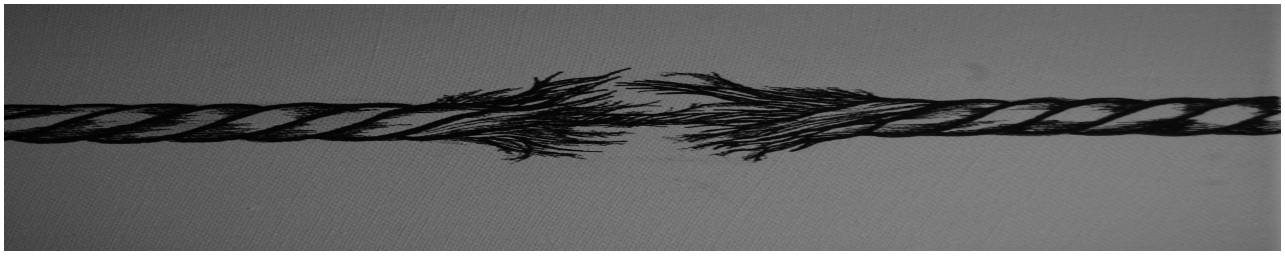
2. **Professional Relationships and Partnerships** – Describe PHN beliefs and attitudes, relational skills, and interactions that promote client care within the health system.

3. **Delivery Structure and Processes** – Articulate PHN service delivery to optimize client care and population outcomes.

4. **Management Practices** – Outline the organizational structures and processes for decision-making and supporting autonomous PHN practice.

5. **Rewards and Recognition**– Describe formal and informal organizational structures and acknowledgements based on nursing attributes and employee motivation.*

The rope cannot do its job well unless all of the components are included.



Professional practice models and professional nursing practice environments can improve client outcomes, staffing, as well as enhance nurse and client satisfaction [9]. In comparison to other nursing models, professional practice models are more holistic. In addition to articulating nursing practice, professional practice models incorporate organizational, community, and system elements. PHNs in the WRHA and across Canada have identified that lack of clarity regarding the PHN role in conjunction with multiple competing workload demands, has created inconsistency and difficulty in working to full scope. Professional practice models hold promise in optimizing PHN practice by providing a framework and the common language to articulate the PHN role, while clarifying roles and responsibilities at organization and system levels.

Professional practice models require adaptation and customization into existing organizational systems and infrastructure [10]. In developing the WRHA PHN professional practice model a wide variety of literature and key WRHA and Canadian documents were reviewed and integrated. This included literature on public health and nursing practice, service delivery models, nursing leadership, and key Canadian research articles and policy documents.

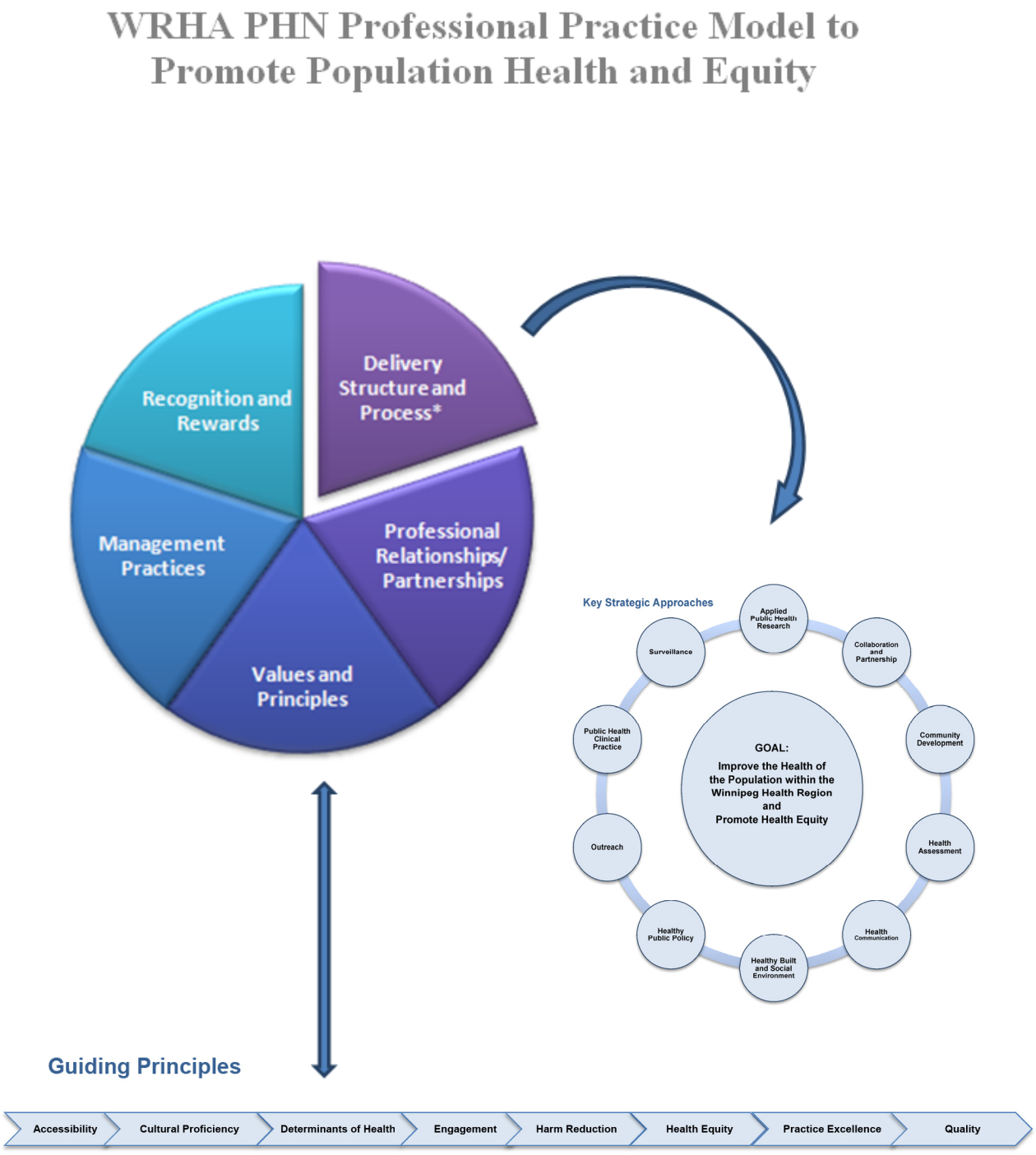
The professional practice model incorporates the following, which are included as appendices for additional information:

- Community Health Nurses of Canada professional practice model - served as the guiding structure for the WRHA PHN professional practice model
- Literature summary - provided the background and evidence
- WRHA PHN position description – Describes expectations for PHN practice, based on the Community Health Nurses of Canada PHN discipline specific competencies, and depicting a PHN leadership role in promoting population health and health equity
- WRHA Population & Public Health conceptual framework - provides the framework to articulate autonomous PHN service delivery in the WRHA that is consistent with organizational vision
- WRHA position statement on health equity – Approved by WRHA senior management and Board, articulating organizational commitment to promote equity

A shared governance approach and participant engagement has been identified as critical in developing a practice model that reflects organizational strategic priorities and staff values [30]. The intention is to articulate the unique aspects of the PHN role within the broader Population & Public Health program, to attain a consistent and evidence based approach. The professional practice model creates a framework and common language to clarify the PHN role.

*The Community Health Nurses of Canada Professional Practice Model does not contain a 5th category. Hoffart titled this category Compensation and Rewards. In the WRHA professional Practice Model, this category was adapted to be applicable within the Manitoba/Canadian context.

WRHA PHN Professional Practice Model Summary



WRHA PHN Professional Practice Model Components

PPM Component	Description
Delivery Structure and Process	PHN practice is delivered based on structures and processes consistent with PPH key strategic approaches
Professional Relationships and Partnerships	PHNs develop professional relationships that are client centered, respectful, strength-based, and therapeutic. Relationships are based on PHN assessments and interventions that incorporate cultural proficiency and harm reduction, aiming to increase client engagement and access to services and resources. To advance client health, PHNs have professional relationships and partnerships with a wide variety of providers and agencies.
Values and Principles	PHN values and principles form the collective belief system and foundation for PHN practice and professional development. The basis of PHN practice is promoting, protecting and preserving the health of populations, and facilitating equitable health outcomes by addressing the determinants of health.
Management Practices	PHN practice is supported by management approaches that promote PHN input, utilizing a collaborative, strength based approach. The role of management is to support and foster nursing excellence and practice model implementation by creating successful organizational structures and facilitating connections both horizontally and vertically in the organizational hierarchy.
Recognition and Rewards	PHN practice and attributes are acknowledged by formal and informal organizational structures that create an empowering practice environment.

PHN Service Delivery Model Summary

WRHA PHN Delivery Structures and Processes:

PHN Practice Definitions and Potential PHN Interventions

PPH Key Strategic Approach	PHN Practice Definition	Potential PHN Interventions/ Roles
Public Health Clinical Practice	PHN clinical practice is broad. It includes health promotion, disease and injury prevention, health protection, health assessment, as well as emergency response and preparedness. Practice is responsive to client needs and utilizes a case management approach to coordinate care and promote equitable access to services and resources for long-term clients with identified risk factors for poor health outcomes.	Health threat response; Case management; Promoting health; Team building and collaboration; Resource management, planning, coordination
Outreach	PHNs use strategies such as outreach, targeted home visiting, and case finding, to promote equity and facilitate access to resources and health services for vulnerable populations. PHN outreach strategies are relationship based and built on trust.	Outreach, Targeted home visiting; Case finding; Increasing access
Healthy Public Policy	PHNs identify opportunities for policy and program development, participating in the development of policies with measurable outcomes based on clear philosophies, objectives, and standards. PHNs influence policy at multiple levels, including schools, daycares, community, and across sectors that affect health determinants.	Policy and program development and implementation; Advocacy; Leadership
Healthy Built and Social Environment	PHNs incorporate the built and social environment into program planning activities. The built environment refers to physical structures developed by humans. It consists of buildings; roads and transportation systems; as well as access to healthy housing, food, water, physical spaces, schools, and recreation facilities.	Collaborating; Advocacy; Building coalitions and networks
Health Communication	PHNs use the most appropriate media, current technology, and communication strategies to support their practice and to mobilize individuals, families, groups, and populations.	Counselling; Health education; Referrals; Facilitating change

PPH Key Strategic Approach	PHN Practice Definition	Potential PHN Interventions/ Roles
Health Assessment	PHN practice priorities are based on analysis of health status within populations. Health assessment incorporates the nursing process components of assessment, planning, intervention, and evaluation.	Advocacy; Communicable disease prevention; Referral and follow-up
Community Development	PHNs utilize knowledge, assessment, and a strength based approach to empower and build capacity of the community to meet its needs.	Capacity building; Empowering; Partnering; Building coalitions and networks
Collaboration and Partnership	PHNs share resources, responsibility, and influence while recognizing the strengths of others and working towards common goals that promote health. Collaboration and partnership is based on effective PHN communication and consultation with clients, team members, and other agencies and organizations.	Consultation; Advocacy; Service /care coordination; Leadership; Facilitation
Applied Public Health Research	PHNs appraise and apply research evidence from public health and nursing sciences. PHN practice is current, accountable and evidence informed.	Applying public health and nursing theory; Appraising; Synthesizing; Research and evaluation
Surveillance	PHNs collect and interpret surveillance data, as well as apply surveillance information to guide their practice. PHNs monitor community based trends and health assessment data to understand the population they work with and to plan PHN interventions.	Monitoring; Immunizing; Screening; Referral and follow-up; Leadership; Resource management, planning, coordination

WRHA PHN Professional Practice Model

Values and principles. The basis of PHN practice is promoting, protecting and preserving the health of populations, and facilitating equitable health outcomes by addressing the determinants of health. In contrast to health care which mainly focuses on the individual, the purpose of public health is to keep people healthy and alleviate pressure on the healthcare system by creating population level health improvements [13]. A distinguishing feature of the PHN role is the prominence of primary prevention activities, to promote equitable health outcomes and prevent future problems by addressing root causes, focusing beyond health risks and/or disease [11, 14]. A population based approach is premised on understanding and influencing complex interacting factors that contribute to individual-level health outcomes [15]. The Ottawa Charter for Health Promotion identifies prerequisites for health that include food, income, shelter, peace, a stable eco-system, education, social justice and sustainable resources. PHNs mediate, enable, and advocate for health by actions identified in the charter that include building healthy public policy; creating supportive environments; developing personal skills; reorienting health services; and strengthening community action [16].

Practice excellence and quality PHN delivery structures and processes will be achieved by recognizing the Population & Public Health key strategic approaches of health equity and population health improvement. According to the WRHA equity statement, equity is an ethical principle that recognizes health services must be allocated proportionately based on need, supporting all citizens to reach their full potential and to not be advantaged or disadvantaged by "social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance." Health inequities are socially produced and amenable to intervention. PHNs will base practice decisions and priorities on the Population & Public Health guiding principles of: health equity, accessibility, cultural proficiency, determinants of health, engagement, harm reduction, practice excellence and quality. Basing PHN practice on these guiding principles and goals articulates the unique focus and value added component that PHNs contribute within an integrated system of healthcare.

Professional relationships and partnerships. PHNs develop professional relationships that are client centered, respectful, strength-based, and therapeutic. Relationships are based on PHN assessments and interventions that incorporate cultural proficiency and harm reduction, aiming to increase client engagement and access to services and resources. In establishing relationships, PHNs respect different levels of education, literacy, and language, utilizing interpreter services as appropriate. PHNs tailor their communication skills to meet complex clients where they are at, with the plan of establishing and maintaining long-term relationships to promote health.

To advance client health, PHNs have professional relationships and partnerships with a wide variety of providers and agencies. The New Public Health movement highlights the importance of moving beyond individual level education and health promotion, to tackle the structural determinants of inequities through collaboration among sectors and agencies [17]. PHNs work within multiple dynamic teams composed of varied health and social service providers. The teams and level of PHN intervention vary depending upon client need, capacity, and other services involved. For example, PHNs may collaborate with staff from Child & Family Services, Housing, Employment & Income Assistance and schools. PHNs are ideally situated to address the determinants of health and promote equity through action at multiple levels that include the individual, community, and government [2, 11, 12].

Delivery structure and process. PHN delivery structure and processes are based on the following components outlined in the Population & Public Health conceptual framework:

Public health clinical practice - PHN clinical practice consists of health promotion, disease and injury prevention, health protection, health assessment, as well as emergency response and preparedness [11]. PHN practice is responsive to various client needs. A case management approach is used to coordinate care and promote equitable access to services and resources for long-term clients with identified risk factors for poor health outcomes.

PHN practice is broad, incorporating the components outlined in the Population & Public Health conceptual framework below within the Population & Public Health key service areas of communicable disease prevention; environmental health; healthy sexuality & harm reduction; immunization; travel health; tuberculosis prevention & management; healthy parenting & early childhood development; healthy children & youth; injury prevention; mental health promotion; nutrition promotion; physical activity promotion; tobacco reduction and substance use, public health information systems, and surveillance.

Outreach - PHNs use strategies such as outreach, targeted home visiting, and case finding, to promote equity and facilitate access to resources and health services for vulnerable populations [2]. Vulnerable populations may include but are not limited to teen mothers, Aboriginal people, refugees or new immigrants; people living in poverty or with mental illness; and those who are isolated or experience communication barriers. PHN outreach strategies are relationship based and built on trust.

Examples:

- A PHN accesses prenatal clients by working in collaboration with community Employment and Income Assistance workers;
- A PHN raises immunization consent return rates by attending organized school-based family events;
- A PHN increases immunization rates by coordinating an inner-city health fair with community partners and providing youth immunizations;
- A PHN works with target populations attending community based groups such as Healthy Baby/Healthy Start;
- A PHN attends a local establishment that an individual is known to frequent in order to re-engage the individual in treatment for Tuberculosis;

Healthy Public Policy - PHNs identify opportunities for policy and program development, participating in the development of policies with measurable outcomes based on clear philosophies, objectives, and standards [11]. This may include PHN advocacy for social, health, environmental or income policies to promote health, resources, and equity [18]. PHNs influence policy at multiple levels, including schools, daycares, community, and across sectors that influence health determinants.

Examples:

- PHNs raise awareness of the importance of bike helmet legislation within their community and advocate for individuals to lobby the government;
- A PHN identifies a trend of increasing chewing tobacco use among youth hockey teams in the community. The PHN works in collaboration with the school division and sports teams to increase awareness of the health risks of chewing tobacco and to influence policies to limit youth access.
- PHNs lead the implementation of Baby Friendly policies across WRHA community programs. A related activity to increase awareness is organizing a "latch on" day at the legislative building in recognition of World Breastfeeding Day;
- PHNs contribute to development of guidelines for Human Immunovirus based on respect for human rights, promotion of health and protection of the public.

Healthy Built and Social Environment – The built environment refers to physical structures developed by humans [19]. It consists of buildings; roads and transportation systems; as well as access to healthy housing, food, water, physical spaces, schools, and recreation facilities [20]. Based on knowledge of the community, PHNs incorporate the built and social environment into program planning activities to promote equity.

Examples:

- A PHN collaborates with a Healthy Child coalition and recreation centre to develop community based programs;
- PHNs works in collaboration with the community and advocate for flu and breastfeeding clinic sites that are welcoming and accessible based on community structure, function, and transportation systems;
- A PHN collaborates with the community facilitator and public health dietician to identify healthy food options and to increase awareness within the community;
- A PHN works with a client, their landlord, and an environmental health officer to address a rodent infestation in an apartment building;
- A PHN identifies a possible restaurant link in the course of a communicable disease investigation and works with the health inspector;
- A low-income housing complex is closed and a PHN works in collaboration with Manitoba Housing, the community facilitator and others to advocate for healthy housing options within the same neighborhood.

Health Communication – PHNs use the most appropriate media, current technology, and communication strategies to support their practice; to coordinate care and social services for complex clients; and to mobilize individuals, families, groups, and populations [2, 12]. Communication involves the exchange of information, ideas, and opinions [12]; it is not just one way, but an interactive process to determine client preferences for learning and to evaluate effectiveness. Communication may be verbal, non-verbal, face-to-face, telephone, group, electronic, or written [2]. PHNs assess client needs, the social media they use, and gear communication to the audience. PHNs are strength based and sensitive to nonverbal communication cues, as well as assessing timing and client readiness. PHNs recognize the influence of culture on communication, and appreciate that culture extends beyond ethnicity. Examples include but are not limited to deaf; homeless; or lesbian, gay, transgender, bisexual, two-spirit and intersex communities. PHNs advocate for current information technology to support their practice, such as the use of evidence based websites, e-mail, and texting. Health communication takes place between team members, between PHN's and primary care practitioners; as well as during referrals to other health services etc.

Examples:

- A PHN is presenting to a group of newcomers and adapts the communication medium and her own approach to be relevant for that target population;

- A PHN is working with a high functioning new mom who has many questions and is requesting information. The PHN refers her to evidence based websites where she can find her own answers;
- A PHN is working with a client with numerous identified risk factors. The client is isolated and doesn't read or have computer access, so the PHN uses visual, hands on and client-centered discussion during home, office and/or community visits;
- A PHN is hoping to complete a parent survey during her home visit. During discussion of abuse and family history, a change in the client's verbal and non-verbal communication indicates she is shutting down. To continue to engage and develop trust, the PHN acknowledges what she has noticed, and explores whether the client wishes to continue or would prefer to discuss more at a subsequent visit and move to a different topic now.

Health Assessment – Health assessment is integral and ongoing in every aspect of PHN work with families, schools, and the community. Health assessment incorporates the nursing process components of assessment, planning, intervention, and evaluation. PHN practice priorities are based on analysis of health status within populations [11].

PHNs collect apply, and analyze information from multiple sources [12]. Based on their health assessment, PHNs facilitate and advocate for equitable access to services and resources. This may include screening, referrals, and/or coordination of services within and outside the health system [2]. Experienced PHNs often integrate assessment and nursing process into their daily work with such proficiency and skill, that the theory upon which the practice is grounded may be difficult to recognize. PHN assessment is holistic, assessing not only health and/or disease status but the broader social determinants that impact health outcomes. Equity is considered within all components of one's health assessment.

Examples:

- Using a client-centered approach, PHNs assess health and social needs to plan PHN interventions. The Families First screen and parent survey, care map, communicable disease follow-up, and immunization consent forms are assessment tools that can be used to plan PHN interventions, referrals, and priorities;
- PHNs make referrals to a range of community partners based on health assessment. Examples may include speech and language pathologists, mental health providers, addictions counsellors, and food banks.
- While completing a health assessment for surveillance purposes in a client diagnosed with pneumococcal infection, the PHN refers the client to housing and other resources identified as needs by the client
- PHNs review information from cases of an infectious disease to determine initial linkages that lead to the identification of an outbreak;
- A PHN surveys the working space of a person diagnosed with infectious respiratory tuberculosis, in order to contribute information to the scope of a contact investigation.

Community Development – PHNs utilize knowledge, assessment, and a strength based approach to empower and build capacity of the community to meet its needs [11]. Community development may include work with neighborhoods, schools, families, and a variety of communities including cultural groups or groups with a common belief.

Examples:

- A PHN works with the nutritionist, community centre, and community members to implement a Community Kitchen where families cook and take home healthy meals made from items available at the local food bank;
- A PHN works with a parent child coalition to develop drop-in programs to meet the needs identified by parents with children age 1-5;
- A PHN works with students and community members to develop a peer led parenting group in an inner city neighborhood.

- A PHN supports the school community to implement actions that promote health based on needs identified by the school population through the Youth Health Survey.

Collaboration and Partnership – PHNs share resources, responsibility, and influence while recognizing the strengths of others and working towards common goals that promote health [12]. Collaboration and partnership is based on effective PHN communication and consultation with clients, team members, and other agencies and organizations [2].

Examples:

- PHNs work in partnership and collaboration with a variety of agencies to promote population health and equity. Examples include Healthy Baby/Healthy Start and other community support groups such as the group for newcomers held at Knox United Church in Central Park and The Network of Organizations Working for War Affected Newcomers (NOWAN)
- A PHN works in collaboration with a community group to influence health by introducing an evidence based program to promote nutrition;
- A PHN advocates for a client requiring medication and works in collaboration with an Employment & Income Assistance worker to navigate system barriers that would have delayed treatment initiation.
- A PHN participates in a working group that is developing program-monitoring indicators.

Applied Public Health Research –Focuses on public health program and policy research interventions. Currently the Manitoba Centre for Health Policy holds a research chair with the Canadian Institutes of Health Research and is examining population health improvements of national relevance [21]. PHNs participate in these and other research initiatives on an ongoing basis.

PHNs appraise and apply research evidence from public health and nursing sciences[12]. PHN practice is current, accountable and evidence informed. Tools to incorporate current research evidence in PHN practice may include raising issues at nursing practice council to develop a consistent system approach, working with team leads (i.e. smoking cessation champions); or collaborating with the clinical nurse specialists (CNS).

Examples:

- Data elements collected by PHNs are used in a variety of population level reports and research studies that include the Families First program evaluation, Towards Flourishing, Early Development Instrument, Youth Health Survey, and Child Health Atlas;
- PHNs assist a University of Manitoba graduate student researcher to access a vulnerable population;
- A PHN uses current safe sleep evidence and anticipatory guidance while working with a vulnerable young mother;
- A PHN participates in the development of a proposal for research funding.

Surveillance – Surveillance involves monitoring disease patterns and trends, to identify events that do not fit expected norms. PHNs collect and interpret surveillance data, as well as apply surveillance information to guide their practice [11]. For infectious diseases surveillance may consist of assessing individuals with a reportable disease and their contacts [22]. PHNs also monitor community based trends and health assessment data to understand the population they work with and to plan PHN interventions. PHNs utilize surveillance data obtained from formal information systems such as the Manitoba Immunization Monitoring System, Panorama, Integrated Public Health Information System, the Healthy Parenting and Early Childhood database, as well as the Community Health Assessment and Manitoba Centre for Health policy reports. PHNs also identify trends through their expertise and ability to integrate surveillance principles and other pertinent sources of information to recognize emerging issues. PHNs recognize that while quantitative data is important, qualitative data obtained from the community may also assist in identifying significant issues for PHN action. Trends not captured by quantitative or formal surveillance methods are often based on PHN knowledge of the community and relationships with key stakeholders.

Examples:

- Formal surveillance data include: Rates of sexually transmitted and blood borne infections, tuberculosis, injury, immunization, teen pregnancy and breastfeeding as well as flu outreach clinic statistics, immunization consent return rates, Families First program reports and statistics.
- Informal surveillance data may consist of recognizing unique patterns of functioning for specific populations within the Canadian health and social system. For instance, while African newcomer families may live in a variety of areas across the city, they access downtown community groups and resources.
- A PHN recognizes a trend that inaccurate information is being disseminated in newspaper articles and advertising on infant sleep training, and that mothers attending a breastfeeding group are being misled. The PHN develops an issue paper for nursing practice council discussion, to determine if this is a new and concerning trend across the city.

Management practices. The management approach pertains to the process and structures for decision-making within an organization [2]. Successful healthcare organizations promote professional practice environments in which nursing input flourishes, contributing to improved organizational relationships and processes [23]. Work that is led by nurses using a collaborative strength based approach to practice decisions is more likely to reduce system costs, increase efficiency, and improve nurse satisfaction and client outcomes [24, 25]. The role of management is to support and foster nursing excellence and practice model implementation by creating successful organizational structures and facilitating "connections both horizontally and vertically in the organizational hierarchy [4]." Decision-makers have to share power, to foster staff commitment and organizational transformation [26].

Accreditation Canada suggest the following organizational responsibilities [27]:

- Ensuring staff are educated, trained, qualified and competent
- Conducting workforce assessments
- Ensuring each team member has the necessary credentials
- Evaluating and documenting team member performance in an objective, interactive, and positive way on a regular basis
- Basing performance assessments on demonstration of core competencies for public health that are specific to the work setting
- Ensuring the workforce is participating in ongoing professional development activities and training
- Evaluating staffing effectiveness and making improvements on an ongoing basis
- Including staff in work and job design, including defining roles and responsibilities and case assignments

Additional feedback provided by the PHN teams/working group include:

- Active PHN leadership, participation, and inclusion in all practice decisions
- Support for PHNs to work to their full scope and to address equity
- Adequate staffing
- Trust and value for PHN Nurse IV role
- Clarify manager versus PHN roles and responsibilities in practice. Eg. Prior to H1N1 PHNs organized, staffed, and ran annual mass flu clinics
- Work as a team to achieve common goals. Individual PHNs assume professional responsibility to provide input to their teams and nursing practice council representative
- Develop an effective organizational structure and process for communication that can be used to disseminate organization changes and future directions

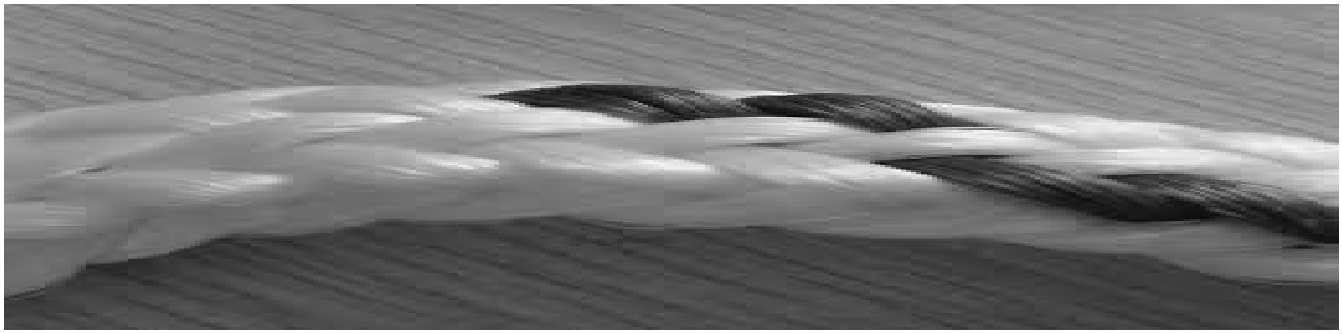
Recognition and rewards. Rewards and recognition describe formal and informal organizational structures for acknowledging nursing attributes and employee motivation. A strength based professional nursing leadership model aims to determine what is significant and motivating to individuals, teams, and systems and to create a professional practice environment that is empowering [25].

Accreditation Canada suggests [27]:

- Organizational incentives for participation in education and training – ie career advancement, time off for course work or conferences, tuition reimbursement, supervisor recognition
- Recognition of team member contributions

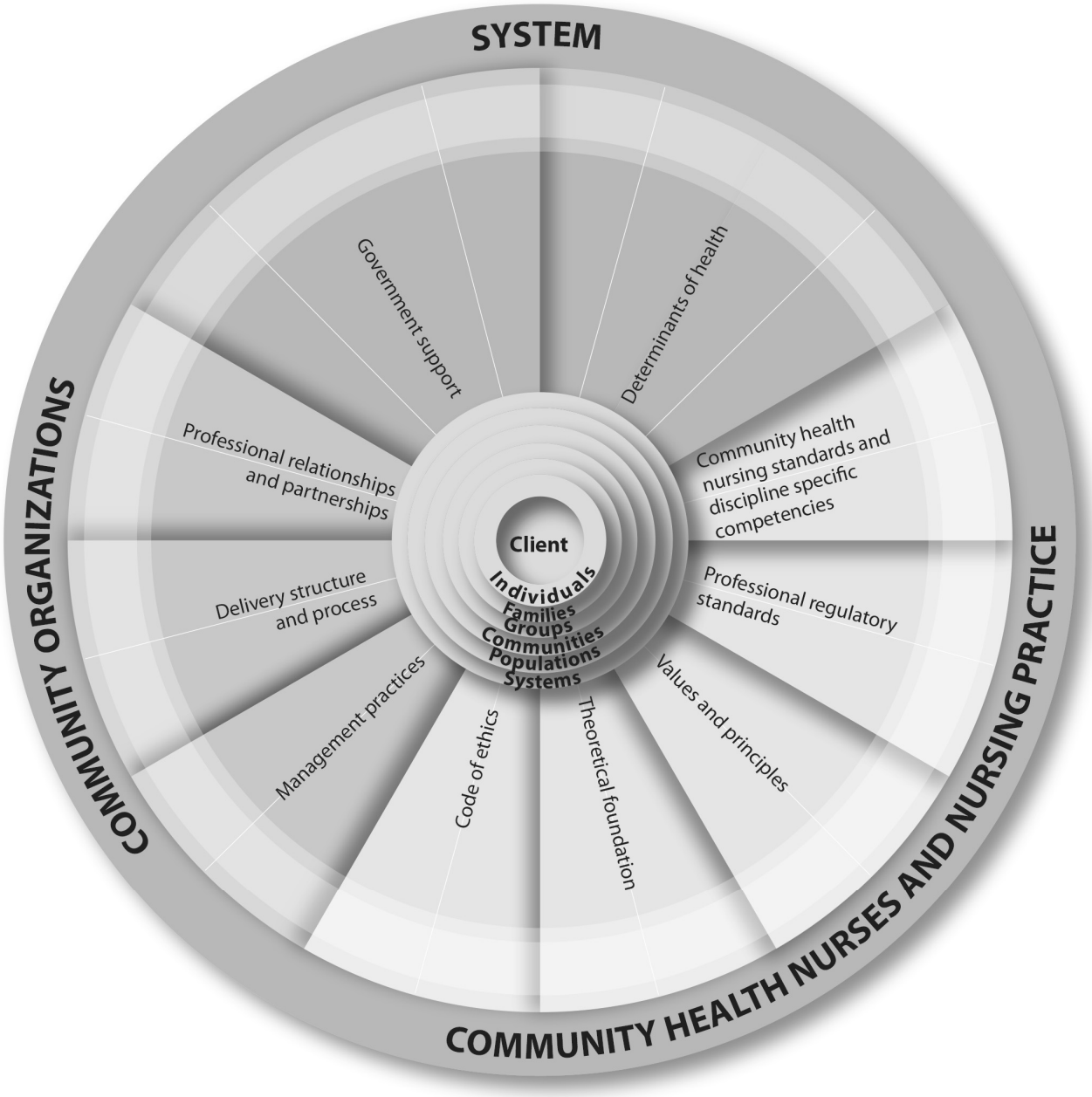
Team and working group suggestions include:

- PHNs expertise valued
- Case studies that cultivate shared learning
- Celebration of successes
- Organization and team manager support
- Staff recognition for certification / education at staff development sessions
- Orientation scheduled over time – focusing on the full scope of PHN practice
- Sharing best practices at nursing practice council
- Building on models of best practice teams
- Mentorship program



Appendix I – Community Health Nurses of Canada Professional Practice Model

Community Health Nurses of Canada, 2013



Professional Practice Model Components

Code of Ethics: The Canadian Nurses Association's *Code of Ethics for Registered Nurses* is a statement of the ethical values of nurses and of nurses' commitments to persons with health-care needs and persons receiving care. It is intended for nurses in all contexts and domains of nursing practice and at all levels of decision-making. It is developed by nurses for nurses and can assist nurses in practising ethically and working through ethical challenges that arise in their practice with individuals, families, groups, communities, populations and systems.

Professional Regulatory Standards: Professional regulatory standards demonstrate to the public, government and other stakeholders that a profession is dedicated to maintaining public trust and upholding the criteria of its professional practice.

Community Health Nurse: Community health nurses:

- View health as a resource for everyday living.
- Promote, protect and preserve the health of individuals, families, groups, communities, and populations in the settings where they live, work, learn, worship and play in an ongoing and/or episodic process.[1]
- Consider and address the impact of the social determinants of health within the political, cultural and environmental context on health.
- Support capacity building focused on client strengths and client participation.
- Protect and enhance human dignity respecting social, cultural, and personal beliefs and circumstances of their clients.
- Advocate and engage in political action and healthy public policy options to facilitate healthy living.
- Incorporate the concepts of inclusiveness, equity and social justice as well as the principles of community development
- Participate in knowledge generation and knowledge translation, and integrate knowledge and multiple ways of knowing.
- Engage in evidence informed decision making.
- Work at a high level of autonomy.
- Have a personal commitment and accountability to professional practice with an emphasis on teamwork, collaboration, consultation and professional relationships.

Values and Principles: Values are part of a collective belief system that underpins professional practice, informs the development of educational programs and guides administration. Community health nursing is rooted in caring[3] and social justice as reflected in public policies such as the Canada Health Act[4], the declaration of Alma Ata[5], the Ottawa Charter for Health Promotion[6], the Jakarta Declaration[7], the Bangkok Charter for Health Promotion[8] and the "Nairobi Call to Action"[9] which are consistent with the Community Health Nurses of Canada Vision Statement.[10] The community health nursing is accountable, committed to quality care and competency through continuous professional development.

Theoretical Foundation: The practice of community health nursing combines nursing theory and knowledge, social sciences and public health science with home health and primary health care principles. The nursing metaparadigm includes: person (individuals, families, community, group, and populations), health, nursing, environment [culture] and social justice as central to the practice of community health nursing.

Discipline Specific Competencies: Competencies are the integrated knowledge, skills, judgment and attributes required of a registered nurse to practice safely and ethically. Attributes include, but are not limited to attitudes, values and beliefs.

Professional Relationships & Partnerships: Professional relationships in community health nursing have an impact on communication, consultation, collaboration and forming effective partnerships with clients, team members other professionals as well as other sectors and organizations.15 Community health nurses:
• Recognize assets and capacity of people/partners in building collaborative partnerships based on the principles of primary health care, caring, social justice and empowerment.
• Establish respectful, trusting relationships / partnerships with individuals, families, groups, communities, populations, and systems.
• Ensure individuals, families, groups, communities, populations and systems are active partners in defining their health issues and in making decisions that affect their health and well being
• Build professional relationships and partnerships with colleagues, other disciplines, communities and sectors that support inter-professional collaboration.
• Recognize socio-political and cultural influences that may impact relationship and partnership building.

Management Practices: Management practices refer to the structure and processes for decision-making within community organizations and agencies. An approach consistent with professional nursing values such as autonomy and accountability will support community health nurses to practice their full scope of skills and knowledge. Effective management practices promote realization of the full potential of community health nursing resources with a goal of excellence in community health/public health nursing practice. Formal communication and decision making mechanisms are essential for effective community health nursing professional practice. This involves having direct authority relating to "creating an environment that supports clinicians to incorporate evidence-based practice, maintain their competency and/or create systems and processes to enhance practice and professional development."16 Community health nurses take personal and professional satisfaction from their contribution in promoting the health and well-being of individuals, families, groups, communities, populations and systems. Community health nurses value a management approach that recognizes their contribution both informally and formally. Examples of rewards include but are not limited to: celebration of successes; certification; promotion and professional advancement or remuneration.

Delivery Structure and Process: A variety of service delivery models that integrate Community Health Nursing Process into practice are used in community health nursing including, but not limited to: generalist practice based on geographic location (e.g. neighbourhood nursing), focused practice (based on developmental stage or health issue (e.g. sexual health, post partum, wound care, shift nursing, palliative care), or care process (e.g. team nursing, primary health care, case management or perhaps family centered care). Community health nursing practice roles and activities are continually evolving to meet the health needs of the different population groups. Service delivery is focused on preventive/curative/social aspects of care and is responsive to community needs and takes into consideration stewardship of resources as an appropriate means of making services less costly, and more efficient and effective.

Community Health Nursing Standards: A key characteristic of a self-regulating profession like nursing is the development of standards of practice based on the values of the profession. Practice standards describe the knowledge, skills, judgment and attitudes needed to practice nursing safely. They represent the desirable and achievable levels of performance expected of nurses in their practice and provide criteria for measuring actual performance.

Government Support: Provision of community health nursing in Canada requires government resources and supportive policies. Decisions about funded services, resources, performance standards and policies that affect community well-being as well as the nursing profession all have an impact on the ability of community health nurses to deliver care consistent with their professional standards. Consultation with the nursing community will assist government to make decisions that optimize health in the community.

Social Determinants of Health: The social determinants of health, are the individual and collective factors and conditions affecting health status. The social determinants of health extend beyond the community health nurses practice environment and scope of influence but impact on CHN practice because of their profound influence on the health of their clients (individuals, families, groups, communities, populations and systems). Community health nurses support their clients by recognizing and identifying these factors as major influences on health status and in advocating for positive means to address these issues.

Health of Client (Individuals, Families, Groups, Communities, Populations, Systems):
Community health nurses practice in health centres, homes, schools and other community-based settings. Using a capacity building and strength-based approach, they provide, coordinate or facilitate direct care and link people to community resources. Community health nurses view health as a dynamic process of physical, mental, spiritual and social well-being. Health includes self-determination and a sense of connection to the community. The practice of community health nursing community health nurses support the health and well-being of individuals, families, groups, communities, populations and systems.

Appendix II - Literature Summary to Support Professional Practice Model – by Cheryl Cusack

Background: The final report of the World Health Organization's Commission on Social Determinants of Health described growing and avoidable health inequities and posed the challenge to improve the conditions that perpetuate inequities within one generation [31]. Specific actions highlighted as solutions within the report present an opportunity for PHNs to contribute to this important global movement. In Manitoba, PHNs work with all new families and have access to others who may be experiencing inequities through mandated communicable disease work and community relationships. These multiple access points, combined with PHN knowledge and expertise, make PHNs ideally situated to reduce inequities and to contribute to population-level health improvements.

Professional practice model: A professional practice model is an organizational tool to provide the framework and common language to articulate the PHN role. A common vision for community health nursing based on the Community Health Nurses of Canada discipline specific competencies and full scope of practice has been identified as a priority by Canadian experts [32]. A paucity of models and theories to guide PHN practice has contributed to lack of PHN role clarity. A recent review of the literature found 12 PHN conceptual models, most had not been tested or used in practice [33]. As nurses incorporate PHN specific theory and knowledge into daily practice, it will become more transparent and visible to the public and other providers [34]. The intention of this professional practice model is to clearly define the PHN Nurse IV role, so that a consistent and evidence based approach to public health nursing work is attainable in the WRHA.

A wide variety of literature was reviewed to articulate the PHN role, as well as to define a structure and process for this project. This included literature on public health and nursing practice, service delivery models, nursing leadership, and key Canadian research articles and policy documents. Though the initial task of the group was development of a service delivery model, after reviewing the literature it became evident that a professional practice model was essential, if the service delivery model was to effectively guide and support PHN practice. Components of a professional practice model include values and principles; professional relationships and partnerships; delivery structure and process; management practices; and rewards and recognition. Each component will be addressed briefly in the following sections, using a summary of current evidence.

Values and principles: Values and principles provide the foundation for a professional practice model. Values and principles are defined as the collective belief systems that guide nursing practice and nurses' decisions [8]. Registered Nurses are autonomous, self-regulated professionals governed by the College of Registered Nurses of Manitoba, the entity that ensures nurses are qualified and competent. Public health nursing is a specialized Registered Nursing role, representing the fusion of public health sciences with nursing theory and practice [11, 12, 14]. Similar to other areas of Registered Nursing practice, PHN practice is founded on professional regulatory standards set out by the College of Registered Nurses of Manitoba and the Canadian Nurses Association Code of Ethics [5, 35, 36].

Several other documents are relevant to PHN practice. The purpose of a professional discipline such as nursing is to develop, disseminate, and use knowledge [37]. Groups claiming professional status must have a social mission or goal, which is based on a distinct body of knowledge. In Canada, the knowledge that articulates the unique PHN scope and function is described within four key documents. These are the Public Health Agency of Canada Core Competencies, Canadian Public Health Associations' Roles and Activities, and the Community Health Nurses of Canada Standards of Practice, and PHN Discipline Specific Competencies [2, 11, 12]. These documents will be discussed in more detail in a subsequent section.

PHNs represent the largest group of public health practitioners. Based on documents articulating their role, PHNs should be working upstream to promote health equity, prevent chronic diseases, and improve population outcomes [2, 38, 39]. Action on the social determinants of health is foundational [2, 12, 38]. Reutter and Kushner (2010) argue that nurses promote equity by facilitating access to health as well as health care, using skills of sensitive and empowering care that appreciates the context of equities and addresses underlying conditions and root causes [40].

Professional relationships and partnerships: The second component of a professional practice model is professional relationships and partnerships. This category describes nurses beliefs, attitudes, relational skills, and interactions with clients and others within the healthcare system [8]. PHNs utilize a variety of skills to develop professional relationships with clients. Based on the voluntary nature of the PHN role, the ability to foster therapeutic relationships with complex clients is essential [41-44]. Adeline Falk-Rafael proposed a mid-range theory of empowered or critical caring, based on the development of a trusting and reciprocal relationship between the nurse and client [43, 45]. Empowerment resulted from the clients' active participation. Aspects included establishing a mutual and trusting relationship; education; developing personal skills; advocacy; and increasing client capacity. A reciprocal relationship developed in which the PHN shared her clinical expertise, and incorporated theoretical and empirical evidence into practice. The theory was rooted in equity, social justice, and feminism. PHN professional relationships with clients are based on understanding the personal, interpersonal, and socio-environmental contexts that impact and promote health [15]. Successful relationships meet client needs, attend to anxiety, and avoid imposing the PHN's agenda [46]. Disconnected relationships may occur when clients feel they are being lectured, treated paternalistically, or agency needs are prioritized [42]. Communication skills, adequate time, and an individualized holistic approach build trust [40, 41]. Nurses have knowledge about health, but the client is the expert regarding their life circumstances [40]. Organizational support for "critical caring" and PHN advocacy for social justice is essential [47].

In addition to developing relationships with clients, PHNs must have skills to work in partnership and collaboration with colleagues, other disciplines, and across sectors [48]. The importance of interprofessional collaboration to address the social determinants of health has been a global priority since the early 1990's [49, 50]. The needs of complex clients are beyond the scope of any one professional, and there is increasing appreciation that interprofessional collaboration is vital in fostering equity [50-54]. The complexities associated with poverty highlight the advantages of interprofessional collaboration in promoting and protecting health, particularly for children [55-58]. In Canada, appreciating the history of First Nations people and working collaboratively to reorient policy and practice through a process of decolonialism and revitalization of Aboriginal communities and culture is an essential component [59-61].

Delivery structure and process: The delivery structure and process in a professional practice model articulates how client care is coordinated and distributed, as well as who is responsible for client decisions. In developing a model, Wolf (2007) suggests current trends be considered that include changes in clients, changes in providers, medical advances, information technology and overall system effectiveness and efficiency [28]. Each of these areas will be discussed briefly in the sections below.

***Changes in clients*:** Health inequities in Manitoba are growing in areas of teen pregnancy, chronic diseases such as diabetes and heart disease, dental caries, childhood mortality, premature mortality and potential years of life lost, hospitalizations for tuberculosis, mental health and suicide [62]. These changes represent the growing gap between individuals, families, and communities living in poverty and others, which has resulted in disproportionate population health outcomes. Barriers are created for people in poverty, by placing the onus on the individual to navigate across complex programs and systems [63]. Simultaneously, poverty is characterized by constant stress, greater exposure to environmental toxins [64], and inadequate nutrition [65, 66]. Living situations tend to be overcrowded and unsanitary, which in conjunction with lower rates of immunization enhances the spread of communicable diseases, contributing to increased morbidity and mortality [67]. Exposure to urban crime and violence may interfere with development and contribute to anxiety, depression, aggression, and poorer academic abilities [67]. Lastly deficiencies in education programs that promote early childhood learning perpetuate inequities for children living in poverty [67].

The Commission on Social Determinants of Health advocates for "equity from the start," recognizing the potent effect that early childhood development has on future lifelong success. Children are more susceptible to environmental toxins and experiences than adults, particularly prenatally [68]. By age five there are significant differences in physical, social/emotional, and language/cognitive development based on level of income, education, and parenting [69]. Readiness for kindergarten is one method of

assessing the adequacy of early childhood experiences [70, 71]. The Early Development Instrument assesses key indicators of development that include physical, social cognitive, emotional and language skills [72]. Research using the Early Development Instrument in Manitoba and British Columbia found that close to 30% of the kindergarten population was delayed in at least one area [73]. While approximately 5% of infants had detectable developmental limitations at birth, Early Development Instrument scores ranged from 5-70% based on neighbourhood diversity. Failure to adequately support early childhood development in Canada has increased inequities and resulted in considerable numbers of children with substantive but preventable learning disabilities, mental health issues, emotional, and social disabilities [57].

Outcomes are particularly troubling for Canadian Aboriginal people; countless numbers experience poor health for their entire life, contributing to a reduced life expectancy rate that is comparable to third world countries [64]. Core areas of Canadian cities are disproportionately populated by homeless and marginalized Aboriginal people with crowded housing, low literacy, and unemployment [74]. Funding to Aboriginal people has not kept up with population growth, further increasing the gap between Aboriginal and non-Aboriginal people [75]. The population is young and growing, with 50% of Aboriginal people being less than 25 years old [64].

Rates of Aboriginal children living in poverty are particularly high [13, 76-78]. Manitoba has a higher proportion of Aboriginal people than other provinces [79] and has been named the "child poverty capital of Canada" with estimates of 43,000 affected children [80]. Poverty has been strongly correlated with low birth weight, and disproportionate infant morbidity and mortality [13, 81-83].Although Aboriginal infant mortality has declined, rates remain significantly higher than for non-Aboriginal people [13, 84]. There are also more Aboriginal children in government care today than during peak times of the residential school system [78].

The greatest concentrations of teens giving birth are in the poorest neighborhoods. Teen pregnancy is an equity issue, universal interventions have widened the gap between higher and lower socioeconomic areas. For instance teen pregnancy rates dropped 17.6% in the areas of lowest socio-economic status, compared to a decline of 48.4% in the richest areas of the WRHA, accounting for a nine-fold difference. The numbers of teen mothers in Downtown, Point Douglas and Inkster with Grade 12 education is also far below the Winnipeg average [89]. In addition, teens in these areas are up to 3 times more likely to be on antipsychotic medications, and rates of suicide and hospitalization for injury under age 19 are also far above WRHA averages [81].

In the WRHA, vastly different health outcomes exist in the lowest income areas of Downtown, Point Douglas, and Inkster [81]. The poorest neighbourhoods have rates of breastfeeding and immunization below average, but rates of dental surgery up to 11 times higher. Newborns are significantly more likely to be readmitted to hospital for respiratory illness, jaundice, and infectious/parasitic diseases. Rates of children taken into care by Child & Family Services, as well as those receiving protective or supportive services, are also highest. More can be done to support the health of women and children in the early childhood period in this province. Many women do not access prenatal care, and one out of every seven reports drinking during pregnancy; the highest rates of alcohol and tobacco use are among Aboriginal women [79]. Manitoba has the highest provincial rates of fetal and neonatal deaths [85], as well as infant deaths in the 1st year of life [86]. Rates of infant mortality are almost double national rates at 6 per 1000, compared to the national average of 3.7 [87]. Each year there are about 100 deaths in infants under 1 year of age, and 100 deaths in children ages 1 to 5 years, largely from preventable causes [79]. In children less than 5 years of age, 24% of deaths are in the lowest income quintiles [62]. Universal injury promotion programs and policies have reduced hospitalizations in higher socio-economic status groups, but rates have increased for children most at risk [88].

Advances in medical/health care: In the WRHA, PHNs have reported that a systemic trend towards earlier postpartum discharge has contributed to a more narrowed PHN role with greater focus on postpartum community based clinical care [90]. Based on WRHA postpartum standards, all mothers discharged within 48 hours of a vaginal delivery and 72 hours of a caesarean are contacted within 24 hours and offered a home visit [91]. Approximately 80% of PHN time is dedicated to postpartum work, and considerable resources have been invested to develop PHN skills and breastfeeding knowledge.

PHNs support breastfeeding and transition to parenthood through ongoing client contact. In 2007, an audit of 302 charts found an average of 6.6 PHN contacts in the initial postpartum period. Breastfeeding is a well documented health promoting strategy with numerous benefits for maternal and infant health [89]. Martens and colleagues reported that in urban Manitoba breastfeeding initiation rates in lower socio-economic areas had improved, and rates were narrowing between socio-economic groups [62]. However, in the areas of Downtown, Inkster, and Point Douglas, as well as among Aboriginal women, breastfeeding rates remain lower than provincial averages and in comparison to higher socio-economic and older mothers [62, 79, 81]. Breastfeeding rates may be positively impacted by PHNs, however it has not been documented that individual level PHN breastfeeding interventions correlates to population level improvements, and that this an effective utilization of public health human resources. In the literature, Whitehead cites examples of nurses confusing the concept of individual focused health education with health promotion [92-94]. Given the intensity and short time frame of PHN involvement with clients identified from the chart audit, it is more likely PHNs are providing individualized clinical care and education, rather than working upstream to change underlying conditions. There is increasing evidence that downstream interventions such as individual education will continue to increase inequities, and more upstream interventions such as resource provision and policy advocacy would be more effective [38, 95].

Women and children living in poverty are at risk for inequities in the postpartum period [96, 97]. Four studies were located that considered the issue of poverty immediately following the birth of a newborn [96, 98] [99] [100]. An Ontario study reported women of lower socio-economic were more likely to be discharged from hospital earlier compared to socio-economically advantaged women, often within 24 hours of birth; in addition they had poorer health status and were less likely to receive recommended levels of community-based follow-up [96]. These women reported feeling overwhelmed and having difficulties adjusting to parenting[96]. Mothers in poverty have been reported to experience the greatest effects of depression [101]; and mental health issues such as postpartum depression have been strongly linked to later childhood problems [102]. Literature advocates the importance of the nursing role in promoting health equity for vulnerable groups [103, 104].

A main government and WRHA intervention to improve family health and address inequities was implementation of the Families First home visiting program. Since 1999, a component of the PHN home visiting role has been screening all women prenatally or postpartum, and offering the Families First program for those who qualify. Families First is a targeted home visiting program aimed at reducing child maltreatment and improving outcomes for families based on identifiable risk factors [105]. Families First home visitors are paraprofessionals trained to deliver a curriculum that promotes positive parenting and a nurturing environment [106]. The program is intended to reduce the risk of child maltreatment by building on parent's strengths, reducing stress, increasing support, and being nonjudgmental [106].

A 3 year program outcome evaluation by Healthy Child Manitoba indicated that Families First was associated with improvements in health and well-being for participating children and families [107]. Regardless of whether the Families First program is accepted, the screen and survey provide PHNs with important information regarding health and social risk factors. The screen was proven effective in identifying risk factors in 77% of children who ended up in the care of Child & Family Services , while 83% without identified risks did not end up in the custody of Child & Family Services [108]. Families not screened, accounting for about 20% of the sample, were twice as likely to be linked with child services [109]. Mothers with risk factors that included low education, lack of supports, financial difficulties, and previous involvement with Child & Family Services were 3-6 times more likely to have their infant taken into care [105]. Financial issues, low levels of education, previous involvement with Child & Family Services, alcohol use during pregnancy, and lack of prenatal care were strongly associated with apprehensions [109]. Mothers with risk factors that included teen pregnancy, financial difficulties, inadequate supports, smoking, low education attainment, and an existing Child & Family Services file were 1.5 to 20 times more likely to receive Child & Family Services assistance. Interestingly, mothers reporting depression and parents with substance abuse issues were not linked with Child & Family Services [109]. Additional research can assist in understanding reasons that families decline the Families First program, as well as PHN interventions with these vulnerable families [41]. Through a qualitative research project in Inkster Community Health Area, 35 parents who declined or quit the program were interviewed to

understand their experiences[110]. A key finding pertained to the important role of the PHN in client acceptance of the program. It is equally important to understand the work of PHNs with families with risk factors that aren't involved with the Families First program, as there is limited guidance to support PHN practice.

In the literature, PHNs have been found to play a critical role in identifying family risk factors and ensuring services that promote health [111, 112]. Advocating and supporting clients to access services and resources are PHN actions that can change underlying conditions and foster health equity for vulnerable clients [113-117]. Social justice involves redistribution of resources to improve health outcomes for disadvantaged populations [118, 119]. Nurses have a role in advocating for, monitoring, and giving voice to those who are vulnerable [38]. A framework by the Canadian Nurses Association identifies "ten defining attributes." Nurses can promote equity and access to health care and other human rights; build capacity, work to reduce poverty, promote enabling environments, advocate for human rights, and develop partnerships to create change [120]. Promoting equity and social justice are key components of effective and culturally appropriate care [103, 113, 121].

Changes in providers: PHNs work in complex and bureaucratic health systems, which influence PHN services and programs [122]. In Canada, public health responsibilities are shared between federal, provincial, and regional governments, as well as Aboriginal organizations [11]. Public health services are often delivered by diverse professionals with on the job training and limited education specific to the field, resulting in varied perspectives when complex program decisions are required [123]. Following the global outbreak of Severe Acute Respiratory Syndrome (SARS), a plan to strengthen and coordinate the public health workforce was deemed necessary to prepare for future pandemics and public health emergencies, as well as to influence chronic disease prevention and health disparities [124]. In 2005, a pan-Canadian framework for public health human resources planning was released by the Public Health Agency of Canada, to support the regions in delivering population based services. Through a number of Public Health Agency of Canada funded projects to strengthen the workforce, the Community Health Nurses of Canada has played a central role in articulating the scope of PHN practice. The Community Health Nurses of Canada is a voluntary organization that represents the voice of PHNs [125]. Based on reviews of the literature and Delphi methodology with expert community health nurses, the Community Health Nurses of Canada has developed several key documents. Standards of practice were originally released in 2003; in 2011, the standards were revised for the third time and published with elements of a professional practice model. The standards exemplify "a vision for excellence" to guide all aspects of PHN practice, research, education, and management. The most recent publication describes standards in the areas of: health promotion, prevention, and maintenance; building capacity and promoting access and equity; professional relationships, accountability and responsibility [2]. The standards are broad in scope; intended for PHNs and other classifications of nurses working in community-based settings. To further define PHN practice, the Community Health Nurses of Canada released discipline specific competencies in 2009 [12]. Eight main PHN competencies were identified: public health and nursing sciences, assessment, program planning, collaboration, diversity, communication, leadership, and professional accountability. Lastly, in conjunction with the Community Health Nurses of Canada, in 2010 the Canadian Public Health Association released a document defining the roles and activities of PHN practice. All of the documents are complementary and intended to guide PHN practice.

Despite support by Canadian literature substantiating a social justice approach and being perfectly positioned [2, 11, 12], PHN skill and knowledge are under-utilized and invisible to the public, professionals, and employers [113, 126-129]. In fact, experts have cited a looming crisis due to the growing disconnect between the desired PHN practice and their daily activities, threatening the sustainability of the PHN role [2, 11, 12]. Practice is narrowing to a focus on clinical care and health education; there is an inability to practice to full scope; lack of understanding regarding the role; and PHNs are feeling devalued and powerless to promote change [90, 127-129] [32]. Incongruence in practice represents a significant theory-practice gap [113, 130]. The Community Health Nurses of Canada and Canadian Nurses Association convened experts to establish priorities for community health nursing in Canada [32]. Public need and population health were identified as levers for health system transformation based on the well-being of individuals, families, and communities. The first priority was development of a common vision for

community health nursing, based on the Community Health Nurses of Canada discipline competencies and full scope of practice [32].

System effectiveness and efficiency: The Canadian Health Human Resource Strategy is based on effective and efficient use of all providers, as well as optimizing skill mix and scopes of practice [131]. Enhancing preventative interventions and service coordination for vulnerable clients has been suggested by creating changes in funding structures and organizational culture [132]. Reports in the United Kingdom have repeatedly highlighted the importance of targeted and integrated preventative services for children in poverty [111]. Professionals may differ in approach, but each can play a role in strengthening client capacity and reducing the likelihood of harm [58, 133]. A theme in the literature is utilization of a case manager, who could be from any number of fields. Case management is an effective model in ensuring one person oversees and coordinates client care when there are multiple providers involved [134].

PHNs working to full scope and within inter-professional teams can improve health outcomes and contribute to system effectiveness and efficiency [135]. Inter-professional collaboration is an efficient approach when multiple providers are involved with the same client [136-138]. Due to the specialization among disciplines, collective decision-making produces more holistic and client-centered care [139-141]. The most tragic situations are preventable childhood deaths; yet inquests into childhood fatalities typically cite inter-professional and inter-agency collaboration as system failures [56, 142, 143]. Current structures have rigid funding and eligibility criteria; creating gaps, service duplication, and system fragmentation that are not responsive to the needs of children and families with complex health and social needs [57, 134, 144]. There tends to be a reactive focus on crises which results in episodic treatment; as opposed to services that are preventative, comprehensive, and family-centred [57]. Coordinated action and shared responsibility are believed to be essential in promoting health equity and creating population level improvements [50-54, 64, 145].

Consistent with other Canadian literature, PHNs in the WRHA reported a lack of system coordination and responsiveness to the needs of complex families [128]. PHNs reported an emphasis on promoting individual health, largely using strategies of education and health behaviour change [128]. The importance of inter-professional collaboration in addressing the social determinants of health was recognized, but PHNs reported organizational conflicts which undermined their role, created barriers to being proactive, and reinforced "the persistence of functional silos'(p.66) [128]." In earlier qualitative studies, PHNs in Manitoba reported the desire to foster population level improvements through activities such as health promotion and community development, but again cited organizational barriers to these activities [146]. In particular, early postpartum discharge polices and the need to respond to immediate medical and breastfeeding needs were identified as a new role for PHNs, and a main factor contributing to the erosion of health promotion and community development activities [90]. PHNs reported feeling powerless to change their practice, and felt that other providers did not understand their role [90].

PHNs have supported a healthcare shift to a model of primary health care, where resources are equitably distributed and clients are supported to increase control over their own health [32]. Within an integrated healthcare system, the unique goals and purpose of public health must be valued. Scutchfield & Howard (2011) argue that public health is the only agency with the "statutory and fiduciary responsibility" to create healthier communities and must be working upstream to address the social determinants of health [147]. In comparison to other healthcare services, public health is legally mandated to provide population based services [148]. The Manitoba Public Health Act states, "the minister has the authority to protect and promote the health and well-being of Manitobans." Roles for regional health authorities are described within the legislation that include health, public health emergencies, as well as information gathering and health surveillance [149].

According to Accreditation Canada, public health organizations are accountable to deliver community based services that empower and build capacity for healthy living [27]. This consists of services and activities that address root causes of health and integrate evidence-based community health promotion interventions into public health services. Organizations must be engaged in community development activities tailored to target populations, which assist in skill development and enabling people to take control over and improve their own health status. Core population health promotion strategies include

reorienting health services, developing personal skills, promoting healthy public policy, fostering supportive environments, and strengthening community action.

Freiden (2010) postulates that the greatest population level impacts would result from reorienting services to incorporate poverty reduction strategies that address socioeconomic factors and reach large segments of the population. Frieden developed the pyramid below to depict public health approaches and the corresponding population impact. In areas of communicable diseases, preventative approaches may focus on housing, nutrition, and sanitation. For non-communicable diseases, approaches may focus on access to healthy nutrition and building capacity to prevent chronic diseases. Poverty reduction approaches may reduce injury by decreasing drug use and violence, as well as exposure to extreme weather. This approach is consistent with the Commission on Social Determinants of Health recommendations to promote equity, that suggests daily living conditions could be improved by tackling the inequitable distribution of power, money, and resources [31].

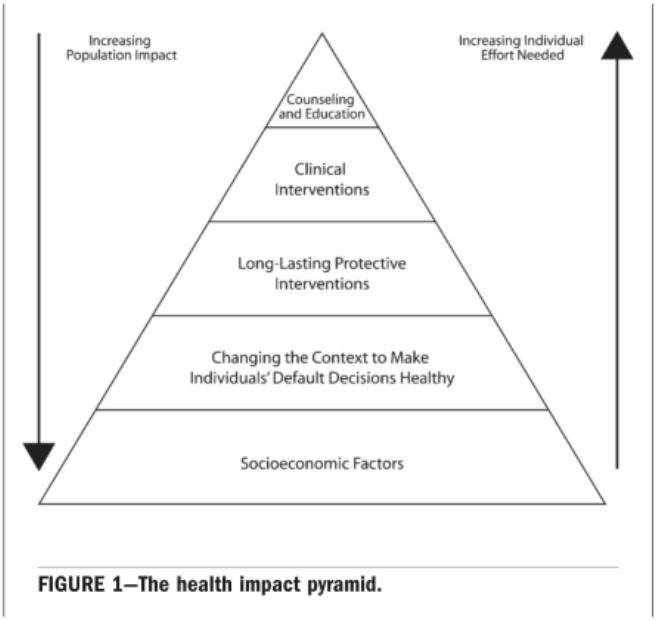


FIGURE 1—The health impact pyramid.

Information technology: The final area to consider in delivery structures is information technology, which is central to modern healthcare [150]. Information technology is a broad category consisting of systems for communication, as well as tools for collecting data, monitoring, and maintaining clinical information [29]. Information technology influences communication with clients, providers, and the public. In public health, social media is becoming an important tool for health promotion [151]. Awareness of positive and negative aspects of communication is critical.

Current client complexity reinforces the importance of regular and ongoing communication between professionals and agencies. Development of formal mechanisms for communication, such as referral systems and case conferences create routines as well as promotes collegiality and trust [134, 152, 153]. Information technology may be a barrier based on staff skill and comfort level [154]. Electronic information can reduce personal dialogue between team members and influence the quality of communication. For instance, an inquest into a death found that communication included messages and letters rather than discussion, and multiple providers had pieces of a larger puzzle. The belief was that had providers communicated directly and information been viewed in its entirety, the death may have been prevented [143]. Providers may also be reluctant to record information accessible by others [155]. Achieving team outcomes requires getting to know one another, defining common goals, and building trust [139]. There needs to be time for reflection and shared problem-solving to move towards mutual ownership[51]. Leadership and time are essential as staff address concerns such as sharing of information, and learn to understand client issues from the perspective of differing professions, while optimizing available technology [56, 136, 156, 157].

There is an abundance of technology available to guide and support PHN practice. Tenets of evidence-based public health include use of peer-reviewed sources; systematically collecting data with information systems; using program planning frameworks founded on theory; community engagement; evaluation; and knowledge translation [123]. Community health assessment data should also inform PHN practice [11]. A main benefit of information technology is program monitoring and improvement. Population based nursing necessitates that evidence-based interventions improve health outcomes for target populations [158]. However, currently no data set exists to describe PHN practice and there are no tools that measure PHNs' unique contributions to population health [159]. There is also limited research linking PHN sensitive indicators to client health outcomes [33]. Public health services must be founded on program activities that have been demonstrated to be effective, and based on data that is reliable and valid [159, 160].

Management practices:

Management practices are integral to the success of a professional practice model. Management practices refer to the structure and processes for decision-making within an organization. A recent study outlined characteristics necessary to support PHN practice in Canada [126]. Attributes in the areas of government, organization, and systems were identified. Frontline management support and organizational culture were critical in promoting and sustaining effective PHN practice. Essential components were a shared vision that was responsive to community needs and evidence based. Working to full scope was also imperative to PHNs, who highlighted the importance of fostering partnerships; community development; flexibility; and role development [126].

To achieve professional practice, all organizational leaders must understand and support a professional practice environment [9]. PHNs have reported feeling disempowered as a result of organizational influences [117]. However, development of a common framework and language has assisted managers in understanding PHN practice in countries outside of Canada [162]. Professional practice models are therefore important organization tools for managers to clarify professional role expectations [9]. While nursing tasks are easier to measure, a workplace based on technical practice is in direct opposition to a professional practice environment [9]. Poulton reported that top-down hierarchal approaches diminish PHN control and negatively influence organizational culture [163].

Professional practice models depend upon development of formal and informal organizational structures to support nursing practice and incorporate nurse's contributions. A positive professional practice environment promotes independent nursing assessment and care planning, scope of practice, and authority for decision-making [164]. Autonomous care is the ability to implement nursing interventions in accordance with professional standards that improve client care based on knowledge, competence, and professional expertise [165].

Formal structures include the adoption of participatory or transformational leadership styles, shared governance and practice councils, continuous quality improvement, action research, and reflective practice [2]. These types of governance structures embody shared decision-making between direct care staff and management; acknowledging, respecting, and trusting the unique content expertise of nurses [4]. Tinkham reported that use of a professional practice model and shared governance nursing environment promotes the "three A's of nursing care: authority, autonomy, and accountability [161]." Shared governance and other leadership styles must be founded on principles of accountability and collaboration that are clearly articulated [29].

Managers play the most important role in promoting quality PHN practice environments. The development of a healthy work environment promotes improved client outcomes and organizational performance [29]. According to the College of Registered Nurses of Manitoba, nurses are responsible for the delivery of safe and competent nursing care, and "no agency policy or professional statement can relieve individual registered nurses of the accountability for their own actions." The employer is responsible to ensure that there are policies and procedures in place to support nurses to practice autonomously. The employer is also accountable to provide orientation and professional development that assists nurses in developing and maintaining their competencies. Nursing practice must be supported to be innovative within an organizational structure that is respectful of nursing knowledge and skills [166]. While the College of Registered Nurses of Manitoba's mandate is to protect the public, the mission of the Manitoba Nurses Union is to care for nurses and promote a positive nursing culture [167]. The manager plays an essential role in creating a safe environment, and

meeting conditions of employment. The position statement on workplace safety states: "MNU takes a strong position with employers and government regarding the employers' responsibility to provide respectful workplace environments free from physical and verbal abuse, easy access to personal protective equipment, assistive devices to protect from musculoskeletal injury and appropriate policies and procedures with respect to dealing with chemicals and/or carcinogenic agents in the workplace[168].

Managers can support PHNs to accomplish health equity work. Action on the social determinants necessitates organizational approaches that prioritize populations based on the distribution of disease and positive characteristics [169, 170]. If the organization does not assume leadership in promoting equity, it is difficult for PHNs to enact change even if they have the knowledge and skill [38]. Beaudet and colleagues interviewed 69 PHNs and managers and reported PHNs were focused on clinical services and individual level behaviour modification at the detriment of population level health promotion. The population level practice was constrained by under-resourced organizational structures that prioritized clinical and curative services. PHNs were worn out by the extent of changes in health delivery and "critical of their lack of involvement in the planning and implementation of the reforms (p.E9)," resulting in few practice changes. A study in the WRHA documented the role of PHNs working with families and children living in poverty [128]. PHNs reported a "grim picture" of the effects of poverty, and expressed frustration that families experienced social exclusion due to barriers such as stigma, language, culture, and trust. These PHNs believed that the region should provide leadership in addressing poverty and suggested actions of increasing awareness, advocating for policy change, and lobbying for funding to expand programs. This suggests a need to challenge PHNs to work to the full scope of their competencies.

Managers provide support for the PHN role within the organization, as well as acknowledge PHN contributions [126]. A strength-based approach to professional practice optimizes the nurse-client relationship, and builds on what is important to individuals, teams, and systems [25]. Leadership is essential in strengthening inter-professional relationships, fostering respect, and promoting teams to function effectively. There is evidence that collaboration and satisfaction among providers improves with education and training [171]. Inter-professional collaboration benefits from organizational policies and structures that are in line with overarching program goals [116, 136, 145, 171-174]. Clearly outlined roles and responsibilities; regular reviews of protocols; and formal mechanisms for documentation of communication and assessments are important [175].

The creation of a common vision, clearly identified goals and responsibilities promotes understanding of the nursing role and enhances organizational efficiency [176]. In addition to creating efficiencies, the clear articulation of nurses roles and responsibilities optimizes collaboration and coordination of care, and assists in communicating one's role to clients and other providers [10, 177]. Managers require skill in team dynamics and facilitating communication within teams as well as across departments and organizations.[49, 137]. Leaders can promote inter-professional collaboration through team building and service coordination, but require education to develop competencies that include fostering skills in staff [58, 178, 179]. Unfortunately there is no single approach to meet the needs of all teams, and team-building activities must be specific to those involved [180]. For these reasons, leaders must value innovation and risk-taking; possess a high degree of credibility and influence; as well as possess interpersonal skills that allows them to negotiate ambiguity, tension, and turf issues [181]. Lastly, managers and the organization are accountable to maintain nursing practice through provision of adequate resources and supports [165].

Rewards and recognition: The final component of a professional practice model is rewards and recognition. To attract and retain PHNs, agencies must develop conditions which promote and sustain their competencies [126]. The PHN role is complex, and advanced preparation has been deemed essential if PHNs are to positively influence current global and societal changes [182]. Understanding the context of inequities is necessary to measure, monitor and to promote equity at individual and population levels. Organizational capacity can be developed by increasing training opportunities in areas of advocacy, intersectoral partnerships, and program evaluation from an equity perspective [183].

An integrated and coordinated healthcare system based on population based needs and health promotion has been suggested as solution to sustain Canada's healthcare system [184]. However system

transformation requires a transformation of nursing practice [25]. Clinical nurse specialists have been utilized in transforming work environments through support and mentorship, knowledge of evidence and quality, and enhancing inter-professional collaboration [185]. A clearly articulated organizational structure outlining opportunities for formal and informal recognition and rewards can promote employee motivation. Informal methods to engage staff may include reinforcement through public recognition [145]. A formal structure would be development of a theoretical perspective to link organizational goals, scope, and the outcomes of nursing practice [186]. Nurses have routinely been challenged to articulate how their practice contributes to health and societal improvements, or the healthcare contexts needed to support the work that they do [187]. Nurses are often unaware that their actions are based on a complex integration of knowledge, tradition, culture, practice norms, work environments, and experience [188]. The organization can develop a comprehensive plan for assessing, analyzing, and improving clinical and operational outcomes that are sensitive to nursing influence [165]. The identification of nursing indicators and outcomes creates nursing actions that are purposeful rather than random or based on intuition [186]. Successful organizations support nurses ongoing personal and professional growth by creating learning environments that offer and value ongoing education, certification, and career development [165].

Next Steps: In the literature, when implementing a professional practice model to create system improvements and change, organizational outcomes, structures, and processes, should be assessed [25, 26]. The following points may be considered:

Outcomes – As a result of PHN intervention, what outcomes do we want to see?

- How can those outcomes be achieved (processes)?
- What does the PHN role do (process indicators)?
- What difference will the PHN role make (outcome)?
- What outcomes should be measured? How? When?
- How will the results be used to improve services?

Structure - What structure is needed to support achievement of identified outcomes?

- What is the most effective and efficient use of the PHN role?
- How can client needs be quantified?
- What skill mix will be used for different populations?
- How will we promote consistency and seamlessness across the continuum of healthcare?
- Who should do what?
- How can staffing decisions be made?

Process – How will client care be delivered across the healthcare continuum?

- What standards will be used and how will they be developed to be current and evidence based?
- How will we work with others healthcare providers and disciplines in coordinating and providing care?
- How will client preferences and priorities be considered?

Some PPH program initiatives under development where the PPM could be incorporated include:

- Standards for PHN practice in the key service areas
- PHN home visiting
- PPH prioritization document
- PHN orientation
- HPECD database – developing indicators for PHN practice
- Organizational communication –including internal program communication as well as communication with other programs

A vision for a PHN professional practice model in the WRHA has been proposed. In the literature, a shared governance approach and participant engagement has been identified as critical in developing a practice model that reflects organizational strategic priorities and staff values [27]. The vision for this professional practice model is based on current Canadian PHN literature and has been adapted to be consistent with WRHA PPH program strategic plan and other organizational documents. The intention was to articulate the unique aspects of the PHN role within the broader Population & Public Health program structure; so that a consistent and more evidence based approach to public health nursing work is attainable in the WRHA. The process has been iterative to include feedback from all PHNs, utilizing the structure established by the nursing practice council. PHN feedback has been incorporated throughout, providing a voice for PHN input to practice. The professional practice model creates a framework and common language to clarify the PHN role.

Ideally, a professional practice model serves as an organizational foundation and tool for "assessment, planning, organizing, job description, a reward and recognition system, recruitment, staff development and research." While components are already in place or planned, multiple considerations and next steps exist to move forward. A roadmap to implement and achieve the professional practice model is necessary. It is the hope that this document will provide the basis and lens to coordinate and guide future Population & Public Health program directions and decisions that impact PHN practice.

Appendix III – Public Health Nurse Position Description

WINNIPEG REGIONAL HEALTH AUTHORITY
POSITION DESCRIPTION (Non-Management)

INCUMBENT: **DATE:June 1, 2011**

POSITION TITLE: PUBLIC HEALTH NURSE (PHN) **CLASS:** Nurse IV
UNION: MNU

DEPARTMENT: POPULATION AND PUBLIC HEALTH

SUPERVISOR'S TITLE: Team Manager

SUPERVISORY RESPONSIBILITIES: May provide day to day guidance to staff (e.g., Families First Home Visitors, Immunization Nurses) students and volunteers.

EDUCATION:

- Baccalaureate Nursing Degree is required.
- In addition, at least one of the following is preferred:
- Successful completion of a Public Health Agency of Canada's Skills Enhancement for Public Health Program content module certificate
- Canadian Community Health Nurses certification - CCHN(C)
- Successful completion of a related course at a master level (e.g., epidemiology, community development, community nursing)

EXPERIENCE

- Four years of recent, relevant experience in public health, primary care / primary health care, population-level health promotion or community development is required. Relevant experience may include:
  - Applying principles of health promotion, primary prevention, population health, primary health care, harm reduction, and community development in public health, primary care / primary health care, northern health (that includes primary care / primary health care or public health) or infection prevention and control settings
  - Family and child health
  - Promoting equity at a population level and community development with populations who experience lower health status (e.g., street-involved persons, lower income, vulnerable families)
  - Communicable disease control

OTHER:

- Demonstrated ability to assume a leadership role.
- Demonstrated ability to work independently and within a professional team.
- Demonstrated knowledge, skill, and interest in working with diverse people with a variety of backgrounds, lifestyles, abilities, health status, choices and other attributes.
- Demonstrated competency in working with community residents, community partners and agencies.
- Demonstrated competence in the areas of conflict management, problem solving, teaching and counseling and organization of activities and workload.
- Excellent interpersonal skills.
- Demonstrated ability to facilitate groups and to apply the principles of adult education.
- Excellent English oral and written communication skills.
- Proficiency in computer software applications.

For designated bilingual positions:

- Must be able to communicate in French at a predetermined linguistic level.

PHYSICAL DEMANDS AND WORKING CONDITIONS:

- Physically capable of carrying out clinical skills such as immunizations, intra-dermal injection, phlebotomy, newborn and maternal physical assessments
- Physically able to lift and carry equipment weighing up to 15 lb or 6.8 kg
- Physically capable of providing service in a wide variety of community settings under varying weather and environmental conditions
- Access to a reliable motor vehicle suitable for all environmental conditions
- Acceptable Child Abuse Registry check and Criminal Record check
- Subject to immunizations and tuberculin testing as per WRHA Policy

LICENCES, REGISTRATIONS, CERTIFICATION:

- Current College of Registered Nurses of Manitoba Registration (CRNM) required
- Possession of a valid Manitoba Class 5 Driver's License required
- Current CPR certification at the basic life support level required
- International Board Certified Lactation Consultant (IBCLC) or successful completion of Douglas College Breastfeeding Counsellor Certificate Program for Community Area positions preferred
- International Society for Travel Medicine (ISTM) Certification for Travel Health positions preferred

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MAIN FUNCTION:

The role of the PHN is to apply public health science and nursing theory to promote, protect and preserve the health of populations. Services may be directed to individuals, families, groups or communities across the life span. PHNs apply appropriate strategies to prevent injuries, chronic and communicable diseases (e.g., immunization); address environmental issues; promote reproductive and sexual health; and promote the health of perinatal women, their partners, infants and families. PHNs strive to improve the health of all people and reduce inequities among populations by addressing determinants of health and promote equitable health outcomes. PHNs provide services in communities, across communities and across the region. PHNs work collaboratively within the Population Public Health team and with colleagues in other programs, sectors and organizations. Population Public Health participates in Winnipeg Integrated Services, supporting integration across WRHA and Family Services and Consumer Affairs (FSCA).

Under the direction of a team manager PHNs respectfully work in and with diversity including sexual and gender minorities, and across all ethnicities and all cultural, spiritual, political, age, ability, family and economic circumstances. PHNs support self-determination through activities such as pregnancy counselling and by respecting client decisions such as those affecting infant feeding, male circumcision, sexual and reproductive behaviour, and immunization status. PHNs work respectfully with those who are involved in drug using, sexual and other behaviour that may be harmful to them or to others. PHNs promote empowerment and community engagement. These values are consistent with a population health approach that is rooted in an understanding of the broad determinants of health and the principles of primary health care, community development, and harm reduction. Practice is strength-based, client-centered and incorporates the strategies of motivating, enabling, advocating, co-operating and collaborating when working with individuals, communities, and colleagues both within the health system and with other sectors.

PHNs may be required to work in locations other than her/his unit/worksite/office within the Population Public Health Program site.

POSITION DUTIES AND RESPONSIBILITIES:

Major Responsibilities:
In the context of working with individuals, families, groups and communities,

1. **Public Health and Nursing Sciences: Applies key knowledge and critical thinking skills related to the public health sciences:**

    1.1. Applies knowledge about the health status of populations, inequities in health, the determinants of health and illness, principles of primary health care, strategies for health promotion, disease and injury prevention and health protection, as well as factors that influence delivery and use of health services.
    1.2. Applies knowledge about the history, structure and interaction of health care services at local, provincial/territorial, national, and international level; in particular as it relates to the Public Health Act and the role of public health staff in the context of communicable disease outbreaks and disaster situations.
    1.3. Applies public health and nursing sciences to practice by synthesizing knowledge from a broad range of theories, models and frameworks.
    1.4. Uses evidence and research to inform health policies, programs and practice by maintaining and applying evidence-informed nursing and public health theory.
    1.5. Pursues lifelong learning opportunities in the field of public health as it relates to current public health nursing practice, new and emerging issues and the changing needs of the population.

2. **Assessment & Analysis: Applies skills to assess and analyze information:**

    2.1. Recognizes when a health concern or issue exists by applying epidemiological principles, knowledge, and management/prevention skills especially with respect to injuries, chronic and communicable diseases, and environmental issues.
    2.2. Identifies relevant and appropriate sources of information, including community assets and resources.
    2.3. Collects, stores, retrieves and uses accurate and appropriate information about public health issues
    2.4. Assesses the health status and functional competence of individuals, families, groups, communities or populations within the context of their environmental and social supports across the lifespan.
    2.5. Analyzes information to determine appropriate implications, issues, gaps and limitations.
    2.6. Determines the meaning of information, considering the current ethical, political, scientific, socio-cultural and economic contexts.
    2.7. Recommends specific actions based on the analysis of information. This includes encouraging and supporting communities, families and individuals to balance choices with social responsibility to create a healthier future.

3. **3. Policy & Program Planning, Implementation and Evaluation: Plans, implements and evaluates policies, programs and/or practice in public health:**

    3.1. Describes selected policy and program options to address a specific public health issue as well as the roles and responsibilities of the PHN and Medical Officer of Health as it relates to the Public Health Act.
    3.2. Describes the implications of each option, especially as they apply to the determinants of health and recommends or decides on a course of action.
    3.3. Develops a plan to implement a course of action taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies.
    3.4. Implements a policy or program and/or takes appropriate action to address specific public health issues in communities, across communities and across the region.
    3.5. Provides care with all client levels using the nursing process: assessment, planning, implementation and evaluation, based on evidence-informed decision making, including available service delivery standards and practice guidelines.
    3.6. Collaborates with and refers to other service providers and experts as needed. Accepts and responds to referrals from service providers and community members and groups who require Public Health support and expertise.

3.7. Conducts individual physical assessments and family assessments.
3.8. Obtains clinical samples (e.g., phlebotomy, urine, bacterial and viral swabbing) in accordance with standards, clinical practice guidelines and/or delegation of function agreements as appropriate.
3.9. Immunizes, tests (e.g., TST) and provides treatments and medications in accordance with standards, and clinical practice guidelines and requirements as appropriate.
3.10. Develops therapeutic relationships with clients.
3.11. Evaluates an action, policy or program.
3.12. Sets and follows priorities, and maximizes outcomes based on available resources.
3.13. Develops a plan, implements and evaluates responses to a public health emergency or disaster.

4. Partnership, Collaboration and Advocacy: Works with others to improve the health and well being of the public through the pursuit of common goals:

4.1. Identifies and collaborates with partners in addressing public health issues.
4.2. Engages in inter-professional practice.
4.3. Builds partnerships, coalitions and networks by using community development approaches and skills such as team building, negotiation, conflict management and group facilitation.
4.4. Mediates between differing interests in the pursuit of health and well-being, and facilitates equitable access to resources.
4.5. Advocates for healthy public policies and services that promote and protect the health and well-being of individuals and communities.
4.6. Involves individuals, families, groups and communities as active partners to identify assets, strengths, and available resources and to take action to address health inequities, needs, deficits and gaps.

5. Diversity and Inclusiveness: Interacts effectively with diverse individuals, groups and communities:

5.1. Addresses population diversity when planning, implementing, adapting and evaluating public health services and policies.
5.2. Applies culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, sexual minorities, and persons of all ages, genders, health status and abilities.
5.3. Uses harm reduction approaches when appropriate.

6. Communication: Communicates effectively with individuals, families, groups, communities and colleagues:

6.1. Interprets information for professional, non-professional and community audiences.
6.2. Connects with individuals and communities by using professional and respectful communication skills, appropriate media, community resources, Health Behaviour Change concepts and contributes to social marketing projects.
6.3. Facilitates groups, makes presentations and applies the principles of adult learning in education.
6.4. Uses current technology to communicate effectively.

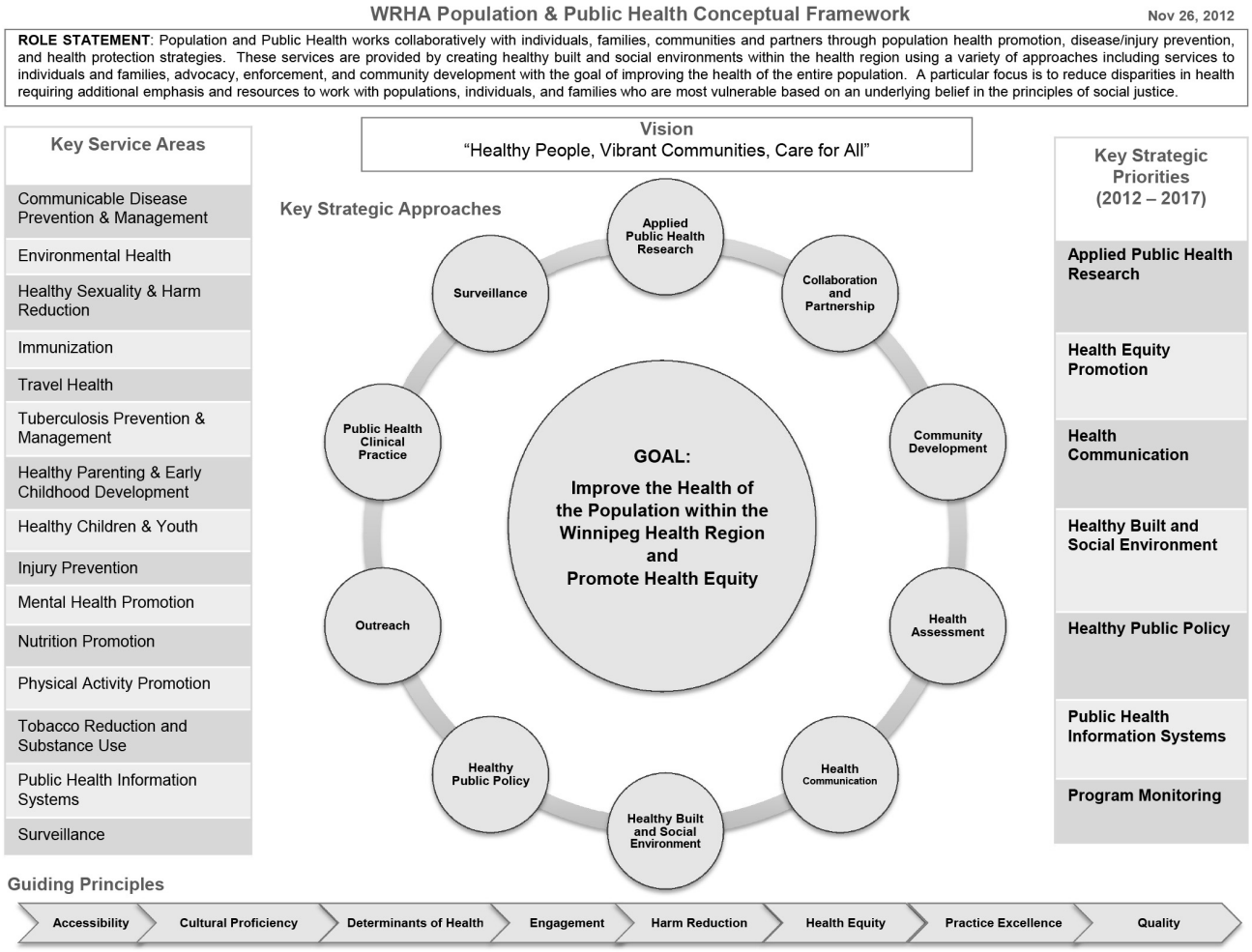
7. Leadership: Provides leadership mainly in primary and secondary prevention health services in a variety of settings:

7.1 Contributes to developing key values and a shared vision in planning and implementing public health programs and policies in the community.
7.2 Contributes proactively to the quality of the work environment by identifying needs, issues and solutions; mobilizes colleagues and actively participates in team and organizational structures and mechanisms.
7.3 Advocates for societal change in support of health for all.
7.4 Systematically evaluates the availability, acceptability, quality, efficiency, and effectiveness of public health practice.

8. **Professional Responsibility and Accountability: Builds capacity, improves performance and enhances the quality of the working environment:**

8.1 Applies the mission, vision, values and priorities of the WRHA in practice.
8.2 Uses public health ethics to manage self, others, information and resources and practice in accordance with all relevant standards, legislation and codes of ethics.
8.3 Contributes to maintaining organizational performance standards and a healthy and responsive workplace and organization.
8.4 Builds capacity by sharing knowledge, through participation in professional development and practice development activities, mentoring students, orienting new staff, providing constructive feedback to colleagues, and participating in research and quality assurance initiatives.
8.5 Completes documentation as per regional and professional standards.
8.6 Completes and submits statistical information, reports and forms according to regional policy.
8.7 Coordinates and facilitates activities of staff (e.g. Families First Home Visitors, Immunization Nurses) and volunteers.
8.8 Adheres to established policies and procedures.
8.9 Takes preventive, as well as corrective action individually or in partnership with others to protect individuals from unsafe, incompetent, or unethical circumstances.
8.10 Responsibly uses and maintains equipment and supplies.

Appendix IV - WRHA Population & Public Health Conceptual Framework



Appendix V - WRHA Position Statement on Health Equity

Health Equity Description:
Health equity asserts that all people have the opportunity to reach their full health potential and should not be disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.

The Winnipeg Regional Health Authority (WRHA) recognizes that:

- Large health gaps exist in Winnipeg due to unfair, unjust and modifiable social circumstances
- Winnipeg's health gaps are larger than many other Canadian cities
- Some health differences or "inequalities" are not modifiable such as those due to genetic or biological factors, whereas "inequitable" health gaps can be significantly reduced or eliminated
- Remediable gaps in health due to modifiable social circumstances should not be tolerated
- Health is affected by the influences of social and economic advantage and disadvantage
- Colonization has had an ongoing negative and tragic impact on all aspect of Indigenous peoples' health and wellbeing
- Culture is a determinant of health and is related to health behaviours, perceptions of illness, social supports and the extent to which people use health care services. However, culture or ethnicity alone do not cause health inequalities; rather, ethnic groups and others who experience current or historical marginalization or oppression are disproportionately affected by economic and social disadvantage which leads to health gaps
- A more equal society is healthier for everyone across the social and economic gradient including those at the top
- Since everyone's health is affected, we are all in this together

The WRHA Commitment

The WRHA is committed to changing health equity outcomes through an increased health equity focus in the services we provide, the way we conduct our planning and operations, in providing knowledge and decision-making support to others, and in real partnerships and committed relationships outside the health care sector. Specifically, we commit to:

1. **Ensure health equity considerations and actions are embedded in the provision of all health care services**
   - Health care planning and service delivery designed to eliminate inequities in health outcomes and create opportunities for individuals to reach their health potential
   - Dignity in all health care service encounters
   - Cultural proficiency and diversity
   - Collaborative practice and interprofessional education
   - Create, implement and evaluate a WRHA health equity action plan that includes clear health outcome targets
2. **Produce and translate health equity knowledge**
   - Describe, translate and communicate health equity status in the WRHA
   - Use and promote the use of best and promising practices
   - Develop and disseminate research to inform action promoting health equity
   - Set health equity targets, monitor progress towards targets and evaluate efforts

3. **Promote health equity in decision-making (governance)**
   - At the WRHA, health equity is a required consideration at the leadership level and in all WRHA organizational decision making (e.g., planning, resource allocation, human resources practices, procurement)
   - The WRHA engages with all levels of government on policies, funding and practices to influence health equity
   - The WRHA advocates with decision makers in key sectors to influence health equity
4. **Facilitate participation and partnerships to amplify health equity action within and beyond the health sector**
   - Engage with partners having similar goals to improve health equity and reduce poverty
   - Support and facilitate coordinated or complementary action
   - Amplify and support successful and promising community initiatives
   - Support community development activities and facilitate authentic public engagement
   - Listen to and involve those with lived experience

Background:

WRHA Health Equity Mission:
- To coordinate and provide equitable health services that promote optimum health and well-being for everyone, recognizing that achieving the provision of universal health care requires proportionally more effort and resources to reach out to those in most need
- To portray and call attention to the impact of social disadvantage on health
- To facilitate sustainable contributions and collaborations from many sectors
- To close the health equity gap in a generation

WRHA Health Equity Vision:
"Health for all" Everyone reaches their full health potential without barriers due to socially determined and modifiable circumstances.

WRHA Health Equity Values ("principles")
- Availability
- Accessibility
- Affordability
- Appropriateness
- Accountability
- Comprehensiveness
- Equity
- Participation
- Social Justice
- Sustainability
- Universality

Appendix VII – Additional Readings

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