CANADIAN COMMUNITY HEALTH NURSING PROFESSIONAL PRACTICE MODEL & STANDARDS OF PRACTICE

Revised January 2019

CANADIAN COMMUNITY HEALTH NURSING PROFESSIONAL PRACTICE MODEL & STANDARDS OF PRACTICE

Revised January 2019

COMMUNITY HEALTH NURSES OF CANADA

The Community Health Nurses of Canada (CHNC), established in 1987, is a national organization for community health registered nurses to support and advance practice and to improve the health of Canadians. CHNC:

- Represents the voices of and advocates for the role of community health nurses.
- Serves as a Centre of Excellence for community health nursing and advances practice excellence.
- Creates opportunities for partnerships across sectors and networks.
- Strengthens community health nursing leadership.
- Advocates for healthy public policy to address social and environmental determinants of health.
- Promotes a publicly funded, universal system for community health.

CHNC is an associate member of the Canadian Nurses Association (CNA) and is classified as a Specialty Practice Group.

CONTACT INFORMATION
Community Health Nurses of Canada
632 Hugel Avenue, Midland ON L4R 1W7
www.chnc.ca
info@chnc.ca

REVISED JANUARY 2019 ISBN 978-0-9733774-9-1

© All material in this document is the property of Community Health Nurses of Canada. Reproduction or retransmission of the materials, in whole or in part, in any manner, without the prior written consent of the copyright holder, is a violation of copyright law. A single copy may be made, solely for personal, non-commercial use.

TABLE OF CONTENTS

Acknowledgements ... 3

Foreword ... 5

The Canadian Community Health Nursing Professional Practice Model ... 6

The Canadian Community Health Nursing Standards of Practice ... 12

Introduction ... 12

Purpose of Standards of Practice ... 12

Using the Standards of Practice ... 12

Community Health Nursing Practice ... 12

Standards of Practice for Canadian Community Health Nurses ... 14

Standard 1: Health Promotion ... 15

Standard 2: Prevention and Health Protection ... 16

Standard 3: Health Maintenance, Restoration and Palliation ... 17

Standard 4: Professional Relationships ... 18

Standard 5: Capacity Building ... 20

Standard 6: Health Equity ... 22

Standard 7: Evidence Informed Practice ... 24

Standard 8: Professional Responsibility and Accountability ... 25

Appendices

Appendix A: Development of the Canadian Community Health Nursing Professional Practice Model and Visual Representation ... 27

Appendix B: Revision Process of the Standards of Practice ... 29

Appendix C: Examples of Theories and Conceptual Frameworks ... 31

Appendix D: Examples of Service Delivery Models in Community Health Nursing ... 32

Appendix E: Examples of Management Practices ... 33

Appendix F: Social and Ecological Determinants of Health Including Indigenous/Aboriginal Peoples' Determinants ... 34

Appendix G: Community Health Nursing by Area of Practice ... 36

Appendix H: Relationship of Standards/Competencies to Community Health Nurses 38
Appendix I: Glossary 39
Appendix J: Health Promotion Actions 4 49
References 50

ACKNOWLEDGEMENTS

The 2019 revised Canadian Community Health Nursing Standards of Practice (the Standards) was made possible by CHNC Board of Directors; the CHNC Standards and Competencies Standing Committee, the Standards Review Advisory Committee and several workgroups.

In 2011 the Practice Model Project Management Team and Practice Model Expert Team identified the components of and developed the Community Health Nurses of Canada (CHNC) Professional Practice Model. In 2013 the Community Health Nursing Professional Practice Model Ad Hoc Committee of the Standards and Competencies Standing Committee developed the visual. This part of the document has not been revised.

For the 2019 revisions of the Standards, CHNC would like to acknowledge the in kind research support from the Loyer-DaSilva Chair in Public Health Nursing at the University of Ottawa for the scoping review. CHNC would also like to acknowledge the in-kind support from the many members of the Standards Review Advisory Committee, several workgroups and independent reviewers for the scoping review. CHNC would like to thank the following members for their generous contribution of time and expertise to complete the revisions to the Standards.

STANDARDS REVIEW ADVISORY COMMITTEE AND WORKGROUP
Katie Dilworth (co-chair), Josephine Etowa (co-chair), Genevieve Currie, Cheryl Cusack, Audrey Danaher, Aliyah Dosani, Françoise Filion, Joyce Fox, Cheyenne Joseph, Julia Lukewich, Jo-Ann MacDonald, Cheryl Reid-Haughian, Ruth Schofield and Leeann Whitney (Round 2 Survey). A special thank you and acknowledgement of Joyce Fox (CHNC Executive Director and volunteer) who's expert guidance and countless hours coordinating and managing various aspects of the review were very much appreciated.

DELPHI SURVEY WORKGROUP
Ruth Schofield, Emily Belita, Genevieve Currie, and Marie Dietrich Leurer.

CONFERENCE CONSULTATION WORKGROUP
Ruth Schofield, Genevieve Currie, Françoise Filon, Katie Dilworth, Morag Granger, and Josephine Etowa.

SCOPING REVIEW WORKGROUP
Shannan MacNiven, Josephine Etowa, and Ruth Schofield in collaboration with Audrey Danaher, Emily Belita, Aliyah Dosani, Jo-Ann MacDonald, Katie Dilworth, and Cheyenne Joseph.

PRACTICE MODEL PROJECT MANAGEMENT TEAM (2011)
Cheryl Cusack, Patricia Seaman, and Evelyn Butler.

PRACTICE MODEL EXPERT GROUP
Catherine Butler, Benita Cohen, Cheryl Cusack, Katie Dilworth, Gillian Duff, Adeline Falk-Rafael, Joyce Fox, Heather Johnson, Myra Kreick, Marie Dietrich Leurer, Heather Lokko, Jo-Ann MacDonald, Rosemary H. McGinnis, Donna Meagher Stewart, Fred Montpetit, Marlene Nose, Moira O'Regan-Hogan, Patricia Seaman, Karen Thompson and Allyn Whyte.

COMMUNITY HEALTH NURSING PROFESSIONAL PRACTICE MODEL AD HOC COMMITTEE
Ruth Schofield, Maryann Kusmurski, Rosemary McGinnis, Katie Dilworth, Barb Kennedy, Karen Thompson, Michelle Hogan, and Françoise Filion

A special thank you to the nearly 500 dedicated community health nurses from across Canada who allowed us to “hear their voices” by attending a consultation and responding to the standards survey.

FOREWORD

This publication describes the components of the Canadian Community Health Nursing Professional Practice Model and Standards of Practice for community health nurses. Canadian community health nurses and experts from all practice areas participated in a number of consultative processes to develop the model (Appendix A) and the standards (Appendix B).

The CHNC is committed to regularly review the components of the Model and the Standards and expects to make revisions as community health and nursing knowledge develops further.

THE CANADIAN COMMUNITY HEALTH NURSING PROFESSIONAL PRACTICE MODEL

Introduction

The components of the CHNC practice model incorporate many of the concepts that were embedded in the original model that was developed in 2003.[1] Professional practice models include the structure, process and values that support nurses' control over the delivery of nursing care and the environment in which care is delivered.[2]

Components of the Practice Model

The following are the clustered categories of the component parts of the CHNC Professional Practice Model:

Client (Individuals, Families, Groups, Communities, Populations, Systems)

Community Health Nurses and Nursing Practice

- Code of Ethics
- Community Health Nurse
- Community Health Nursing Standards
- Discipline Specific Competencies
- Professional Regulatory Standards
- Theoretical Foundation
- Values and Principles

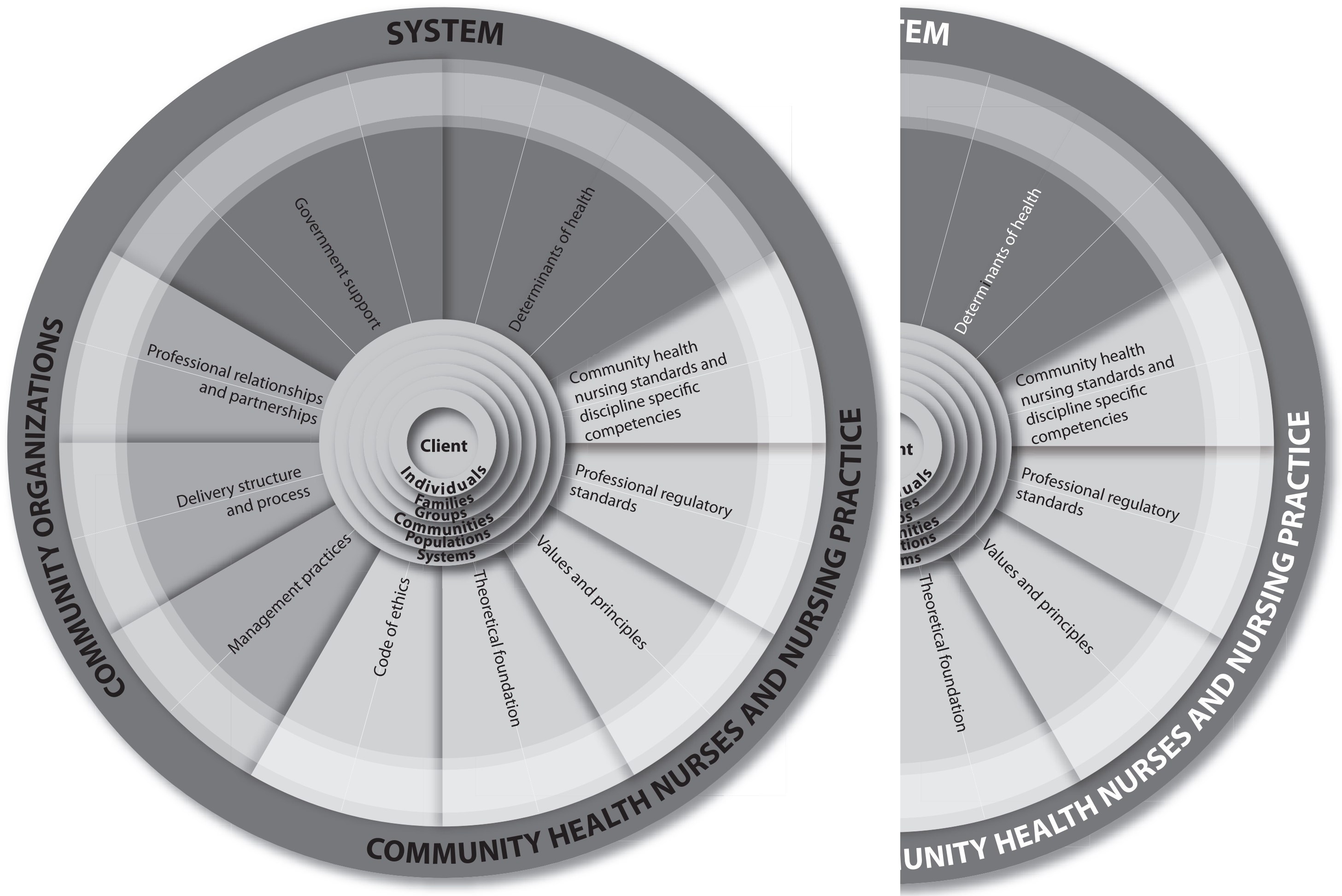
Community Organizations

- Delivery Structure and Process
- Management Practices
- Professional Relationships & Partnerships

System

- Determinants of Health
- Government Support

Figure 1. **Canadian Community Health Nursing Professional Practice Model**



The visual representation of the Canadian Community Health Nursing Professional Practice Model depicts the client as central in the model surrounded by the 3 categories of the components: community health nurses and nursing practice, community organizations and system.

Client (Individuals, Families, Groups, Communities, Populations, Systems)

Community health nurses support the health and well-being of individuals, families, groups, communities, populations and 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. They 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.

Community Health Nurses and Nursing Practice

Code of Ethics

The Code of Ethics has been developed by nurses for nurses to assist them to practice ethically and to work through ethical challenges that arise in their practice with individuals, families, groups, communities, populations and systems:

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.[3]

The Community Health Nurse

Community health nurses:

- 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[4]
- Consider and address the impact of the determinants of health within the political, cultural and environmental context on health
- Support capacity building approaches 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
- Practice with an emphasis on teamwork, collaboration, consultation and professional relationships.

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.[5,6]

Community Health Nursing Standards

Canadian Community Health Nursing Professional Practice Model and Standards of Practice

Standards define the scope and depth of practice by establishing criteria for acceptable nursing practice.[7] They represent the desirable and achievable levels of performance expected of nurses in their practice and provide criteria for measuring actual performance.[5]

Professional Practice Model & Standards of Practice

Community health nursing roles and activities continually evolve to meet the health needs of the different population groups. Service delivery is focused on preventive, curative, social and environmental aspects of care; is responsive to community needs; and takes into consideration stewardship of resources for making services efficient and effective.

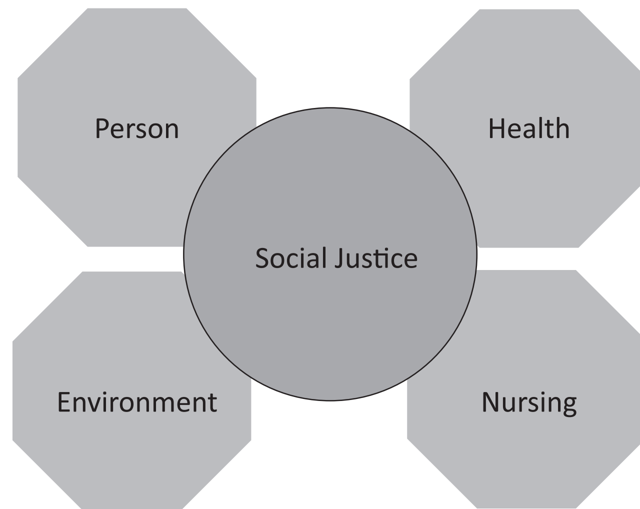
Discipline Specific Competencies

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.[8,9]

Theoretical Foundation

The practice of community health nursing combines nursing theory and knowledge (including social sciences and public health science) with home health and primary health care principles. The nursing metaparadigm includes: the person (individuals, families, communities, groups, and populations), health, nursing, environment [culture] and social justice as central to the practice of community health nursing (Figure 2[10]; Appendix C).

Figure 2. Key Aspects of Nursing Knowledge



The figure identifies the metaparadigm of the 4 concepts of nursing knowledge. Schim amended for community and public health nursing to include the central concept of social justice.[10]

Values and Principles

Values are part of a collective belief system that underpin professional practice, inform the development of educational programs and guide administration. Community health nursing is rooted in caring and social justice as reflected in public policies such as the Canada Health Act[11], the Declaration of Astana[12], the Ottawa Charter for Health Promotion[13], the Jakarta Declaration[14], the Bangkok Charter for Health Promotion[15] and the Nairobi Call to Action[16] which are consistent with the Community Health Nurses of Canada Vision Statement.[17]which are consistent with the Community Health Nurses of Canada Vision Statement.[17]

Community Organizations

Delivery Structure and Process

A variety of service delivery approaches (Appendix D) that integrate community health nursing process into practice are used. These include, but are not limited to:

- A generalist practice based on geographic location (e.g., neighbourhood nursing)
- A focused practice based on developmental stage or health issue (e.g., sexual health, postpartum, wound care, shift nursing, palliative care)
- A care process approach (e.g., team nursing, primary health care, case management or family centered care).

Management Practices

Management practices refer to the decision making structures and processes within community organizations and agencies. Effective management practices: promote the realization of autonomous practice; enable community health nurses to practice to the full scope of their abilities; and encourage community health nurses to incorporate evidence and research into their practice.

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 (Appendix E).

Professional Relationships & Partnerships

Professional relationships recognize the strengths and contributions of others and require effective communication, consultation, collaboration and partnerships with clients, team members, professionals and other organizations.

System

Determinants of Health

The determinants of health are the individual and collective factors and conditions affecting health status. The determinants of health extend beyond the community health nurse's practice environment and scope of influence. The determinants of health influence community health nursing practice because of the profound impact they have on the health of the client (individuals, families, groups, communities, populations and systems). Community health nurses support the client by advocating for change to address the determinants of health (Appendix F).

Government Support

Community health nursing in Canada is usually funded by government resources and influenced by government policies. Decisions about funded services, resources, performance standards and policies that affect community have an impact on the ability of community health nurses to deliver care. The nursing community can work with governments and advocate for decisions that optimize health in the community.

THE CANADIAN COMMUNITY HEALTH NURSING STANDARDS OF PRACTICE

Introduction

The Canadian Community Health Nursing Standards of Practice (the Standards) represent a vision for excellence in community health nursing. The Standards define the practice of a registered nurse in the specialty area of community health nursing. They build on the generic practice expectations of registered nurses and identify the practice principles and variations specific to community health nursing in Canada. The Standards apply to community health nurses who work in the areas of practice, education, administration and research.

Purpose of Standards of Practice

- Define the scope and depth of community health nursing practice
- Establish criteria and expectations for acceptable nursing practice and safe, ethical care
- Provide criteria for measuring actual performance
- Support ongoing development of community health nursing
- Promote community health nursing as a specialty and provide the foundation for certification of community health nursing by the Canadian Nurses Association and
- Inspire excellence in and commitment to community health nursing practice.

Using the Standards of Practice

- Nurses in clinical practice use the standards to guide and evaluate their practice
- Nursing educators include the standards in course curricula to prepare new graduates for practice in community settings
- Nurse administrators use the standards to direct policy and guide performance expectations
- Nurse researchers use the standards to guide the development of knowledge specific to community health nursing and
- Nurse policy advisors/advocates use the standards to guide policy recommendations.

Community Health Nursing Practice

"Community health nurses value caring, principles of primary health care, multiple ways of knowing, individual and community partnerships, empowerment, and social justice."[17]

Community health nursing acknowledges its roots and traditions, embraces advances, and recognizes the importance of the need to continually evolve as a dynamic nursing specialty[1] (Figure 3).

A new nurse entering community health practice will likely need at least two years to achieve the practice expectations of these specialty Standards. Strong mentorship, leadership and peer support, as well as self-directed and guided learning all contribute to the achievement

of the expertise required. Community health nurses practice in a variety of specialty care services and work in a variety of settings (Appendix G).

Home health nursing and public health nursing are linked historically through common beliefs, values, traditions, skills and above all their unique focus on promoting and protecting community health.

Home health nursing, public health nursing and primary care nursing differ in their client and program emphasis. Public Health Nurses,[8] Home Health Nurses[9] and Registered Nurses in primary care setting have discipline specific competencies that define the integrated knowledge, skills, and attributes required to achieve the both provincial/territorial regulatory and Canadian Community Health Nursing Standards of Practice (Appendix H).

Community health nurses view health as a dynamic process of physical, mental, spiritual and social well-being. Health includes self-determination, realization of hopes and needs, and a sense of connection to the community.[1] Community health nurses consider health as a resource for everyday life that is influenced by circumstances, beliefs and the determinants of health. The determinants of health are factors and conditions that affect health status and include social, cultural, political, economic, physical and environmental health determinants. Additional determinants of health specific to Indigenous/Aboriginal peoples have also been identified (Appendix F).

Figure 3. History of community health nursing

Evolving from centuries of community care by laywomen and members of religious orders, community health nursing started to gain recognition as a nursing specialty in the mid-1800s. Florence Nightingale and Lillian Wald as well as organizations such as the Victorian Order of Nurses, the Henry Street settlement and the Canadian Red Cross Society have permanently shaped community health nursing. During the 20th century, public health and home health nursing emerged from common roots to represent the ideals of community health nursing. Community health nursing is situated on a foundation of ethical practice and caring.[1]

A glossary of terms, which further describes relevant concepts and terms related to community health nursing practice is found in Appendix I.

Standards of Practice for Community Health Nurses

Standard 1: Health Promotion

Standard 2: Prevention and Health Protection

Standard 3: Health Maintenance, Restoration and Palliation

Standard 4: Professional Relationships

Standard 5: Capacity Building

Standard 6: Health Equity

Standard 7: Evidence Informed Practice

Standard 8: Professional Responsibility and Accountability

Standard 1: Health Promotion

Charter health promotion strategies (build healthy public policy, create supportive environments, strengthen community actions, develop personal skills and reorient health services)[13] (Appendix J). "Health promotion is the process of enabling people to increase control over, and to improve, their health."[13]

The community health nurse…

a. Applies health promotion theories and models in practice such as change theories, primary health care, population health promotion model, and social and ecological determinants of health including Aboriginal peoples."[18,19]

b. Collaborates with client to do a comprehensive, evidence informed, and strength-based holistic health assessment using multiple sources and methods to identify needs, assets, inequities and resources.

c. Seeks to identify and assess the root and historical causes of illness, disease and inequities in health, acknowledges diversity and the adverse effects of colonialism on Indigenous people, and when appropriate incorporates Indigenous ways of knowing including connectedness and reciprocity to the land and all life in health promotion.

d. Considers the determinants of health, the social and political context, and systemic structures in collaboration with the client to determine action.

e. Implements appropriate communication approaches such as social marketing and media advocacy to disseminate health information and raise awareness of health issues at individual and/or societal level.

f. Includes cultural safety and cultural humility approaches in all health promotion interventions.[20]

g. Uses a collaborative relationship with the client and other partners to facilitate and advocate for structural system change and healthy public policy using multiple health promotion strategies.

h. Evaluates and modifies health promotion activities in partnership with the client.

Standard 2: Prevention and Health Protection

Community health nurses use the socio-ecological model to integrate prevention and health protection activities into practice.[21] These actions are implemented in accordance with government legislation and nursing standards to minimize the occurrence of disease or injuries and their consequences.

The community health nurse …

a. Participates in surveillance, recognizes trends in epidemiology data, and utilizes this data through population level actions such as health education, screening, immunization, and communicable disease control and management.

b. Uses prevention and protection approaches with the client to identify risk factors and to address issues such as communicable disease, injury, chronic disease, and physical environment (e.g. air, climate, housing, work, water, land).

c. Applies the appropriate level of prevention (primordial, primary, secondary, tertiary and quaternary) [22,23] to improve client health.

d. Facilitates informed decision making with the client for protective and preventive health measures.

e. Collaborates with the client to provide emergency management including prevention/ /mitigation, preparedness, response and recovery.[24]

f. Uses harm reduction principles grounded in social justice and health equity perspectives to identify and reduce risks, and increase protective factors.

g. Includes cultural safety and cultural humility approaches in all aspects of prevention and health protection interventions.[20]

h. Engages in collaborative, interdisciplinary and intersectoral partnerships in the delivery of preventive and protective services with particular attention to populations who are marginalized.

i. Evaluates and modifies prevention and health protection activities in partnership with the client.

Standard 3: Health Maintenance, Restoration and Palliation

Community health nurses integrate health maintenance, restoration and palliation into their practice to maintain maximum function, improve health, and support life transitions including acute, chronic, or terminal illness, and end of life.

The community health nurse…

a. Holistically assesses the health status, and functional competence of the client within the context of their environment, social supports, and life transitions.

b. Supports informed decision making and co-creates mutually agreed upon plans and priorities for care with the client.

c. Uses a range of intervention strategies related to health maintenance, restoration and palliation to promote self-management of disease, maximize function, and enhance quality of life.

d. Includes cultural safety and cultural humility approaches in all aspects of health maintenance, restoration and palliation interventions.[20]

e. Facilitates maintenance of health and the healing process with the client in response to adverse health events.

f. Evaluates and modifies health maintenance, disease management, and restoration and palliation interventions in partnership with the client.

Standard 4: Professional Relationships

Community health nurses work with others to establish, build and nurture professional and therapeutic relationships. These relationships include optimizing participation, and self-determination of the client.

The community health nurse…

a. Recognizes own personal beliefs, attitudes, assumptions, feelings and values including racism and stereotypes and their potential impact on nursing practice.

b. Assesses the client's beliefs, attitudes, feelings, and values about health and the impact of these on the professional relationship and potential interventions.

c. "Acknowledges that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies" in working with Indigenous people as stated in the Truth and Reconciliation Commission of Canada: Calls to Action.[25]

d. Respects and supports the client in identifying their health priorities and making decisions to address them while being responsive to power dynamics.

e. Uses culturally safe communication strategies in professional relationships, recognizing communication may be verbal or non-verbal, written or graphic. Communication can occur via a variety of mediums.

f. Recognizes and promotes the development of the client's social support networks as an important social determinant of health.

g. Promotes awareness of, and supports linkages to, appropriate community resources that are acceptable to the client.

h. Maintains professional boundaries in therapeutic client relationships.

i. Negotiates terminating therapeutic relationships in a professional manner.

j. Builds a network of relationships and partnerships with a wide variety of individuals, families, groups, communities, and systems to address health issues and promote healthy public policy to advance health equity.

k. Incorporates the domains from the National Interprofessional Competencies framework in working with other nurses and health care team members. Domains include 1) interprofessional communication, 2) patient/client/family/community-centered-care, 3) role clarification, 4) collaborative leadership, and 6) interprofessional conflict resolution.[26]

l. Evaluates and reflects on the nurse/client and other community relationships to ensure responsive and effective nursing practice.

Standard 5: Capacity Building

Community health nurses partner with the client to promote capacity. The focus is to recognize barriers to health and to mobilize and build on existing strengths.

The community health nurse…

a. Uses an asset approach and facilitates action to support the priorities of the *Jakarta Declaration*.[14]

b. Enhances the client's ability to recognize their strengths[27] their challenges, the causal factors, and the resources available that impact their health.

c. Assists the client to make an informed decision in determining their health goals and priorities for action.

d. Uses capacity building strategies such as mutual goal setting, visioning and facilitation in planning for action.

e. Helps the client to identify and access available resources to address their health issues.

f. Supports the client to build their capacity to advocate for themselves.

g. Supports the development of an environment that enables the client to make healthy lifestyle choices, recognizing relevant cultural factors and Indigenous ways of knowing.

h. Recognizes the unique history of Indigenous people, and incorporates Indigenous ways of knowing and culturally safe engagement strategies in capacity building efforts.

i. Uses a comprehensive mix of strategies such as coalition building, inter-sectoral collaboration, community engagement and mobilization, partnerships and networking to build community capacity to take action on priority issues.

j. Supports community-based action to influence policy change in support of health.

Figure 4. The Jakarta Declaration

The Jakarta Declaration identified the following priorities:

1. Promote social responsibility for health
2. Increase investments for health development
3. Consolidate and expand partnerships for health
4. Increase community capacity and empower the individual
5. Secure an infrastructure for health promotion.[14]

k. Evaluates the impact of capacity building efforts including both process and outcomes in partnership with the client.

Standard 6: Health Equity

Community health nurses recognize the impacts of the determinants of health, and incorporate actions into their practice such as advocating for healthy public policy. The focus is to advance health equity at an individual and societal level.

The community health nurse …

a. Engages with the client using critical social theory and intersectional approach from a foundation of equity and social justice.[28,29]

b. Assesses how the social determinants of health influence the client's health status with particular attention to clients who are marginalized.

c. Understands how power structures, unique perspectives and expectations may contribute to the client's engagement with health promoting services.

d. Advocates for and with client to act for themselves.

e. Participates with community members and advocates for health in intersectoral policy development and implementation to reduce health equity gaps between populations.

f. Engages with clients who are marginalized in the coordinating and planning of care, services and programs that address their needs and perspectives on health and illness.

g. Refers, coordinates and facilitates client access to universal and equitable health promoting services that are acceptable and responsive to their needs across the life span.

h. Collaborates with community partners to coordinate and deliver comprehensive client services with the goal of reducing service gaps and fragmentation.

i. Understands historical injustices, inequitable power relations, institutionalized and interpersonal racism and their impacts on health and health care and provides culturally safe care.

j. Supports the client's right to choose alternate health care options, including "to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal

patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients" as stated in the Truth and Reconciliation Commission of Canada: Calls for Action.[25]

k. Advocates for resource allocation using a social justice lens.

l. Uses strategies such as home visits, outreach, technology and case finding to facilitate equitable access to services and health-supporting conditions for populations who are marginalized.

m. Advocates for healthy public policy and social justice by participating in legislative and policy-making activities that influence determinants of health and access to services.

n. Takes action with and for the client at the organizational, municipal, provincial, territorial and federal levels to address service gaps, inequities in health and accessibility issues.

o. Evaluates and modifies efforts to increase accessibility to health and community services, and to advance health equity.

Standard 7: Evidence Informed Practice

Community health nurses use best evidence to guide nursing practice and support clients in making informed decisions.

The community health nurse…

a. Uses professional expertise in considering best available research evidence, and other factors such as client context and preferences, and available resources to determine nursing actions.

b. Seeks out reliable sources of available evidence from nursing and other relevant disciplines.

c. Understands and uses critical appraisal skills to determine quality of research evidence.

d. Understands and uses knowledge translation strategies to integrate high quality research into clinical practice, education, and research.

e. Uses quality evidence to inform policy advocacy, development and implementation.

f. Uses a variety of information sources including acknowledging diverse perspectives and Indigenous ways of knowing.

Standard 8: Professional Responsibility and Accountability

Community health nurses demonstrate professional responsibility and accountability as a fundamental component of their autonomous practice.

The community health nurse…

a. Assesses and identifies unsafe, unethical, illegal or socially unacceptable circumstances and takes preventive or corrective action to protect the client.

b. Recognizes ethical dilemmas and applies ethical principles and CNA Code of Ethics.[3]

c. Works collaboratively in determining the best course of action when responding to ethical dilemmas.

d. Provides leadership in collaboration with the community to advocate for healthy public policy based on the foundations of health equity and social justice.

e. Identifies and acts on factors which enhance or hinder the delivery of quality care.

f. Participates in the advancement of community health nursing by mentoring students and new practitioners.

g. Participates in professional development activities and opportunities to be involved in research.

h. Identifies and works proactively (individually or by participating in relevant professional organizations) to address health and nursing issues that affect the client and/or the profession.

i. Provides constructive feedback to peers as needed to enhance community health nursing practice.

j. Documents community health nursing activities in a timely and thorough manner.

k. Advocates for effective and efficient use of community health nursing resources.

l. Uses reflective practice to continually assess, and improve personal community health nursing practice including cultural safety and cultural humility.

m. Acts upon legal obligations (applicable provincial / territorial / federal legislation) to report to relevant authorities any situations involving unsafe or unethical care.

n. Uses available resources to systematically evaluate the achievement of desired outcomes for quality improvement in community health nursing practice.[30]

APPENDIX A

Development of the Canadian Community Health Nursing Professional Practice Model and Visual Representation

Part 1: Canadian Community Health Nursing Professional Practice Model *Components*

The process to identify and describe the components of the practice model was guided by a project management team and included:

- A review of the literature[31]
- An environmental scan with a convenience sample of community health nurses at the Community Health Nurses of Canada (CHNC) 2010 Annual Conference that included practice experts and community health nurses
- Five face-to-face focus groups in Manitoba, Quebec, Ontario, New Brunswick and Nova Scotia
- Modified Delphi process to achieve consensus from an expert group of members appointed by CHNC.

The Expert Group of 20 members of CHNC represented varied community health nursing expertise and included frontline nurses, managers, consultants, directors, educators, researchers and senior decision makers. Based on the results the literature review, environmental scan and the focus groups, the consulting team developed a draft list of components of the practice model (with definitions) for an electronic survey. Using a modified Delphi approach, Expert Group members responded to two rounds of surveys. Additional feedback was obtained from the Expert Group in a series of teleconferences. The Project Management team submitted the final report to the CHNC Board of Directors.

Part 2: Canadian Community Health Nursing Professional Practice Model *Visual Representation*

In 2012 The CHNC Board approved the formation of the Community Health Nursing Professional Practice Model Ad Hoc Committee (Committee) with the Standards and Competencies Standing Committee in partnership with the Community Health Nurses Initiative Group, Ontario (CHNIG) and Community Health Nurses of Alberta (CHNAlberta) to develop a visual representation of the CHN Professional Practice Model. The Committee had 8 CHNs from across Canada with diverse community health nursing experience. The initial analysis was to organize the 12 components into clusters: Community Health Nurses and Nursing Practice (Code of Ethics, Professional Regulatory Standards, Community Health Nurse, Values and Principles, Theoretical Foundation, Discipline Specific, Competencies, Community Health Nursing Standards); Community Organization (Professional Relationships and Partnerships,

Management Practices, Delivery Structure and Process); and System (Government Support, Determinants of Health). Central to the visual representation was The Client. A professional graphic artist was consulted and the clustered components were organized in two graphic options interactive and nested concentric.

A consultation was conducted with CHNC Board, Standards and Competencies Standing Committee and Workshop attendees at the 2012 CHNC Conference. In addition an on-line national survey was completed to obtain the opinions of CHNs. In total the opinions of 250 community health nurses agreed with cluster components and preferred the nested concentric graphic to represent the Model. Furthermore the survey results indicated the four top ways that CHNs could use the Model were: provide a common framework for practice; facilitate community health nurses to be able to speak in a unified manner; facilitate narrowing of the gap between theory; practice and research; and support my professional growth and development.

APPENDIX B

Revision Process for the Canadian Community Health Nursing Standards of Practice

Methodology

The process to review, revise and update the 2011 Standards was guided by the Community Health Nurses of Canada (CHNC) Standards Review Advisory Committee (Advisory Committee) in collaboration with the Canadian Indigenous Nurses Association (CINA), the Canadian Family Practice Nurses Association (CFPNA), and the CHNC Standards and Competencies Standing Committee. The Advisory Committee is comprised of 13 members from across Canada, each association, representing varied community health nursing expertise and perspectives. There were four workgroups (Conference Consultation, Scoping Review, and Delphi Survey) completing specific tasks.

The process included:

- A scoping review of the literature[32]
- Seven focus groups using a world café format with a convenience sample of 35 community health nurses (CHNs) at the CHNC 2018 Conference, and
- A Delphi consensus process.

The purpose of the scoping review was to examine current literature relevant to each of the *Canadian Community Health Nursing Standards of Practice*[1] and to identify potential content gaps. Using the Arksey and O'Malley framework[33,] a scoping review of literature published in English was conducted in three bibliographic databases and gray literature. The search identified a total of 147 articles published between January 2012 and August 2018. Review selection and data extraction were performed by a research team consisting of seven independent reviewers using the seven current Standards as a guiding framework.

Data analysis was performed by three independent researchers using descriptive and conceptually oriented matrices as described by Miles and Huberman.[34] The development of matrices was an iterative process that involved systematically reading and judging the meaning of the text within each descriptive thematic node (i.e. each of the Standards) and determining key patterns. Data from each category and its sub-categories were lifted from its original text and plotted in a separate chart (e.g., main categories as rows and subcategories as columns). The review resulted in updates of the seven previous standards and development of one additional standard for a total of eight CHNC standards of practice.

The Conference Consultation Workgroup developed questions for the focus groups at the 2018 CHNC Conference and implemented the world café format. The world café format involved 35 conference attendees giving feedback on three different standard domains and their statements. Feedback was recorded.

Based on the scoping literature review and focus group findings, the Delphi Survey Workgroup reviewed each standard category and respective statements and revised accordingly. The Delphi Survey Workgroup led the standards review, using the modified Delphi process to achieve consensus. This process gathers the opinions of experts through a series of carefully designed questionnaires using both qualitative and quantitative methods in order to establish agreement.[35] Consensus was achieved when greater than 80% agreement was attained on each statement and at each round of the consultation. The Delph Survey Workgroup drafted the preliminary statements for Round 1. In Round 2 the preliminary standard statements were reviewed and revised by the Advisory Committee. In Round 3 a snowball sampling methodology was used, with a survey invitation sent to CHNs from across Canada involved with CHNC, CINA, and CFPNA. The invitation was distributed by email, website, and Facebook to members in each respective national professional association, provincial professional associations, and other groups of CHNs. CHNs were encouraged to complete the survey and to forward the survey invitation to other interested CHNs. There were 3 rounds and 4 reminders circulated to CHNs to encourage completion of the survey.

Results

A total of 462 CHNs participated in the modified Delphi method. There were 195 questionnaires partially completed. The results indicated a high level of agreement with each of the standards. All comments and edits were considered, consensus was achieved with over 80% agreement for each statement. The final standard statements were approved by the Advisory Committee and received by CHNC Board of Directors.

APPENDIX C

Examples of Theories and Conceptual Frameworks

Theories and conceptual frameworks that pertain to community health include, but are not limited to:

- Socio Ecological Model (Bronfenbrenner)
- Systems Theory (Von Bertalanffy, Rapoport, Boulding, Ashby and others)
- Critical Theories (critical social theory) (Habermas)
- McGill Model (Allen)
- Critical Caring (Falk-Rafael*)*
- Adult Learning Theory (Knowles)
- Integrated Model of Population Health and Health Promotion (Hamilton & Bhatti)
- Principles of Harm Reduction (Wodak)
- Health Promotion Model (Lalonde, Pender)
- Behaviour Change Theory (Prochaska & DiClemente)
- Transtheoretical (stages of change) Model (Prochaska, Redding & Evers; DiClemente)
- Theory of Planned Behaviour& Reasoned Action (Ajzen & Fishbein)
- Community Organization Theory (Lindeman)
- Community Mobilization (Minkler, Wallerstein, & Wilson)
- Multiple Interventions For Community Health Framework (Edwards)
- Social Norms Theory (Perkins & Berkowitz)
- Diffusion of Innovation Theory (Furneaux, Rogers)
- The Circle of Health 1996 Framework (Prince Edward Island)
- Transcultural Nursing Model (Leininger)
- Theory of Interpersonal Relations (Peplau)
- Ecological Theory (Bronfenbrenner)
- Theory of Human Caring (Watson)
- Social Cognitive Theory (Bandura)
- Assets and Strengths (Kretzman & McKnight)
- Communication Theory (various)
- Organizational Change (various)

APPENDIX D

Examples of Service Delivery Models Used in Community Health Nursing

Common service delivery models include, but are not limited to:

- Family Centred Care Model
- Primary Health Care
- Primary Nursing
- Participatory Model
- Collaborative Care Model
- Harm Reduction
- Nurse Family Partnership Model
- Street Health Nursing
- Calgary Case Management Framework and Service Delivery Model
- Person/Family/Client Centered Care
- Community Development

APPENDIX E

Examples of Management Practices

The following are examples of management practices that support organizations to fully realize the potential of their community health nursing resource.

- Participatory Management
- Shared Governance
- Transformational Leadership
- Nursing Practice Council
- Approach using Professional Practice Leaders (e.g. Clinical Nurse Specialist)
- Quality, Evaluation and Continuous Improvement
- Change Management Approach
- Reflective Practice
- Action Research

APPENDIX F

Social and Ecological Determinants of Health Including Indigenous/Aboriginal Peoples' Determinants

Social Determinants of Health

Determinants of health are conditions that are known to greatly influence health and include social, economic, physical and environmental health determinants and are collectively referred to as the Social Determinants of Health.[36]

Environmental Determinants of Health

Environmental determinants of health include the chemical and biological factors and physical and natural settings external to a person that are amenable to reasonable intervention.[37] Examples include, but are not limited to: ozone layer; oxygen levels; nitrogen and phosphorus cycles; fresh water and marine aquatic systems; and natural processes to detoxify waste; chemical and biological hazards; indoor and outdoor air quality; water and soil quality; occupational risks; behaviours associated with hygiene and sanitation; built environments such as housing and road conditions; noise; and man-made climate and ecosystem changes.[38,39,37] This may also be conceptualized as physical environment (natural).[40]

Indigenous/Aboriginal Peoples' Determinants of Health

Indigenous/Aboriginal peoples' determinants are generally classified as proximal, intermediate or distal. Please refer to the references specifically about Indigenous/Aboriginal Peoples' determinants of health to help visualize and understand why they are organized in this way.[41, 18]

The identification of what determines health is an evolving area. Community health nurses should seek further reading to maintain their expertise in the area of health determinants. The following are some of the most commonly recognized determinants of health (Including Indigenous/Aboriginal peoples' determinants of health) or factors that can shape a person's health.[36-48]

Recognized determinants of health:

- Income and Income Distribution/Poverty
- Education/Literacy/Education systems
- Unemployment and Job Security/Precarious Employment
- Employment and Working Conditions
- Early Childhood Development (early life)/Childhood Experiences/Healthy Child Development

- Food Insecurity
- Housing
- Physical Environment (including natural and built environments, community infrastructure, resources, and capacities)/Environmental Stewardship
- Migration/Dislocation
- Immigration
- Cultural continuity (the degree of social and cultural cohesion within a community)
- Relationships with Territory/Land
- Social Environment
- Politics/War/Conflict
- Colonization
- Biology and Genetic Endowment
- Healthy Child Development
- Social Exclusion
- Social Status
- Social Safety (Support) Networks/Social Capital
- Access to Health Services/Health Service Systems
- Personal Health Practices and Coping Skills/Healthy Behaviours
- Self-Reliance and Self-Determination
- Aboriginal/Indigenous Status
- Gender
- Culture
- Race/Racism (social stratification along racial lines with consequent hierarchical distribution of resources, power, freedom, and control)
- Having different abilities

APPENDIX G

Community Health Nursing by Area of Practice

A registered nurse working in primary care:

- this role is typically known as a *‘family practice nurse’* or *‘primary care nurse’*
- works in partnership with physicians, nurse practitioners, and other healthcare providers
- delivers a broad range of healthcare services to diverse populations, across the lifespan.
- focuses on preventative health screening, health education, comprehensive assessment, treatment of minor acute illnesses, chronic disease management, case management, system navigation, therapeutic interventions (e.g. wound care, vaccinations), and medication review
- role varies considerably across practice settings - typically depends on funding (private vs. public), scope of practice (i.e. functions that the nurse is authorized, educated, and competent to perform), and population needs and
- provides care in clinic/office setting, as well as client’s home, school, and/or workplace.

A registered nurse working in home health in the community:[1]

- combines knowledge from primary health care (including the broad determinants of health), nursing science and social sciences
- focuses on prevention, health restoration, maintenance or palliation
- focuses on clients, their designated caregivers and their families (within the context of groups, communities, populations and systems)
- focuses on client and family teaching to support clients in self-management of client diseases or to support client in disease process or palliation.
- integrates health promotion, teaching and counselling in clinical care and treatment
- initiates, manages and evaluates the resources needed for the client to reach optimal well-being and function
- often works in funded environment that requires communication and collaboration with case managers for clients service delivery and care needs and
- provides care in the client’s home, school or workplace.

A registered nurse working in public health in the community:[1,49,50]

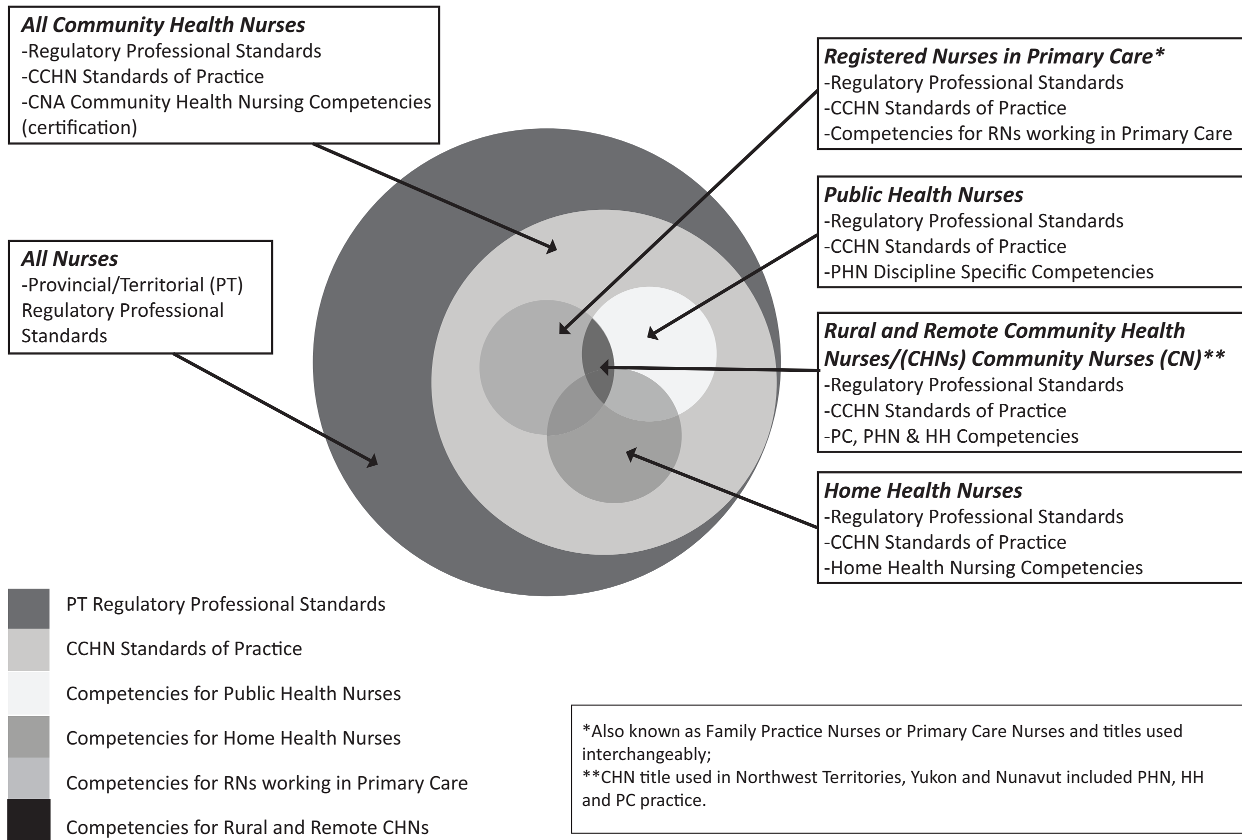
- combines knowledge and applies principles from public health science, primary health care (including the broad determinants of health), nursing science, and the social sciences
- focuses on promoting, protecting, and preserving the health of populations
- links the health and illness experiences of individuals, families, and communities to population health promotion practice
- recognizes that a community’s health is closely linked to the health of its members and implies equal rights and opportunities for individuals and

families to acquire basic prerequisites for health (i.e., peace, education, food, and income)

- recognizes that healthy communities, environments and systems that support health contribute to opportunities for health for individuals, families, groups, and populations and
- practices in increasingly diverse settings, such as community health centres, homes, schools, workplaces, street clinics, youth centres, and outposts settings, and with diverse partners, to meet the health needs of specific populations.

APPENDIX H

Relationship of Standards/Competencies to Community Health Nurses (Moyer, 2007 updated with permission 2019)



*Also known as Family Practice Nurses or Primary Care Nurses and titles used interchangeably;
**CHN title used in Northwest Territories, Yukon and Nunavut included PHN, HH and PC practice.

APPENDIX I

GLOSSARY

Aboriginal peoples

Aboriginal peoples of Canada are defined in the Constitution Act, 1982, Section 35 (2) as including the Indian, Inuit and Métis peoples of Canada.[51]

Adverse health event

An event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. There are three types of patient safety incidents: 1. harmful incident - a patient safety incident that resulted in harm to the patient (replaces "preventable adverse event"); 2. near miss - a patient safety incident that did not reach the patient and therefore no harm resulted; and 3. no-harm incident- a patient safety incident that reached the patient but no discernible harm resulted.[52]

Advocacy

"Advocacy involves engaging others, exercising your voice and mobilizing evidence to influence policy and practice. It means speaking out against inequity and inequality. It entails participating directly and indirectly in political processes and acknowledging the importance of evidence, power and politics in advancing policy options".[53]

Asset-based approach

Promotes capacity and connectedness by making visible and valuing the skills, knowledge, connections, and potential in an individual, group or community.[54]

Capacity building

A process to strengthen the abilities of an individual, an organization, a community, or a health system to take action.[55]

Care coordination

Deliberate organization of client care activities and sharing information among all of the participants concerned with a client's care to achieve safer and more effective care. This means that the client's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the client.[56]

Coalition building

Promotes and develops alliances among groups or constituencies for a common purpose. It builds links, solves problems, and/or enhances local leadership to address health concerns.[57]

Colonialism

Is a way to control land, people, culture and society. Colonialism refers to the beliefs, philosophies, and politics that one group uses to claim their superiority or dominance over another group.[58]

Colonization

An act of colonialism and begins with taking over an area and sending people to live there. Colonization continues when one group or society imposes their values or ways of life on another group in order to suppress the group. Colonized groups are expected to assimilate or adopt the colonial ways of living.[58]

Community

A group of people, who live, learn, work, and play in an environment at a given time. They share common characteristics and interests, and function within a larger social system such as an organization, region, province, or nation. The core of any community is its people, who are characterized by their age, sex, socioeconomic status, education, occupation, ethnicity and religion. A community can also be defined by its place or geopolitical boundaries.[55]

Community-based action

Is the basis of community-based participatory research (CBPR). CBPR increasingly is being recognized by health scholars and funders as a potent approach to collaboratively studying and acting to address health disparities.[59]

Community development

A process of involving a community in the identifying and strengthening those aspects of daily life, cultural life, and political life which support health. This might include support for political action to change the total environment and strengthen resources for healthy living. It could also be work that reinforces social networks and social support within a community or seeks to develop the community's material resources and economic base.[49]

Community engagement

A process involving people at various levels of participation based on interpersonal communication and trust and a common understanding and purpose. The purpose of community engagement is to inform, educate, consult, involve, and empower stakeholders and community members.[55]

Critical appraisal

Is the skill to critically appraise different types of evidence such as systematic reviews, randomized controlled trials (RCTs), qualitative research, economic evaluation studies, cohort

studies, case control studies, and diagnostic test studies. Critical appraisal skills assess internal validity, the results and the relevance to practice [60]

Critical social theory

Is the emancipation of "people from conscious or unconscious constraints... [through facilitating], by uncoerced negotiated agreement, the making of community life."[29]

Cultural humility

An approach to health care based on humble acknowledgement of oneself as a learner when it comes to understanding a person's experience. It is a life-long process of learning and being self-reflective.[61]

Cultural safety

Cultural safety within an Indigenous context as the practitioner, whether they are Indigenous or not, means the practitioner can communicate competently with a client in that client's social, political, linguistic, economic, and spiritual realm. "Cultural safety analyzes power imbalances, institutional discrimination, colonization, and colonial relationships as they apply to health care and professional education."[20]

Determinants of health

Determinants of health definable entities that cause, are associated with, or induce health outcomes. Public health is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health – not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environment. These, determinants of health, in combination, create different living conditions which impact on health[62] (Appendix D).

Diversity

Refers to the demographic characteristic of populations attributable to perceptible ethnic, linguistic, cultural, visible or social variation among groups of individuals in the general population.[62]

Emergency management

Refers to the management of emergencies concerning all hazards, including all activities and risk management measures related to prevention and mitigation, preparedness, response and recovery.[24]

End of life

There is no exact definition of end of life; however, evidence supports the following components: (1) the presence of a chronic disease(s) or symptoms or functional impairments that persist but may also fluctuate; and (2) the symptoms or impairments resulting from the underlying irreversible disease require formal (paid, professional) or informal (unpaid) care and can lead to death. Older age and frailty may be surrogates for life-threatening illness and comorbidity; however, there is insufficient evidence for understanding these variables as components of end of life.[63]

Epidemiology

Is the study of the distribution and determinants of health-related states or events (including disease), and the application of this knowledge to the control of diseases and other health problems.[64]

Evidence informed decision making

The process of distilling and disseminating the best available evidence from research, context and experience, and using that evidence in the decision making process.[65]

Health protection

Describes important public health activities, in food hygiene, water purification, environmental sanitation, drug safety and other activities that eliminate as far as possible the risk of adverse consequences to health linked to environmental hazards.[62]

Health status

Refers to health, health inequality and health inequity/health equity.

Health

The physical, spiritual, mental, emotional, environmental, social, cultural and economic wellness of the individual, family, and community.

Health inequality

Measureable differences in health between individuals, groups or communities. It is sometimes used interchangeably with the term ‘health disparities’.

Health inequity

A sub-set of health inequality and refers to differences in health associated with social disadvantages that are modifiable, and considered unfair.

Health equity

Means all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions.[54]

Healthy public policy

Is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of health public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible or easier for citizens. It makes social and physical environments health-enhancing.[66]

Indigenous peoples

Refers to anyone who traditionally occupied a territory that is threatened by colonization. It may be considered more inclusive than terms like 'Aboriginal' because it looks at common experiences rather than legal status or designation.[58]

Indigenous ways of knowing

"Indigenous knowledge comprises the complex set of technologies developed and sustained by Indigenous civilizations. Often oral and symbolic, it is transmitted through the structure of Indigenous language and passed on to the next generation through modeling, practice and animation, rather than written word."[67, 68] Indigenous knowledge is embedded in community practices, rituals, and relationships. Indigenous knowledge has 5 characteristics: personal, orally transmitted, experiential, holistic and narrative.[69]

Interdisciplinary approach

Involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities. This team, together with the client, undertakes assessment, diagnosis, intervention, goal-setting and the creation of a care plan. The client, their family and caregivers are involved in any discussions about their condition, prognosis and care plan.[70]

Interprofessional collaboration

"The process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/ families and communities to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision making, and partnerships."[71]

Intersectional approach

Uses “a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression.”[72]

Intersectoral collaboration

Refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector. Major influences that shape the health of populations and the distribution of health inequities are located outside the health sector. The fact that most of these influences lie outside of the exclusive jurisdiction of the health sector, requires the health sector to engage with other sectors of government and society to address the determinants of health and well-being.[73]

Knowledge translation

Refers to a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound use of knowledge to improve the health of Canadians, provide more effective health services and products.[74] Knowledge mobilization is a synonymous umbrella term.[75]

Life transitions

Refers to changes at the individual and family levels that occur in identities, roles, relationships, abilities, and patterns of behavior constitute transitions. Circumstances that may influence the quality of the transition experience and the consequences of transitions are meanings, expectations, level of knowledge and skill, environment, level of planning, and emotional and physical well-being.[76]

Marginalized

Refers to individuals, groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions.[65]

Mobilization

At the individual level, mobilization refers to the concrete actions taken by a person in the direction of change. At the organizational, mobilization refers to the process of rallying and propelling different segments of the organization to undertake joint action and to realize common goals.[78] At a community level, mobilization means the process of change with one or more individuals at a grassroots level to take action collectively to generate solutions to common problems and eventually involve the larger community.[55]

Palliation

Defined as patient goal directed symptom relief from a non-curative intervention, administered via human presence.[79] *Palliative care* is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[79]

Partnerships

Refers to the collaboration between individuals, groups, organizations, governments or sectors for the purpose of joint action to achieve a common goal. The concept of partnership implies that there is an informal understanding or a more formal agreement (possibly legally binding) among the parties regarding roles and responsibilities, as well as the nature of the goal and how it will be pursued.[62]

Policy development

A process of putting health issues on decision-makers' agendas. It involves having a plan to solve the problem and setting out what resources are needed. Policy development results in laws, rules, and regulations, ordinances, and policies.[57]

Population health

Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.[80]

Prevention

"An intervention or interventions that interrupts the web of causality leading to one or more aspects of ill health… It is certain that there is a web of interactions that determine the state of health, from those that are most distal to those that are most proximal. The most distal are likely to be the political context in which the determinants are operative, followed by aspects of policy (health, social, environmental), followed by the context of social as well as medical contacts in communities, followed by individual social and behavioural characteristics (such as social isolation and health behaviours), followed by physiological states such as are related to perceived stressors. When interventions are designed to prevent the occurrence of a risk state, they are known as primary prevention. In a web of determinants, several interventions might be considered "primary". Primordial prevention occurs when there is a focus on a more antecedent primary preventive strategy. The most effective prevention focuses on the weakest part of the web and not necessarily on the most proximal."[81]

Primordial prevention

Prevention of the development of clinical risk factors; for example, adoption of a healthy lifestyle can be defined as primordial prevention for cardiovascular disease;[22] or the removal of access to tobacco products and environmental tobacco smoke from public venues.[82]

Primary prevention

Reducing the impact of specific risk factors. This will lead to the reduction in incidence of disease.[82]

Secondary prevention

Aims to reduce the prevalence of disease by shortening its duration. If the disease has no cure, it may increase survival and quality of life; it will also increase the prevalence of the disease. It seldom prevents disease occurrence; it does so only when early detection of a precursor lesion leads to complete removal of all such lesions. It is a set of measures available to individuals and communities for the early detection and prompt intervention to control disease and minimize disability (e.g., by the use of screening programs). It is a core task of preventive primary health care medicine. Both early clinical detection and population-based screening usually aim at achieving secondary prevention.[83,82]

Tertiary prevention

Measures aimed at softening the impact of long-term disease and disability by eliminating or reducing impairment, disability, and handicap; minimizing suffering; and maximizing potential years or useful life. It is mainly a task of rehabilitation.[83,82]

Quaternary prevention: Quaternary prevention encompasses actions taken for identifying people at risk of medical mishaps (e.g. over-medicalization), in order to protect them from new medical invasion and to propose ethically acceptable alternatives.[23]

Primary care

Refers to services commonly access at the first point of contact with the health system.[55]

Primary health care

Is based on the new Astana Declaration on Primary Health Care that has replaced the Alma-Alta Declaration. It describes "a commitment to health and well-being for all based on

universal health coverage (UHC). UHC means that all people, including those who are marginalized or vulnerable, should have access to quality health services that put their needs at the centre, without financial hardship. PHC is the most effective, efficient and equitable approach to enhance health, making it a necessary foundation to achieve UHC. The Declaration envisions:

a. governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;
b. primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;
c. enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;
d. partners and stakeholders aligned in providing effective support to national health policies, strategies and plans."[12]

Protective factors

Represent an asset based approach. They enhance people's capacity to cope and mitigate the effects of negative events, reducing the likelihood that a disorder will result.[84]

Quality Improvement

Is the availability of robust, coherent, defensible and credible data on healthcare system performance is an essential component of any effort to improve quality. A chart book developed by Canadian Foundation for Healthcare Improvement (CFHI) takes a multifaceted approach to assessing quality and examines international, national and provincial/territorial data. It has been designed using four guiding principles – accessibility, validity, diversity of perspectives, and balance in presentation of data. They use six evaluation domains: effectiveness, access, capacity, safety, patient-centeredness and equity.[85]

Racism

Is a social construct that has been embedded in institutions for generations, and currently is defined as :"…a belief that race is the primary determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race; a doctrine or political program based on the assumption of racism and designed to execute its principle or a political or social system founded on racism (structural violence); or racial prejudice or discrimination."[86,87]

Self-management

The ability of the patient to deal with all that chronic illness entails, including symptoms, treatment, physical and social consequences.[88]

Social Justice

Is the fair distribution of society's benefits, responsibilities, and their consequence. Social justice is based on the concept of human rights and equity. It focuses on the position of one social group as compared to others, as well as the root causes of disparity and what can be done to eliminate them.[3, 62]

Socio-ecological Model

The socio-ecological model considers the complex interplay between individual, relationship, community, and societal factors. The model allows an understanding of the range of factors that put people at risk or protect them. The overlapping rings in the model illustrate how factors at one level influence factors at another level. Besides helping to clarify these factors, the model also suggests that for preventive interventions, it is necessary to act across multiple levels of the model at the same time. This approach is more likely to sustain prevention efforts over time than any single intervention.[21]

Social marketing

The design and implementation of health communication strategies intended to influence behaviour or beliefs relating to the acceptability of an idea such as desired health behaviour, or a practice such as safe food hygiene, by a target group in the population.[62]

Strength-based nursing

"An approach that considers the whole person, focuses on what is working and functioning well, what the person does best, and what resources people have available to help them deal more effectively with their life, health, and health care challenges."[27]

Surveillance

Systematic, ongoing collection, collation, and analysis of health-related information that is communicated in a timely manner to all who need to know which health problems require action in their community. Surveillance is a central feature of epidemiological practice, where it is used to control disease. Information that is used for surveillance comes from many sources, including reported cases of communicable diseases, hospital admissions, laboratory reports, cancer registries, population surveys, reports of absence from school or work, and reported causes of death.[62]

APPENDIX J

Health Promotion Actions

Health Promotion Action includes:[13]

a. Build Healthy Public Policy to ensure that policy developed by all sectors contributes to health promoting conditions (e.g., healthier choices of goods and services, equitable distribution of income).

b. Create Supportive Environments (physical, social, economic, cultural, spiritual) that recognize the rapidly changing nature of society, particularly in the areas of technology and the organization of work, and that ensure positive impacts on the health of the people. (e.g., healthier workplaces, clean air and water).

c. Strengthen Community Action so that communities have the capacity to set priorities and make decisions on issues that affect their health (e.g., healthy communities).

d. Develop Personal Skills to enable people to have the knowledge and skills to meet life's challenges and to contribute to society (e.g., life-long learning, health literacy).

e. Reorient Health Services in a health promotion direction, beyond the provision of clinical and curative services, embracing an expanded mandate which is sensitive and respects cultural needs, supports the needs of individuals and communities for a healthier life, and opens channels between the health sector and broader social, political, economic and physical environmental components.

The Ottawa Charter [13] identified the following prerequisites for health:

- Peace
- Shelter
- Education
- Food
- Income
- Stable ecosystem
- Sustainable resources
- Social justice
- Equity

REFERENCES

1. Community Health Nurses of Canada. Canadian community health nursing professional practice model & standards of practice. Community Health Nurses of Canada website. https://www.chnc.ca/en/standards-of-practice. Published March 2011. Accessed December 29, 2018.

2. Hoffart N, Woods C. Elements of the nursing professional practice model. *J Prof Nurs*. 1996; 12(6):354-364. doi: 10.1016/S8755-7223(96)80083-4.

3. Canadian Nurses Association. Code of ethics for registered nurses. Canadian Nurses Association website. https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive.pdf. Published 2017. Accessed December 29, 2018.

4. Cradduck G. Primary health care practice. In: Stewart M, ed. *Community Nursing: Promoting Canadians' H*ealth. 2nd ed. Toronto, Ontario: WB Saunders; 2000: 352-369.

5. College of Nurses of Ontario. Professional standards, revised 2002. College of Nurses of Ontario website. http://www.cno.org/globalassets/docs/prac/41006_profstds.pdf. Published 2018. Accessed December 29, 2018.

6. Canadian Nurses Association. Framework for the practice of registered nurses in Canada. Canadian Nurses Association website. https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/framework-for-the-pracice-of-registered-nurses-in-canada.pdf. Published November 2015. Accessed December 29, 2018.

7. Canadian Nurses Association. *A national framework for the development of standards for the practice of nursing: A discussion paper.* Ottawa, Ontario, Canada: Author; 1998.

8. Community Health Nurses of Canada. Public health nursing discipline specific competencies: Version 1.0. Community Health Nurses of Canada website. https://www.chnc.ca/en/competencies. Published May 2009. Accessed December 29, 2018.

9. Community Health Nurses of Canada. Home health nursing competencies: Version 1.0. Community Health Nurses of Canada website. https://www.chnc.ca/en/competencies. Published March 2010. Accessed December 29, 2018.

10. Schim SM, Benkert R, Bell SE, Walker DS, Danford CA. Social justice: Added metaparadigm concept for urban health nursing. *Public Health Nurs.* 2007; 24(1):73–80. doi: 10.1111/j.1525-1446.2006.00610.x.

11. Parliament of Canada. Canada health act. R.S., 1985, c. C-6. Parliament of Canada website. https://www.canlii.org/en/ca/laws/stat/rsc-1985-c-c-6/latest/rsc-1985-c-c-6.html. Published 1985. Updated December 6, 2018. Accessed December 29, 2018.

12. World Health Organization. Declaration of Astana. World Health Organization website. https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf. Published October 25-26, 2018. Accessed December 29, 2018.

13. World Health Organization. Ottawa charter for health promotion. World Health Organization website. https://www.who.int/healthpromotion/conferences/previous/ottawa/en/. Published November 1986. Accessed December 29, 2018.

14. World Health Organization. Jakarta declaration on leading health promotion into the 21st century. World Health Organization website. https://www.who.int/healthpromotion/conferences/previous/jakarta/declaration/en/ Published 1997. Accessed December 29, 2018.

15. World Health Organization. The Bangkok charter for health promotion in a globalized world. World Health Organization website. https://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/. Published 2005. Accessed December 29, 2018.

16. World Health Organization. Nairobi call to action. World Health Organization website. http://www.ngos4healthpromotion.net/wordpressa4hp/wp-content/uploads/2017/04/Nairobi_Call_to_Action_Nov09.pdf. Published 2009. Accessed December 29, 2018.

17. Community Health Nurses of Canada. Community health nurses of Canada vision statement & definition. Community Health Nurses of Canada website. https://www.chnc.ca/upload/membership/document/2016-07/2009englishchndefinition-visionstatement.pdf. Published 2010. Accessed December 29, 2018.

18. Reading C, Wein F. Health equity and social determinants of Aboriginal peoples' health. National Collaborating Centre for Aboriginal Health website. https://www.ccnsa-nccah.ca/docs/determinants/RPT-HealthInequalities-Reading-Wien-EN.pdf. Published 2013. Accessed December 29, 2018.

19. Canadian Public Health Association. Global change and public health: Addressing the ecological determinants of health. Canadian Public Health Association website.

https://www.cpha.ca/sites/default/files/assets/policy/edh-discussion_e.pdf. Published 2015. Accessed December 29, 2018.

20. Baba L. Cultural safety in First Nations, Inuit, Métis public health: Environmental scan of cultural competency and safety in education, training and health services. National Collaborating Centre for Aboriginal Health website. https://www.ccnsa-nccah.ca/docs/emerging/RPT-CulturalSafetyPublicHealth-Baba-EN.pdf. Published 2013. Accessed December 31, 2018.

21. Centres for Disease Control and Prevention. The social-ecological model: A framework for prevention. Centres for Disease Control and Prevention website. https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html. Published 2002. Updated February 20, 2018. Accessed December 31, 2018.

22. Chomistek AK, Chiuve SE, Eliassen AH, Mukamal KJ, Willett WC, Rimm EB. Healthy lifestyle in the primordial prevention of cardiovascular disease among young women. *JACC* .2015; *65*(1):43-51. doi: 10.1016/j.jacc.2014.10.024.

23. Tesser CD, Norman AH. Differentiating clinical care from disease prevention: A prerequisite for practicing quaternary prevention. *Cad Saude Publica.* 2016; *32*(10): e00012316. doi: 10.1590/0102-311X00012316.

24. Public Safety Canada. Emergency management planning guide 2010–2011. Public Safety Canada website. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/mrgnc-mngmnt-pnnng/index-en.aspx#section_two. Published 2011. Accessed December 29, 2018.

25. Truth and Reconciliation Commission of Canada. Truth and reconciliation Commission of Canada: Calls to action. Truth and Reconciliation Commission of Canada website. http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf. Published 2015. Accessed December 29, 2018.

26. Canadian Interprofessional Health Collaborative. A national interprofessional competency framework. Canadian Interprofessional Health Collaborative website. https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf. Published February 2010. Accessed December 29, 2018.

27. Gottlieb L. *Strengths-Based Nursing Care: Health and Healing for Person and Family*. New York, NY: Springer Publishing Company; 2013.

28. Bowleg L. The problem with the phrase women and minorities: Intersectionality-an important theoretical framework for public health. *Am J Public Health.* 2012; 102(7):1267-73. doi: 10.2105/ajph.2012.300750.

29. Ray MA. Critical theory as a framework to enhance nursing science. *Nurs Sci Q.* 1992; *5*(3):98–101. doi.org/10.1177/089431849200500302.

30. Leatherman S. Sutherland K. Quality of healthcare in Canada: A chartbook. Canadian Health Services Research Foundation website. https://www.cfhi-fcass.ca/migrated/pdf/chartbook/CHARTBOOK%20Eng_June_withdate.pdf. Published February 2010. Accessed December 29, 2018.

31. Betker C. Community health nurses of Canada: Practice model literature review. Community Health Nurses of Canada website. https://www.chnc.ca/upload/membership/document/2016-07/chnc-practice-model-literature-review-final-2-.pdf#upload/membership/document/2016-07/chnc-practice-model-literature-review-final-2-.pdf. https://www.chnc.ca/upload/membership/document/2016-07/chnc-practice-model-literature-review-final-2-.pdf - upload/membership/document/2016-07/chnc-practice-model-literature-review-final-2-.pdf. Published August, 2010. Accessed December 29, 2018.

32. MacNevin S, Etowa J, Schofield R et al. Summary of Process Undertaken to Inform Revisions to the Canadian Community Health Nursing Standards of Practice. Community Health Nurses of Canada website. https://www.chnc.ca/membership/documents/2048. Published August 2018. Accessed January 15, 2019.

33. Arksey H, O'Malley L. Scoping studies: Towards a methodological framework. *Int J Soc Res Methodol*. 2005; 8(1): 19-32. doi:10.1080/1364557032000119616.

34. Miles M, Huberman M. *An Expanded Sourcebook: Qualitative Data Analysis.* 2nd ed. Thousand Oaks, CA: Sage Publications; 1994.

35. Linstone HA, Turoff M. *The Delphi Method: Techniques and Applications*. Boston, Mass: Addison-Wesley Educational Publishers; 1975.

36. Mikkonen J, Raphael D. Social determinants of health: The Canadian facts. The Canadian Facts website. http://thecanadianfacts.org/The_Canadian_Facts.pdf. Published 2010. Accessed December 29, 2018.

37. World Health Organization. Environmental health. World Health Organization website. http://www.searo.who.int/topics/environmental_health/en/. Published 2011. Accessed December 29, 2018.

38. Canadian Nurses Association. The environment and health: An introduction for nurses. Canadian Nurses Association website. https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/environmental_health_2008_e.pdf. Published December, 2007. Accessed December 29, 2018.

39. Canadian Public Health Association. Global change and public health: Addressing the ecological determinants of health. Canadian Public Health Association website. https://www.cpha.ca/sites/default/files/assets/policy/edh-discussion_e.pdf. Published May, 2015. Accessed December 29, 2018.

40. Health Canada. What makes Canadians healthy or unhealthy? Health Canada website. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/what-makes-canadians-healthy-unhealthy.html#evidence. Published January 2013. Accessed December 29, 2018.

41. Greenwood M, de Leeuw S, Lindsay NM, Reading C. *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social.* 2nd ed. Toronto, ON: Canadian Scholars' Press; 2015.

42. Benach J, Vives A, Amable M, Vanroelen C, Tarafa G, Muntaner C. Precarious employment: Understanding an emerging social determinant of health. *Annu Rev Public Health.* 2014; 35:229-53. doi: 10.1146/annurev-publhealth-032013-182500.

43. Castañeda H, Holmes SM, Madrigal DS, Young ME, Beyeler N, Quesada J. Immigration as a social determinant of health. *Annu Rev of Public Health.* 2015; 36:375-392. doi: 10.1146/annurev-publhealth-032013-182419.

44. Martin LS, Evans DP. Conflict as a social determinant of health. *SM J Epidemiol Public Health Rev.* 2015; 1(2):1008. https://smjournals.com/public-health-epidemiology/fulltext/smjphe-v1-1008.pdf. Published 2015. Accessed January 3, 2019.

45. Martyn C. Politics as a determinant of health. *BMJ.* 2004; 329(7480):1423-1424. doi:10.1136/bmj.329.7480.1423.

46. Paradies Y, Ben J, Denson N, et al. Racism as a determinant of health: A systematic review and meta-analysis. *PLoS One*. 2015; *10*(9). doi.org/10.1371/journal.pone.0138511.

47. Pearce N, Smith GD. Is social capital the key to inequalities in health? *Am J Public Health.* 2003; 93(1): 122-129. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447706/ . Published January 2003. Accessed January 3,2019.

48. Public Health Agency of Canada. Social determinants of health and health inequalities. Public Health Agency of Canada website. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html. Published September, 2018. Accessed December 29, 2018.

49. Canadian Public Health Association. Public health ~ community health nursing practice in Canada: Roles and activities. Canadian Public Health Association website. https://www.cpha.ca/sites/default/files/assets/pubs/3-1bk04214.pdf. Published March, 2010. Accessed December 29, 2018

50. Phillip C, Schofield R. Nursing roles, functions and practice setting. In Stamler LL, Yiu L, Dosani A, Etowa J, van Daalen-Smith C. eds. *Community Health Nursing: A Canadian Perspective.* 6th ed. Toronto, Ontario, Canada: Pearson Prentice Hall; 2019.

51. Statistics Canada. Aboriginal identity of person. Statistics Canada website. http://www23.statcan.gc.ca/imdb/p3Var.pl?Function=DECI&Id=59224. Published December, 2018. Accessed December 29, 2018.

52. Canadian Patient Safety Institute. Patient safety incident. Canadian Patient Safety Institute website. http://www.patientsafetyinstitute.ca/en/Topic/Pages/Patient-Safety-Incident.aspx. Published 2018. Accessed December 29, 2018.

53. Canadian Nurses Association. Policy and advocacy. Canadian Nurses Association website. https://www.cna-aiic.ca/en/policy-advocacy. Published 2018. Accessed December 29, 2018.

54. National Collaborating Centre for Determinants of Health. Glossary of essential health equity terms. National Collaborating Centre for Determinants of Health website. http://nccdh.ca/images/uploads/comments/Glossary_EN.pdf. Published February, 2015. Accessed December 29, 2018.

55. Stamler LL, Yiu L, Dosani A, Etowa J, van Daalen-Smith C. *Community Health Nursing: A Canadian Perspective*. 6th ed. Toronto, Ontario, Canada: Pearson Prentice Hall; 2019.

56. Agency for Healthcare Research and Quality. Care coordination. Agency for Healthcare Research and Quality website. https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html. Published August, 2018. Accessed Dec. 29, 2018

57. Minnesota Department of Health Division of Community Health Services Public Health Nursing Section. Public health interventions applications for public health. Intervention: coalition building. Minnesota Department of Health Division of Community Health Services Public Health Nursing Section website. http://www.health.state.mn.us/divs/opi/cd/phn/docs/0301wheel_manual.pdf. Published March 2001. Accessed December 29, 2018.

58. Hamid-Balma S. Indigenous people: Reconciliation and healing. *BC's Mental Health and Addictions Journal Visions.* 2016.11(4). http://www.heretohelp.bc.ca/sites/default/files/visions-indigenous-people-vol11.pdf. Accessed December 29, 2018.

59. Minkler M, Blackwell AG, Thompson M, Tamir H. Community-based participatory research: Implications for public health funding. *Am J Public Health.* 2003; 93(8): 1210-1213. doi: 10.2105/ajph.93.8.1210.

60. Public Health Resource Unit. The critical skills appraisal programme: Making sense of evidence. Public Health Resource Unit website. http://www.casp-uk.net/. Published 2006. Accessed December 9, 2018.

61. Ward C, Branch C, Fridkin A. "What is Indigenous cultural safety—and why should I care about it?" *BC's Mental Health and Addictions Journal Visions*. 2016. 11(4). http://www.heretohelp.bc.ca/sites/default/files/visions-indigenous-people-vol11.pdf. Accessed December 29, 2018.

62. Health Canada. Glossary of terms. Health Canada website. https://www.canada.ca/en/public-health/services/public-health-practice/skills-online/glossary-terms.html. Published 2017. Accessed December 29, 2018.

63. Registered Nurses Association of Ontario. End-of-life care during the last days and hours. https://rnao.ca/sites/rnao-ca/files/End-of Life_Care_During_the_Last_Days_and_Hours_0.pdf. Published 2011. Accessed December 31, 2018.

64. World Health Organization. Health topics: Epidemiology. World Health Organization website. http://www.who.int/topics/epidemiology/en/. Published 2018. Accessed December 31, 2018.

65. National Collaborating Centre for Methods and Tools. Evidence-informed decision making. National Collaborating Centre for Methods and Tools website. http://www.nccmt.ca/uploads/media/media/0001/01/4504c27e14836059b8fd3ce3b3eaac2ed2ce6ed6.pdf. Published 2018. Accessed December 31, 2018.

66. World Health Organization. Adelaide recommendations on healthy public policy. World Health Organization website. https://www.who.int/healthpromotion/conferences/previous/adelaide/en/index1.html. Published April 1988. Accessed December 31, 2018.

67. Battiste M. Indigenous knowledge and pedagogy in First Nations education a literature review with recommendations. https://www.afn.ca/uploads/files/education/24._2002_oct_marie_battiste_indigenousknowledgeandpedagogy_lit_review_for_min_working_group.pdf. Published 2002. Accessed December 31, 2018.

68. Restoule JP. Indigenous education: Indigenous ways of knowing. University of Toronto, Ontario Institute for Studies in Education website. https://www.oise.utoronto.ca/abed101/indigenous-ways-of-knowing/. Published December 2018. Accessed December 31, 2018.

69. Castellano MB. Updating Aboriginal traditions of knowledge. In Sefa Dei GJ, Hall BL, Rosenberg DG. ed. *Indigenous Knowledges in Global Contexts: Multiple Readings of Our World* . Toronto Ontario, Canada: University Press; 2000: 21-36.

70. Victoria State Government, Department of Health & Human Services. An interdisciplinary approach to caring. Victoria State Government, Department of Health and Human Services website. https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/resources/improving-access/ia-interdisciplinary. Published 2015. Accessed December 31, 2018.

71. Canadian Interprofessional Health Collaborative. A national interprofessional competency framework. Canadian Interprofessional Health Collaborative website. https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf. Published 2010. Accessed December 31, 2018.

72. Bowleg L. The problem with the phrase women and minorities: Intersectionality-an important theoretical framework for public health. *Am J Public Health.* 2012; 102(7):1267-73. doi: 10.2105/ajph.2012.300750.

73. Barr V, Pedersen S, Pennock M, Rootman I. Health equity through intersectoral action: An analysis of 18 country case studies. World Health Organization website. https://www.who.int/social_determinants/resources/health_equity_isa_2008_en.pdf?ua=1 . Published 2008. Accessed December 31, 2018.

74. Canadian Institute of Health Research. Hacking the knowledge gap in health research. Canadian Institute of Health Research website. http://www.cihr-irsc.gc.ca/e/49872.html. Updated 2018. Accessed December 31, 2018.

75. Social Sciences and Humanities Research Council. What is knowledge mobilization? Social Sciences and Humanities Research Council website. http://www.sshrc-crsh.gc.ca/funding-financement/policies-politiques/knowledge_mobilisation-mobilisation_des_connaissances-eng.aspx#a1. Updated June 2018. Accessed December 31, 2018.

76. Schumacher K, Meleis AI. Transitions: A central concept in nursing. *J Nurs Scholarsh.* 1994;26(2): 119-127. doi.org/10.1111/j.1547-5069.1994.tb00929.x.

77. Community Health Nurses of Canada. (2015). Leadership competencies for public health practice in Canada: Leadership competency statements release 1.0. Community Health Nurses of Canada website. https://www.chnc.ca/en/competencies. Published June 2015. Accessed December 31, 2018.

78. Applequist H, Daly BJ. Palliation: A concept analysis. *Res Theory Nurs Pract*. 2015; 29(4): 297-305. doi: 10.1111/j.1744-6198.2009.00121.x.

79. World Health Organization. WHO definition of palliative care. World Health Organization website. http://www.who.int/cancer/palliative/definition/en/. Published Accessed December 31, 2018.

80. Public Health Agency of Canada. What is population health approach? Public Health Agency of Canada website. https://www.canada.ca/en/public-health/services/health-promotion/population-health/population-health-approach.html#What. Updated February 2012. Accessed December 31, 2018.

81. Starfield B. Basic concepts in population health and health care. *J Epidemiol Community Health*. 2001; *55*(7): 452-454. doi: 10.1136/jech.55.7.452.

82. Vollman AR, Anderson ET, McFarlane J. *Canadian Community as Partner: Theory and Multidisciplinary Practice.* 4th ed. Philadelphia, PA: Wolters Kluwer; 2017.

83. Porta M. *A Dictionary of Epidemiology.* 6th ed. New York, NY: Oxford University Press; 2014.

84. National Collaborating Centre for Determinants of Health. Foundations: Definitions and concepts to frame population mental health promotion for children and youth. National Collaborating Centres for Public Health website. http://nccph.ca/images/uploads/general/02_Foundations_MentalHealth_NCCPH_2017_EN.pdf. Published 2017. Accessed December 31, 2018.

85. Leatherman S, Sutherland K. Quality of healthcare in Canada: A chartbook. Canadian Health Services Research Foundation website. https://www.cfhi-fcass.ca/migrated/pdf/chartbook/CHARTBOOK%20Eng_June_withdate.pdf. Published 2010. Accessed December 31, 2018.

86. Merriam Webster Dictionary. Racism. Merriam Webster Dictionary website. https://www.merriam-webster.com/dictionary/racism. Accessed December 31, 2018.

87. Canadian Public Health Association. Racism and public health. Canadian Public Health Association website. https://www.cpha.ca/racism-and-public-health. Published December 2018. Accessed December 31, 2018.

88. Bodenheimer T, MacGregor K, Sharifi C. Helping patients manage their chronic conditions. California Healthcare Foundation website. https://www.chcf.org/wp-content/uploads/2017/12/PDF-HelpingPatientsManageTheirChronicConditions.pdf. Published June 2005. Accessed December 31, 2018.