June 2017 PHN Survey: Outstanding Questions Answered

In June 2017, Community Area Public Health Nurses (PHNs) were asked to complete an online survey which included the question "I still have the following outstanding question(s)". Below are those questions that were directly asked by the PHNs who participated in the survey.

The results of the survey will be summarized and shared with teams, along with the information received from the focus groups, in early 2018. To address your questions while awaiting the comprehensive evaluation report, the Clinical Nurse Specialists, Managers, Population Health Initiatives Leads and Program Director have provided the following answers. Please review the following Q and A and continue the discussion with your colleagues about the implementation of the PHN Professional Practice Model.

Q1. What equity changes can we make on the weekend, when you are out of your area, and do not know the resources?

We have reduced the number of PHNs available on the weekends to ensure resources are available during the week to emphasize activities that will improve population health outcomes. Weekend PHN practice involves reviewing incoming referrals to identify and prioritize those families who require more immediate PHN services.

Q2. Could there ever be a time whereby PHN weekend services is solely for urgent communicable disease management?

Weekend service currently supports our ability to meet the Provincial Public Health Nursing Standards (Prenatal, Postpartum and Early Childhood) in addition to responding to urgent communicable diseases.

Q3. There are empty FF spots in suburbs and we turn away families everyday in DTW, why? This is a waste of tax payer's money and vulnerable families need support.

The PPH program reallocated FFHV positions in 2015/2016 based on the number of positive parent surveys and the number of families on FFHV caseload by community area. PHN resources related to reflective supervision and case management were realigned in relation to the new FFHV EFT allocation and included in the overall PHN allocation.

FFHV allocations and PHN allocations are interrelated. We know from experience that FFHV and PHN allocations must be considered together so that supports are in place to successfully implement the model. The success of the program relies on ensuring we consider the supports of the model, including sufficient resources for lead roles and case managers, which have led to that success.

Availability of space on a FFHV's caseload is impacted by a number of factors. FFHV absences/extended leaves impact availability of spaces on a number of levels. When a vacancy occurs, other FFHVs on the team need to assume the care of existing program families thereby reducing program availability. As well, while the new FFHV is completing orientation, their caseload capacity is limited for the first 6 months. Teams that experience more FFHV turnover also experience lower caseload capacity.

Lead Roles and Team Managers can maximize program space by reviewing the monthly caseload management reports and ensuring that levelling criteria and recommended caseload weights are applied.

Q4. What happens to those that are equity and qualify for FF program but the program is full?

The Families First program can and does have a positive impact in terms of outcomes for those families who are impacted by social and structural inequity. Both the Families First Program Standards and the Manitoba PHN Standards for Prenatal, Postpartum and Early Childhood outline the importance of ongoing PHN case management for families who experience disadvantage. When there is no space available on the FFHVs caseload, the PHN should continue to support the family, and should refer the family to other supports and/or services in their community area as deemed appropriate by the family. It is recognized that all families could benefit from Families First, but like any resource there is a limit to its availability. It is important to recognize the many other valuable services that can support families in the community, including the PHN.

Note: the question above describes families who are "equity." Being intentional about our use of language is a practical way to further action health equity promotion. For more information see Language We Use To Promote Health Equity. This document, written by PPH team members, suggests choosing systems-focused language whenever possible (e.g., families who are impacted by social and structural inequity).

Q5. Why are casual PHNs no longer utilized?

The current emphasis on health system sustainability has driven the expectation that all WRHA programs and sites explore key cost drivers and identify and take action on opportunities to improve efficiency and effectiveness of services. The Population and Public Health Program (PPH) has been in a deficit and Regional direction to all sites and programs was to eliminate deficits in the 2017/18 fiscal year and ongoing. The main driver of the PPH budget is salaries. Upon exploration of opportunities to improve efficiency and effectiveness, PPH identified that in the previous fiscal year (16/17), a large number of PHN extra shifts were filled. When added together the extra shifts translated into the cost of more than two actual fulltime positions. The nature of PPH work is based upon relationships with

families and communities, and driven by their needs and priorities. This is reflected in the full scope of practice as outlined in the Professional Practice Model (PPM).

The needs of the communities and the nature of PHN practice are not well served by the practice of filling shifts, particularly when compared to the continuity of a fulltime practitioner. Prioritization within a full scope of practice as identified by the PPM necessitates a fluid approach and professional judgment, facilitated by continuity. Implementation of the Provincial Prenatal and Postpartum Public Health Nursing Standards provides more flexibility within the referral-driven components of PHN practice than the more restrictive previous standards. This should change the focus from completing tasks based on referrals, which led to a reliance on bringing in staff to complete those tasks, to the broader focus indicated by the PPM. In this sense, a consistent practitioner makes home visits in a smaller geographical area, gains knowledge about the community through this contact and applies it to their population health assessment. The purpose of the home visiting is this broader focus, beyond providing individual services.

Q6. What is truly driving this change?

The PHN Professional Practice Model was initiated, developed and implemented to support the work of PHNs in reducing inequities in population health outcomes. Numerous respected organizations (PHAC, CAN, CHNC, etc.) have articulated the role of the PHN as working with a broad focus, and at multiple levels to promote health equity and action on the social determinants of health. This articulation has informed the development of our current model. Schofield et al. (2011) describes a crisis threatening the sustainability of the PHN role, based on the rising disconnect between PHN daily activities and competency-based practice. The PHN Professional Practice Model clarifies roles, and defines PHN service delivery (Cusack et al., 2017). Promoting and supporting the role of the PHN to full scope of practice is congruent with the public health role of improving population health outcomes.

For more information see:


Cusack 2017.pdf


CHN Vision 2020.pdf

Q7. How do you rank what is most important in practice?

There are a number of things to consider in prioritizing PHN work. Generally speaking, the role of the PHN is to improve the outcomes in the health of the population, and promote equity in health between populations. Those actions that enable this are the most efficient use of the resources available.

This should be the lens that is always applied to our work (i.e., what is the public health impact of this activity?). This may involve actions in any number of strategic approaches. Our clinical care services

derive from programs with evidence based public health benefits. There are standards ('must do's') and guidelines that inform the scope of the work as well as prioritization.

Q8. How do I have time in my day to do all this?

Prioritizing and finding time in your day is challenging. There is a significant level of autonomy in PHN practice. This affords the flexibility to schedule our day to prioritize interventions to meet the needs of our clients/ communities and leverage opportunities for upstream action on the social determinants. This comes with a responsibility to assess the needs of the clients and communities you work with and seek support in building skills to manage your practice. PHNs are encouraged to consult with CNSs as their practice supports.

Q9. How well are PHN's equipped to practice with an equity lens in their daily work?

Despite momentum and increased discussion of health equity promotion across Canada, the incorporation of health equity into daily public health practice remains challenging. Public health practitioners from across the country describe barriers and limited organizational support and capacity to take effective action on the social determinants of health (NCCDH, 2014). To build capacity and learn from the experiences of others, the PPH program has led activities and team discussions in this area of public health practice since 2014. For example, the Let's Talk series was a Standing Team Agenda at team meetings to promote discussion and understanding of health equity concepts in practice. Continuous learning is part of any professional practice and we have seen a significant increase in our staff's confidence in understanding and valuing of the concept of equity [more details will be available soon from the 2017 PHN Survey.] Ongoing assessment and evaluation will give direction to next steps in how to support this positive progress.

Health equity is a core value of public health practice. The PHN position description includes requirements for education and experience in public health, population-level health promotion, primary prevention, health promotion and/or community development. It is everyone's responsibility to equip themselves and use an equity lens in their daily work.

Q10. What exactly do I do to build a connection or trust when working with an Indigenous client? How you hold yourself and speak to the client [in a way] that supports the cultural respect?

Public health nursing practice is about relationships. Relationships with Indigenous clients can be improved with an understanding of cultural safety.

Cultural safety expands the concept of cultural understanding to analyze power imbalances, institutional discrimination, colonization and colonial relationships as they apply to, and impact on, service delivery.

Cultural safety means providing services that show respect for culture and identity, incorporate a person's needs and rights, and are free of discrimination. It requires us to examine our history, policies, and processes that create a power imbalance and health and social inequities between Indigenous people and all others. Indigenous cultural safety is often seen on a continuum that includes cultural awareness, cultural sensitivity, and cultural competence.

To learn more about cultural safety register to take part in the online Manitoba Indigenous Cultural Safety Training (MICST). Visit this website to find out more:
https://wrha.mb.ca/aboriginalhealth/education/MICST.php

Q11. What's our role in schools?

PHNs are ideally situated to make a difference in the lives of children and their communities which can affect generations. The role of the PHN is to promote optimal health and development of children and youth. This can include enhancing health in the entire school community through communication, collaborations, relationships and partnerships. PHNs acknowledge the school and it's community health by assessing for strengths (what is going well) and gaps, using equity and social justice lens. This can include historical factors such as racism, adversity, or chronic diseases. This may or may not involve working directly in or with a specific school in your community.

Decisions to be involved in schools are based on your community assessment and determining if schools in your area are a priority access point for community interventions with youth in that community. For further information please refer to *Practice Guideline for PHNs Working with Children and Youth.*

Q12. Can we receive referrals for families who are at risk for apprehensions?

Yes, we should receive referrals for families who are at risk of having their child (ren) apprehended. Families who are experiencing this type of challenge are exactly the population that we want to work with to offer targeted resources to prevent negative outcomes.

A family who is involved with the child welfare system may be part of a structurally disadvantaged population. The work of the PHN with this family may include introducing resources that promote and protect health, with the aim of decreasing inequities experienced by the family. In the case of a long term apprehension, offering Families First as a program for the family would not be suitable, as working with the child is part of the curriculum requirement. This does NOT preclude the PHN from being involved with the family.

Q13. Can bili/metabolics ever be completely eliminated from PHN work?

Newborn Screening (NBS) is a public health program preventing thousands of deaths per year by detecting rare disorders early; screening must be timely. Cadham Provincial Lab requests repeats to be done through PHN services for twins at 10 days (TSH), poor specimens, <24 hours of age, and mildly elevated results. Discussions continue regarding what is best practice for the community and the health of its members since implementation of the PPM. CNSs and management are currently in the process of collaborating and building on our partnerships with CPL and primary health care providers in regards to the current practice of CPL's requests for repeat blood sampling.

The Home Phototherapy program was developed in partnership with the acute and primary care. The delivery of Home Phototherapy services is part of ongoing discussions and partnerships continue to be explored. There is awareness that the current system needs improvement. The solution requires collaboration across the system and therefore requires time to resolve.

Q14. Teams are not practicing consistently in pods across the region. This makes moving forward more challenging. What is being done to support teams with the practice change?

The evaluation of the Professional Practice Model (including data received through surveys, focus groups, HPECD database, MIS enhanced information) will provide further valuable insight into the challenges and successes that teams are experiencing. It is anticipated that once challenges and successes are more clearly identified, we will be in a position to focus support of teams and PHN practice as indicated.

PHNs are encouraged to bring any issues that they are experiencing (related to their practice) to Nursing Practice Council, and to consult with the Clinical Nurse Specialist assigned to their team who can assist in supporting practice.

Q15. How will the system be ensuring nurses are actually following the new model? I feel like there is not a lot of follow up to address when it is clear that nurses are not practicing as guidelines recommend. This creates issues amongst teams and can lead to inequitable workload. I also feel like if nurses are practicing in a vastly different fashion, it does not help the public and other professional sectors understand our role very well.

All Public Health Nurses are accountable to meet the Standards as outlined in the Provincial Public Health Nursing Standards. The Program has and is currently seeking input from PHNs and Team Managers to identify areas where we can focus and improve. The ongoing evaluation of the implementation of the Professional Practice Model provides an opportunity to identify barriers and opportunities to support consistent and flexible practice across all Community Areas.

The PPM evaluation includes Key Performance Indicators from the HPECD database. PHN service intensity to advantaged vs disadvantaged families is one of the indicators that will be reported on. Part of a change process is recognizing that people understand, engage in, and adopt change at different rates and change takes time. Sharing information from the PPM implementation evaluation about where we are at will contribute to that change process and help identify where we need to intervene further to support the envisioned system change.