

## **Improving Health Equity in Peterborough**

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# IMPROVING HEALTH EQUITY IN PETERBOROUGH

## INFORMING THE 2023-2026 360 NPLC STRATEGIC PLAN

### Strengths, Weaknesses, Opportunities and Threats (SWOT) ANALYSIS

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**Abstract:** This report assesses the organizational activities and strategic partnerships of the Peterborough 360 Degree Nurse Practitioner-Led Clinic (NPLC). The clinic operates to reduce barriers to social determinants of health and primary healthcare for marginalized populations. The research includes a literature review on the contextual factors that shape the NPLC's work, followed by two analyses of the strengths and weaknesses of, opportunities for, and threats to the clinic based on pre-existing NPLC data and interviews with NPLC partners. The findings highlight the clinic's success in providing inclusive low-barrier health care, and responsiveness to community needs. Research also suggests prevalent challenges such as staff burnout and top-down models of partnerships, as well as external threats such as institutional boundaries, asymmetrical power dynamics within the Ontario Health Teams, general underfunding of health care, and attitudes of prejudice and stigma. The research suggests opportunities for specialized employment outreach strategies, prioritizing bottom-up partnership-centered approaches to care, advocating for increased funding, and the development of digital tools to increase work hour flexibility. The research also emphasizes the need for increased presence of Indigenous-led healthcare approaches and partnerships. Overall, the research aims to inform the NPLC's next strategic plan.

**Key Words:** Nurse Practitioner-Led Clinic, SWOT analysis, health equity, strategic planning, strategic partnerships, network model of care, Ontario Health Teams, bottom-up networking

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## **Executive Summary**

The Peterborough 360 Degree Nurse Practitioner-Led Clinic (NPLC) operates to reduce barriers to social determinants of health and primary health care for marginalized populations in Peterborough. The clinic's 2019-2022 strategic plan is made up of four strategic goals (Equity & Inclusion, Enhanced Services & Access, Workplace Wellness, Improve System Integration). The purpose of this research is to examine the strengths, weaknesses, opportunities of, and threats to, the NPLC's operational activities and institutional partnerships with a view to inform the development of the next strategic plan.

Researchers undertook a literature review covering the contextual factors which shape the NPLC's work in Peterborough, as well as literature on strategic partnerships, network models

of social support and health care, and the benefits of Indigenous-led health care. Following this, two SWOT (Strengths, Weaknesses, Opportunities, and Threats) analyses were conducted: The first SWOT analysis drew on the clinic's existing data, and the second was based on semi-structured interviews conducted with four of the NPLC's partners. Lastly, the findings of both SWOT analyses were synthesized through the lens of the four strategic goals, providing goal-specific assessments and suggestions moving forwards.

The clinic has achieved success in upholding patient satisfaction with all interviewed partners agreeing on its provision of high-quality care and adaptability to community needs. The clinic's role (in collaboration with external partners) in advocacy for harm reduction services in Peterborough was also noted as a significant area of success. However, staff burnout and work stressors within and across organizations, as well as top-down models of partnerships, were mentioned as prevalent challenges. Institutional boundaries and differences, underfunding, and asymmetrical power dynamics within system networks are threats which pose significant limitations. The greatest opportunity for overcoming weaknesses and threats, as well as enhancing existing strengths, lies in the following activities: use of innovative and specialized employment outreach strategies; prioritizing bottom-up partnership-centred approaches to care networks; advocating for increased funding and reform of physician payment models; engaging in initiatives to tackle prejudice and stigma within Peterborough; and further development and use of digital tools aimed at increasing work hour flexibility. Although analysis of the clinic's Indigenous partnerships was limited, information available suggests that the clinic should continue to strive for an increased presence of Indigenous-led healthcare approaches and partnerships.

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## 1. Introduction:

The Peterborough 360 Degree Nurse Practitioner-Led Clinic (360 NPLC) is a not-for-profit clinic organization that works with low-income and marginalized groups in the region to reduce barriers in access to healthcare services and social determinants of health. Nurse Practitioner-Led Clinics deliver comprehensive primary care across Canada to improve access to those who do not have a primary healthcare provider<sup>1</sup>. Operating from a comprehensive approach to primary health care involves holistic, patient-centred care through an interdisciplinary team that includes nurse practitioners and support services such as social workers, dietitians and mental health counselors.

Through their core values such as responsiveness, collaboration, diversity, equity, inclusiveness, accessibility and respect, the 360 NPLC's goal is to reduce the effect of access barriers through a commitment to health equity, harm reduction approaches to substance use, and collaboration with community partners and initiatives<sup>2</sup>. Their mission statement is to: *“Provide integrated, accessible, nonjudgmental primary health care; strive for health equity in all our services and programs; be engaged with our community to identify and address community needs; collaborate with a diverse range of external partners; advocate to improve the health and quality of life of all people in the community; [and] embrace a harm reduction philosophy in all*

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<sup>1</sup> The Peterborough 360 Degree Nurse Practitioner-Led Clinic. NPLC Handbook

<sup>2</sup> The Peterborough 360 Degree Nurse Practitioner-Led Clinic. *Alternative Model of Primary Health Care*.

*our programs and services*".<sup>3</sup> In 2019, four strategic goals to strive for over a three-year period were identified<sup>4</sup>:

- **Equity and Inclusion:** Continue to provide integrated health care to vulnerable and often-stigmatized populations in a compassionate, non-judgmental, and safe environment, using trauma-informed and harm-reduction approaches and systemic advocacy to improve access to the social determinants of health.
- **Enhanced Services and Access:** Increase the number of patients served and continue to develop accessible programming that meets their identified needs.
- **Workplace Wellness:** Promote staff well-being by fostering a healthy and supportive workplace culture that recognizes the impact on staff of working in a highly trauma-exposed environment.
- **Improved System Integration:** Foster collaboration with local health and social services partners to improve the overall quality and integration of services, particularly mental health, and addictions.

Now that the three-year period has ended, an assessment of the 360 Degree NPLC's achievements, and current state—with consideration of both internal and external influences—is due. The purpose of the project is thus to undertake a SWOT (strengths, weaknesses, opportunities, threats) analysis that will inform the development of the clinic's next strategic plan. Accordingly, the research questions which informed the present study are:

### **Research Questions:**

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<sup>3</sup> The Peterborough 360 Degree Nurse Practitioner-Led Clinic. Strategic Plan, 2019, p.8

<sup>4</sup> The Peterborough 360 Degree Nurse Practitioner-Led Clinic. Strategic Plan 2019-2022 (2019) .

1. What are the strengths, weaknesses, opportunities of, and threats to, NPLC's operational activities and institutional partnerships (SWOT analysis)?
2. What are the implications for the 360 Degree NPLC's strategic planning exercise?

## **2. Methodologies & Limitation:**

### **2.1. Methodologies**

#### Literature review:

The first stage of research was a review of existing literature pertaining to primary health care, nurse practitioner-led clinics in Ontario, social determinants of health, and social issues in Peterborough. Literature which unpacks social determinants of health and primary care provides a foundational understanding of the nature of services provided by the 360 clinic and the issues which the organization addresses. Reports and statistics about social determinants of health in Peterborough provide context and inform our SWOT analysis. Academic journal articles, research reports, and case studies on partnership models and healthcare-social work networks provide insight into what elements are needed for successful partnerships in this field of work. Ultimately, this review of existing relevant literature provides background information to guide the rest of the research and analysis.

#### Analyzing existing data:

A SWOT analysis of the former strategic plan and current state of the organization was conducted based on existing data from interviews and surveys conducted by the 360 Degree NPLC between 2019 and 2022. The purpose of this data was to have a comprehensive and holistic external and internal understanding of the organization in order to assess the progress the NPLC has made towards adhering to and thus fulfilling the strategic plan set in place.

Participants in this research included staff, clients, and external partners, but clinic staff were the primary informants. In addition to chronicling the strengths, weaknesses, opportunities, and threats, the data synthesized in this process provides an overview of how the NPLC operates, and insight into the NPLC's inter-organizational relationships and positionality. Moreover, they provide insight into the gaps in the findings of former research and shaped the direction and focus of this project.

#### Conducting interviews with external partners of the 360 Degree NPLC:

Given that most existing information on the clinic's operation was collected internally, this research will seek to address gaps in the data through a more in-depth investigation of outside perspectives. Three virtual semi-structured interviews—of approximately 30 minutes each—were conducted. In addition—for a total of four interviews— one interview was conducted with a researcher whose expertise is in social support systems. Interview questions (see **Appendix B**) were informed by the organization's strategic plan, our literature review, and the assessment of existing qualitative data provided by the clinic. Interview questions sought insights on the nature of partnerships, the impacts of partnerships on each of the strategic goals, sources of successes and shortcomings, and future visions and hopes with regard to the

partnership and shared goals. From these responses, researchers identified and developed an understanding of the strengths, weaknesses, opportunities, and threats pertaining to partnerships and the achievement of relevant strategic goals of the NPLC. Each section of both the SWOT analyses is broken down into significant and recurrent themes identified by the researchers.

## **2.2. Limitations:**

Some limitations were encountered throughout the process that should be noted:

- **Representation:** Participants in this research do not represent the full range of the NPLC's organizational partnerships. Only three partner organizations are represented in the interviews, and only one representative from each of these three organizations was interviewed. Moreover, the absence of insights from an Indigenous-led community partner in this research poses considerable limitations, especially given the NPLC's strategic goal of equity and inclusion and its Indigenous-specific targets.
- **Informant's Scope of Knowledge:** While the researchers in social support systems who were interviewed provided valuable insights with regards to sociological and political contexts and social support systems in a broad sense, they were not connected to the NPLC themselves and were thus unable to speak on clinic-specific matters.
- **Patient Insight:** More in-depth client perspectives could have enriched this research by providing insight with regard to patient satisfaction, needs, and concerns.
- **Data Interpretation:** Researchers were not involved in the data collection for the NPLC prior to this project, creating the potential for misinterpretation of existing raw data due to a lack of contextual familiarity.

- **Selection Bias:** Interviewees were recruited directly by NPLC and were asked to engage in critical dialogue about their partnership with the NPLC and the broader context of their work. Accordingly, informants may have chosen to omit contentious opinions of potential relevance to the SWOT analysis.

### **3. Literature Review:**

#### **3.1 Context**

This research is situated within the context of Peterborough City and County and addresses the current lack of adequate primary health care available to low-income and other marginalized populations, as well as the ongoing challenges with housing and homelessness, access to healthcare services, substance abuse and inadequate income faced by residents. These factors depict a multifaceted problem that plays an important role in the health outcomes of populations as they depict barriers to the accessibility and quality of healthcare services.

The 360 Degree NPLC works within the guidelines of the People's Health Care Act of 2019<sup>5</sup>. The “Quadruple Aim” (Better Patient and caregiver experience; Better patient and population health outcomes; Better value and efficiency; and Better provider experience) is a set of goals which are the primary drivers of transformation in the health-care delivery of NPLC and Ontario health care more broadly<sup>6</sup>. Ontario Health Care Teams are expected to focus especially on digital and virtual healthcare, community engagement and partnership, and performance

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<sup>5</sup> The Peterborough 360 Degree Nurse Practitioner-Led Clinic. Strategic Plan 2019-2022, 2019

<sup>6</sup> Ibid

measurement and improvement<sup>7</sup>. As previously mentioned, the 360 Degree NPLC operates within a community affected by multiple social and public health crises which worsen the population's health outcomes, create and intensify barriers to receiving health care for some individuals, and put additional pressure on local healthcare providers and human resources.

Lack of access to the social determinants of health is the key feature of the 360 Degree NPLC target population and so it is important to know who is most likely to experience such barriers and what their health needs are. As of January 2022, an estimated 13, 000 people in the County and City of Peterborough did not have a family doctor<sup>8</sup>. An analysis of Peterborough's population without a regular primary care provider indicates that such individuals are disproportionately recent immigrants, and likely to be poor, younger, and male<sup>9</sup>. It was also found that racialized individuals, Indigenous persons, and members of the 2SLGBTQ+ community face barriers to receiving the health care they need<sup>10</sup>. It is often the case that those who are unable to have regular primary care providers are those who need the most care and support due to extreme poverty, disability, complex mental health issues, and addiction<sup>11</sup>. A 2012 analysis of Ontario communities facing barriers to primary health care identified Peterborough as being in critical need of a Community Health Center (CHC) to serve unattached

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<sup>7</sup> Ibid

<sup>8</sup> Community Safety and Well-being Plan. (2022, June 23). Selwyn Township. Retrieved from <https://www.selwyntownship.ca/en/township-hall/resources/Policies/CSWBP---Final-Plan---CSD22-008---June-23-2022-AODA.pdf>

<sup>9</sup> Laidman, S. (2022). Support for Community Health Centre, Report CSSS22-010.

<sup>10</sup> Ibid

<sup>11</sup> Ibid.

patients<sup>12</sup>. Now, a decade later, although the need persists, there is still no such CHC due to lack of funding, making 360 Degree NPLC a crucial and leading organization in addressing inequality in access to healthcare and social determinants of health in Peterborough.

While only 3.4% of Peterborough's population identifies as Indigenous, 8.8% of 360 Degree NPLC patients identify as having Indigenous heritage<sup>13</sup>. Some of the Truth and Reconciliation Commission Calls to Action refer specifically to health<sup>14</sup>. All levels of government and those who can effect change within Canada's healthcare system are called upon to recognize the value of Aboriginal healing practices, to collaborate with Aboriginal healers and Elders, to increase the number of Aboriginal people working in healthcare, to ensure retention of Aboriginal health care providers in Indigenous communities, and to provide cultural competency training for all health-care professionals<sup>15</sup>. The 360 Degree NPLC is responsible for taking such action in order to facilitate cultural equity for patients<sup>16</sup>.

Income tends to heavily influence health because it largely dictates living conditions and overall quality of life. Poverty is inextricably linked to other social determinants of health as people who live in low-income households suffer from a greater chance of experiencing food, housing, and employment insecurity, social exclusion, difficulty accessing quality health care, community support and adverse health outcomes<sup>17</sup>. Since approximately 15% of the local

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<sup>12</sup> Ibid

<sup>13</sup> The Peterborough 360 Degree Nurse Practitioner-Led Clinic. Strategic Plan 2019-2022, 2019

<sup>14</sup> Ibid

<sup>15</sup> Ibid

<sup>16</sup> Ibid

<sup>17</sup> City of Peterborough (2022) Peterborough Community Safety and Well-Being Plan 2022 pg. 26

population is low-income, poverty and its impacts on health are a major concern in Peterborough<sup>18</sup>. Statistics from a Peterborough Public Health report indicate just how stark income-based health discrepancies are in our community. In Peterborough, 43% of the adult population who are in the lowest income bracket are smokers, while only 13% of the highest income bracket are smokers<sup>19</sup>. Only 57% of people in the lowest income group reported their mental health as excellent or very good, compared to 76% of the population in the highest income group<sup>20</sup>. The percentage of self-reported diabetes in lowest-income groups above the age of 50 is more than twice as high as the percentage of self-reported diabetes in high-income people of the same age group<sup>21</sup>. Such discrepancies in health are linked to a lack of access to primary health care and social determinants of health. One in six households in Peterborough experiences food insecurity<sup>22</sup>, and as of April 2022, there were found to be at least 317 people in Peterborough experiencing homelessness<sup>23</sup>.

While drug addiction is a health issue itself, it can also have secondary health impacts by reducing access to the social determinants of health. Drug addiction is a considerable risk factor for homelessness and can create barriers to receiving health care due to the stigma surrounding drug use and addiction. In 2018, research on homelessness in Peterborough indicated that 17% of

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<sup>18</sup>Peterborough Public Health. (2017) Low Income and its impacts on health in Peterborough Country and City.

<sup>19</sup> Ibid

<sup>20</sup> Ibid.

<sup>21</sup> Ibid

<sup>22</sup> Ibid

<sup>23</sup> City of Peterborough (2022) Peterborough Community Safety and Well-Being Plan 2022

homeless people became homeless for reasons related to addiction<sup>24</sup>. Although the opioid crisis is nationwide, Peterborough is particularly impacted. The age-adjusted rate of opioid poisoning emergency department visits in Peterborough is nearly double that of the province, and Peterborough Public Health Unit ranked 4th in the country for the highest number of opioid-related deaths per 100 000 population<sup>25</sup>.

The COVID-19 pandemic has exacerbated many of these preexisting issues and has been especially harmful to those who already face greater barriers to accessing health care; particularly those living with mental health issues and addiction, seniors, and the homeless<sup>26</sup>. The combination of job losses and rising housing costs due to the pandemic has made it increasingly difficult for people to afford housing<sup>27</sup>. Furthermore, with fewer open public spaces and reduced access to social services, it is reported that unsheltered people face more challenging conditions than before the pandemic. Mental health issues and substance use have risen during the pandemic due to isolation, reduced access to supports, and increased stress<sup>28</sup>. With a growing need for mental health care and no increase in mental health budgets in nearly a decade, the pandemic has exposed the need to increase the health system's capacity<sup>29</sup>. Healthcare providers and human resources have experienced higher demands while also having aspects of their operation compromised by the pandemic, creating longer wait times for clients, and reducing

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<sup>24</sup> The Peterborough 360 Degree Nurse Practitioner-Led Clinic. Strategic Plan 2019-2022, 2019

<sup>25</sup> Ibid

<sup>26</sup> City of Peterborough (2022) Peterborough Community Safety and Well-Being Plan 2022

<sup>27</sup> Ibid

<sup>28</sup> Ibid

<sup>29</sup> Ibid

people's access to them<sup>30</sup>. The 360 Degree NPLC has been unable to offer some services and has had more limited capacity to take new patients during the pandemic<sup>31</sup>. At the same time, people in the clinic's target group are likely the most impacted by the pandemic and in need of care.

### **3.2 Health Care Partnerships and Social Support Networks**

With growing demands and limited resources, strategic partnerships in the public health sector (PH) and primary care sector (PC) have become pivotal in enhancing operational efficiency, pooling skill sets and knowledge, driving digital innovation and meeting community needs at a broader scale. Although these sectors are independent of each other, there is growing complexity and interconnectedness of social, economic and legal barriers to adequate healthcare which has resulted in a forced integration of these as a necessary means to improve health and social outcomes. This reality has increasingly pressured providers to strengthen existing partnerships and create new ones. Foundational features of strategic partnerships include a shared vision and close work relations that drive innovation and increase value to both organizations<sup>32</sup>. A strong partnership requires both parties involved to have collaborative governance structures, dedicated resources and opportunities for evolution and innovation. These structures should be built to foster symbiotic relationships, enabling both parties to access

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<sup>30</sup> Ibid

<sup>31</sup> The Peterborough 360 Degree Nurse Practitioner-Led Clinic. Strategic Plan 2019-2022, 2019

<sup>32</sup> Van Houten, Frans (2021) *Driving Innovation Through Strategic Partnerships*. Harvard Business Review Analytic Services.

resources, workflows, and care systems<sup>33</sup>. In theory, this would allow for effective partnerships to overcome operational, technological and resource barriers through collaborative processes, promoting organizational self-scrutiny and even service development if and when boundaries are defined and trust in network management is produced.

The notion of ‘*partnership synergy*’ is the result of the successful combination and mobilization of resources, knowledge and expertise of all partners, enhancing the outcomes beyond what could have been achieved individually<sup>34</sup>. According to Loban et al. (2020) partnership synergy can manifest itself through the following actions: the integration of resources; partnership atmosphere; perceived stakeholder benefits; and capacity for adaptation to context<sup>35</sup>. Under this ‘synergy’ framework, ongoing partnerships can be assessed on their achievement of long-term goals and mutually envisioned outcomes. Given the growing number of people who experience long-term conditions and thus require a consistent system of coordinated support, partnership-centred approaches to care must be prioritized as a leading strategy. The objectives are to improve quality, capacity and efficiency while continuing to meet the needs and demands of patients facing complex barriers to social determinants of health.

Like the notion of ‘partnership synergy’, Banarsee et al. (2018) discuss community-oriented integrated care and the new care model of a three-tier system of shared care to help

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<sup>33</sup> Ibid

<sup>34</sup> Loban, Ekaterina, Catherine Scott, Virginia Lewis, Susan Law, and Jeannie Haggerty (2021) “*Improving Primary Health Care through Partnerships: Key Insights from a Cross-case Analysis of Multi-stakeholder Partnerships in Two Canadian Provinces.*” Health Science Reports.

<sup>35</sup> Ibid

increase vertical and horizontal integration<sup>36</sup>. In their view, partnership coordination and collaboration can result in the creation of alliances, horizontally building teams and communities, and vertically connecting with experts and specialists. This would facilitate coordination and address barriers in the local context- what the World Health Organization (WHO) has coined ‘*community-based hubs*’<sup>37</sup>. These community-based hubs, consolidated through strategic partnerships, facilitate the development of local health communities by benefiting the organizations both clinically and financially.

Naturally, however, obstacles to primary care and public health multi-agency collaboration may arise. These may result from things as simple as different organizational aims, where a lack of mutual goals and shared visions can result in diverging strategies and resource use, as well as different constituencies which could further result in a lack of synchronized work and strategic inefficiency<sup>38</sup>. System fragmentation can also prove to be a significant obstacle as it may result in fractured communication and disjointed working environments.

### **3.3 Integrated Public Health and Social Care**

The network model or ‘integrated care’ is closely related to, but distinct from, the concept of strategic partnership. While a successful partnership requires strong ideological and administrative integration between two community actors, a robust network requires the same integration but more broadly and collectively amongst groups of organizations serving the same

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<sup>36</sup>Ricky Banarsee et al. (2018) *Towards a strategic alignment of public health and primary care practices at local levels – the case of severe and enduring mental illness*, London Journal of Primary Care. Pg.21

<sup>37</sup> Loban, Ekaterina, Catherine Scott, Virginia Lewis, Susan Law, and Jeannie Haggerty (2021) “*Improving Primary Health Care through Partnerships: Key Insights from a Cross-case Analysis of Multi-stakeholder Partnerships in Two Canadian Provinces.*” Health Science Reports.

<sup>38</sup> Ibid

population<sup>39</sup>. In other words, the process of forming and strengthening strategic partnerships makes up a large part of a broader project of creating a network. A strong social service and healthcare network is particularly important when it comes to supporting marginalized and vulnerable individuals who may be reliant on a wide variety of resources which come from different sources<sup>40</sup>. Kristy Buccieri, a sociologist specializing in homelessness and healthcare, argues that the current fragmented system of healthcare and social support services makes it difficult for homeless people to access the support and care they need, and puts strain on emergency departments<sup>41</sup>. Often, individuals experiencing homelessness will be faced with a time-consuming and potentially overwhelming process of finding and engaging with multiple organizations for each of their needs to be met<sup>42</sup>. Receiving patch-work support is not only more difficult, but is also less effective in addressing complex and often interconnected issues when compared to treatment provided by more integrated support systems.

In theory, system integration within and across sectors provides seamless access to a variety of services and resources such as primary health care, shelter and housing support, mental health care, food support, and addiction treatment<sup>43</sup>. There are many known strategies for enhancing system integration such as: shifting from informal partnerships to more formal and standardized inter-organizational relationships; using liaisons for filling administrative gaps

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<sup>39</sup> Buccieri, K. (2016). *I'll Tell You What I Want, What I Really, Really Want: Integrated Public Health Care for Homeless Individuals in Canada*. *Journal of Canadian Health Libraries Association*, 40(3), 96-99.

<sup>40</sup> Ibid

<sup>41</sup> Ibid

<sup>42</sup> Ibid

<sup>43</sup> Buccieri, K. (2016). *I'll Tell You What I Want, What I Really, Really Want: Integrated Public Health Care for Homeless Individuals in Canada*. *Journal of Canadian Health Libraries Association*, 40(3)

between institutions; streamlining institutional practices such as referrals and client intake; and using shared digital tools for data collection and information sharing<sup>44</sup>. However, there are also well-known challenges to establishing a truly seamless healthcare and social support system such as institutional boundaries between public and private sectors, lack of funding, misalignment of goals or ideology between organizations, lack of human resources to support partnerships, and organizational territoriality<sup>45</sup>.

### **3.4 Indigenous-Led Partnerships in Primary Health Care**

Indigenous communities in Canada are experiencing positive outcomes from revitalizing and reinforcing their traditional cultural practices, particularly in the areas of health and healing<sup>46</sup>. These cultural practices have historically been repressed by colonization and oppressive government policies, but many Indigenous communities are now making efforts to return to them and strengthen them. Indigenous-led healthcare partnerships are contributing to interprofessional collaboration with innovative models being implemented in a range of settings such as community-based healing lodges, clinics, and hospitals<sup>47</sup>. Emerging evidence suggests that these partnerships are improving the holistic health outcomes of Indigenous Peoples, including their access to care, uptake of preventative measures, and adherence to care plans<sup>48</sup>.

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<sup>44</sup> Ibid

<sup>45</sup> Ibid

<sup>46</sup> Allen, L., Hatala, A., Ijaz, S., Courchene, E. D., & Bushie, E. B. (2020). Indigenous-led health care partnerships in Canada. *Cmaj*, 192(9) pg.208

<sup>47</sup> Ibid

<sup>48</sup> Ibid

In 2018, a program for mental health and well-being, which involved the inclusion of Elders in the direct care of Indigenous patients in an inner city primary care clinic, was evaluated using semi-structured interviews with 37 Indigenous participants over a 6-month period<sup>49</sup>. The study found that, with the exception of one participant, all participants reported substantial benefits from their encounters with Elders, while none reported negative effects<sup>50</sup>. The study identified five overarching themes: experiencing healing after prolonged periods of seeking and desperation; strengthening cultural identity and belonging; developing trust and opening up; coping with losses; and engaging in ceremony and spiritual dimensions of care as a resource for hope<sup>51</sup>. The program was perceived by participants to have a broad range of positive impacts on their care and well-being<sup>52</sup>. Although the study was conducted at a single urban clinic, the findings support the calls to action of the Truth and Reconciliation Commission of Canada regarding the inclusion of Elders as a strategy to improve the care of Indigenous patients in Canadian healthcare systems<sup>53</sup>.

#### **4. 2019-2022 Data SWOT Analysis:**

##### **4.1 Strengths:**

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<sup>49</sup> Hadjipavlou, G., Varcoe, C., Tu, D., Dehoney, J., Price, R., & Browne, A. J. (2018). "All my relations": experiences and perceptions of Indigenous patients connecting with Indigenous Elders in an inner city primary care partnership for mental health and well-being. *Cmaj*, 190(20), E608-E615.

<sup>50</sup> Ibid

<sup>51</sup> Ibid

<sup>52</sup> Ibid

<sup>53</sup> Ibid

The 360 Degree NPLC seeks to serve and support marginalized populations in Peterborough by removing barriers to health and primary care. Data collected between 2019 and 2022 affirm the following strengths in the NPLC's operational actions: staff values; staff education and training; staff values and attitude; staff education and training; adaptability and responsiveness; and evaluation and strategic action. The NPLC generally has a great deal of success in providing quality care to the populations that need it. In client interviews, all interviewees said that the NPLC meets their needs, and almost all interviewees explicitly stated that no other organization serves them better.

#### *Staff Values and Attitudes*

Strong alignment of staff values and priorities with those of the organization is prominent and repeatedly affirmed throughout our data set. This is reflective of a rigorous hiring standard which, as noted from staff interviews, is 'based on values and morals that align'. Staff interviews and notes in the Strategic Plan Table (SPT) show that staff maintain positive attitudes and an effort to create a positive work environment. This is vital to the goal of Workplace Wellness.

#### *Staff Education & Training*

Existing data indicate a strong commitment to keeping staff well informed in relevant matters, such as harm reduction, non-violent communication, cultural safety, and peer debriefing, among others. This plays a key role in supporting Workplace Wellness, Equity & Inclusion, and Enhanced Services & Access. Aside from the staff, the clinic is well equipped in its program services and outreach for providing low-barrier primary care, especially for populations that experience the most barriers to accessing health care otherwise.

#### *Adaptability & Responsiveness*

Data indicate adaptability in the clinic's operational actions. While the COVID-19 pandemic has presented considerable challenges to the NPLC and indeed the community at large, the clinic has successfully employed strategies involving the use of online platforms and community partnerships to support their staff, and continued serving clients despite the public health crisis and the additional social burdens and barriers that came with it. Sensitivity and responsiveness to the crisis in the community is also demonstrated in its advocacy efforts, particularly in response to the opioid crisis. NPLC has been a key player in advocating for harm reduction services in Peterborough and has done so in collaboration with community partners.

#### *Evaluation & Strategic Action*

Many of these successes can be attributed to an overarching strength in the clinic's operations (evaluation capacity and ability to change course). Over the four years of operational activities documented in the SPT, there is observable progress in strategies used and improvements in various areas, demonstrating considerable capacity for self-evaluation and strategic action. Together, these strengths enable the clinic to foster and maintain a strong culture of inclusivity and equip the staff to provide a high quality of care.

#### **4.2 Weaknesses:**

Beyond the clinic's strengths, several weaknesses were also uncovered concerning work stressors and resource limitations.

#### *Work Stressors*

The issue of staff burnout is a prevalent theme throughout the SPT and is brought up by nearly every respondent in the data. Staff shortages, increased workload and emotionally taxing working conditions appear to be the main factors for burnout, resulting in a continuous struggle

with staff retention. Human resources appear to be stretched ‘too thin’ in efforts to meet the needs of patients and fill gaps in local social support systems. In staff interviews, one interviewee said: “by trying to be the only ones that do this kind of work for this population we’re stretching ourselves too thin”.

#### *Resource Limitations (Human, Spatial, and Financial)*

Spatial limitations in the clinic’s building result in an inability to increase numbers of appointments and services. In 2021, a one-time government disbursement was used towards increasing the availability of social workers at the clinic. This influx of funding in human resources eliminated waiting lists for counseling, which was unprecedented. Because this funding was temporary, however, the waiting list for case management (which tends to be more complex and long term) remained. Together, these limitations in human, physical, and monetary resources undermine the clinic’s ability to take on more patients despite the high demand, and in some cases restrict accessibility for existing patients. Data storage and management, including bookkeeping, also appeared to be areas deserving more attention. This is likely to also be a product of human resources being stretched ‘too thin’.

### **4.3 Opportunities:**

The data also identified areas of opportunity related to partnerships, hiring outreach and Indigenous-led health care.

#### *Partnership Opportunities*

Throughout the period 2019 to 2022, there were numerous attempts to renew partnerships and create new ones. The NPLC’s presence in Ontario Health Teams and continual efforts to

reinforce community partnerships and networks provides an opportunity for a greater ‘seamless’ continuum of care and strategic collaboration, alleviating resource and spatial limitations. These efforts also allow for a greater opportunity in the creation of more preventative care programs and specialized services through an increase in resource pooling, information and system sharing as well as patient access. Similarly, greater exposure to a collaborative environment and group projects affords greater networking opportunities that facilitate mobilization and advocacy efforts.

### *Hiring Outreach*

Collaborative efforts can also serve the function of alleviating the prevalent staff burnout due to human resources being ‘stretched too thin’ through greater workload distribution, volunteering and collaborative programs and services that would include more professionals. It is also worth noting that an opportunity to alleviate staff burnout and turnover could be found in their employment process. While high and specific standards for hiring can make staffing difficult, this practice is a strength which must be preserved as it is integral to upholding the clinic’s inclusive and safe environment and outstanding quality of care. As a solution, the clinic may consider engaging in exploring far-reaching and specialized methods of outreach for scouting employment prospects. This could be achieved by connecting to online communities of like-minded nurse practitioners or connecting to universities that offer specialized programs which reflect the clinic's values and mandate. If such spaces or university/med-school programs do not already exist, the opportunity to engage in their creation through advocacy and networking presents itself.

### *Indigenous-Led Health Care*

The literature shows that Indigenous Peoples in Canada benefit from access to traditional cultural health care and healing practices. The 360 Degree NPLC has made important strides in creating a culturally safe environment for Indigenous patients through staff training and partnership with Indigenous community actors. However, there is still potential for Indigenous representation and Indigenous-led healing within the clinic. Having on-site Indigenous Elders and health care providers (either through a co-located partnership or the creation of a new position within the clinic) would not only contribute to the cultural safety of the clinic, but would likely be impactful on the health of Indigenous patients.

#### **4.4 Threats:**

It is apparent that one of the clinic's overarching threats is systemic barriers to funding, the overall community stigma around the clinic's target population, as well as sector competitiveness and advocacy.

##### *Barriers to Funding:*

The data suggest that systemic and political factors are key obstacles in the clinic's scope of work as they limit their ability to improve and create new long-term care facilities and programs due to lack of funding and long wait times prior to the release of funding decisions. According to the 2019-2022 Strategic Plan Table (SPT), there is constant mention of numerous funding proposals regarding issues such as homelessness-related health advocacy strategies and actions; increased funding for new nurse practitioner (NP) and personal support worker (PSW) positions; renewed projects and programs such as the expansion of the safer supply project, among others. Several funding delays were noted, as well as long periods of uncertainty about

whether funding proposals were accepted or not. Despite efforts and resources put into funding proposals, funding is not always successfully acquired and is often delayed, forcing the clinic to turn to alternative fundraising efforts. Overall, data show that funding is precarious.

### *Stigma and Prejudice*

Moreover, community stigma around marginalized populations, homeless populations and patients who abuse substances, result in limited opportunities for the expansion of safe injection sites and other harm reduction initiatives as well as the possibilities to create new partnerships. Stigma and prejudice are a result of the city's contextual factors and misinformation surrounding these populations. For example, the Consumption and Treatment Services (CTS) Site was 'thwarted' by landlords unwilling to host the site on their property. This comes as a great threat to the clinic's overall ability to enhance its services and increase its capacity to promote health equity, form new or strengthen existing partnerships and increase patients' access to services and programs.

Data indicate that prejudice against homeless populations may also be a problem within the healthcare sector itself. In the STP, the Primary Care Working Group [PCWG] (a focus group within the OHT) is described as '*one of the bright spots*' of an otherwise '*disappointing*' experience with OHT. It is suggested that this is because members of the PCWG are generally supportive of prioritizing marginalized populations while this is not the case more broadly within the OHT. In a 2021 PCWG meeting, the fact that "marginalized individuals are not welcomed in mainstream models of health care" was a concern raised. "*The discussion that ensued demonstrated a surprising level of support for more resources for the 360NPLC to care for*

*marginalized individuals.*” In the following months the NPLC and other members engaged in efforts to raise this concern to the chair of the OHT, but were met with dismissal:

*“The Formal Alliance Partners of the Peterborough OHT met in later February. The Chair (PRHC) suggested they would be going back to the community for ‘town halls’ to discuss next priorities. The Executive Director inquired if and why there was a diversion from the submitted application that identified homeless populations as a priority population for year two. The chair said ‘thank you for this input’ and moved along.”*

Later in mid-May, the NPLC reached out to members of the OHT steering committee, inquiring about “the status of studies that were intended to inform future priorities, particularly homelessness”. In July it was noted in the STP that there was still no response to these emails. It may be inferred that the seeming lack of concern for the homeless population by members of the OHT is rooted in prejudice.

#### *Sector Competitiveness in Employment*

There is frequent mention of the struggle to find new employees given the clinic’s rigorous hiring process based on morals and values— something which is not common practice sector-wide. Beyond hiring standards, the NPLC is at a disadvantage with staffing retention due to the particularly emotionally taxing nature of this work. This is compounded by a lack of funding, and community stigma towards many of the NPLC’s clientele which creates additional burdens for staff. This may narrow the pool of available or willing candidates who fit these specific needs of the clinic. Notes from staff interviews indicate that one staff member lists the following as perceived threats: *“dealing with vicarious trauma and chaos from this environment and its not sustainable for a long period of time, short staffed, hiring based on values and morals that align is hard.”* Another staff member mentions issues of *“nurse turnover and burnout, [and] finding good employees with values and keeping them”*.

Together, these external threats act as barriers to the Clinic's strategic plan's goals, particularly, but not limited to, that of Equity & Inclusion, System Integration and Enhanced Services & Access.

## **5. Partner Interviews SWOT Analysis:**

### **5.1. Strengths:**

Several strengths of the NPLC's internal operations and external partnerships were identified by interviewees, point to the clinic's dedication to its mission and core values. Themes include advocacy and education efforts; a safe environment and excellent quality of care; adaptability and responsiveness; and partnership synergy, which supports the achievement of strategic goals.

#### *Advocacy and Education:*

The Clinic's ability to raise and promote awareness, particularly around stigma and misconceptions regarding harm reduction and safe consumption was identified by half of the interviewees. However, given the pressing opioid crisis and lack of harm reduction approaches and local drug strategies in larger healthcare facilities, like the hospital, all interviewees emphasized the importance of the clinic's work surrounding this issue. Reference is made, for example, to the importance of building strength and expertise in these '*little pockets*' of healthcare and community organizations that amplify the voice and needs of marginalized communities. An example of a joint initiative to address stigma and misconception is the Harm Reduction and Safe Consumption site. This was a voiced example of community initiatives based on the provision of joint services and programs that strive to tackle stigma and

misconceptions based on the organization's mandates, mission, and the translation of specialized healthcare frameworks into concrete projects.

### *Safe Environment and Excellent Quality of Care*

Another identified strength was the clinic's consistency in ensuring a safe and non-judgmental space for its clients. Two interviewees put particular emphasis on the clinic's ability to provide a service that was non-stigmatizing or coercive and in alignment with the principles of harm reduction and trauma-informed care. One of the interviewees in particular spoke in depth about both personal and professional ties to the clinic, praising the 360 NPLC for its dependably safe, non-judgmental environment, and exceptional quality of care through a continual growth in its programs and services that would be otherwise unavailable to target populations. For social workers, the NPLC is a dependable resource that clients can be referred to. One interviewee described how this impacts their work experience:

*"I'm confident when I say, 'this is a safe place for you' regardless of what their concerns may be, whether it be substance use, gender identity, any of that, I know that I'm sending them to a place where that's true, right [...] I know, regardless of who walks through that door, and who's sitting there waiting for them, that, you know, they're going to be treated with dignity and respect."*

The clinic stands out for its commitment to providing a safe, inclusive, and non-judgmental environment for its clients. Its dedication to harm reduction and trauma-informed care, combined with an exceptional quality of care has earned the trust of both clients and partners.

### *Adaptability and Responsiveness*

The clinic's adaptability and responsiveness to community needs appear to be the strongest features identified both throughout the interviews and in the previous data analysis. The recurrence of this theme demonstrates the clinic's responsiveness is one of its most prominent strengths. This can be attributed to the organization's self-assessment, strategic planning, and partnerships. The success of the clinic's crisis response in light of unprecedented public health circumstances and emerging community needs was particularly impressive., as attested by one interviewee who highlighted the clinic's ability to maintain and even improve communication during COVID.

*"We've had to collaborate much more effectively through this [COVID] experience, and I would say coming out of Covid, some of our core mission and vision is more aligned than ever."*

This shows the clinic's capability to adapt under pressure, despite a lack of resources, spatial limitations, and increased demand.

#### *Synergic partnerships:*

Informed by the concept of 'partnership synergy' (as discussed in the literature review), our literature review assumes that partnership coordination and collaboration can be nurtured through mutually perceived stakeholder benefits, a positive partnership atmosphere, and resource sharing. Evidence of strong partnership synergy was found in the interview data.

As previously mentioned, one of the interviewee's personal connections and admiration for the clinic demonstrates a mutually reinforcing work integration through a recurrent feeling of patient security and satisfaction. This positive outlook regarding the clinic's work ethic and overall service quality and importance is also perceived by other interviewees who are currently less integrated with the 360 NPLC. These organizations expressed enthusiasm for working on

future collaborative projects that would inevitably enhance working relationships and integration by breaking down structural and financial barriers.

A particular common theme that encouraged greater cooperation was the clinic's necessary presence in the city's healthcare scene.

*“It's a very specific and, niche mandate compared to other clinics and like, and just healthcare providers and that is to serve marginalized communities and people who wouldn't be receiving primary healthcare and provide this support to people that wouldn't get it going to any other, any other place.”*

This was a strong commonality among the interviewed partners as several expressed the clinic's niche as integral in the community.

The clinic also fills a niche in how it supports other organizations and their shared goals. One of the interviewees described the clinic's work as *“taking the pulse of our community's health.”* This was in addition to other interviewees expressing a desire to continue fostering a *“spirit and culture of collaboration”*. The harm reduction and safe consumption programming that the clinic undertook alongside Peterborough Public Health and Fourcast is described by one of our interviewees as an important vehicle of increased collaboration through a tight-knit referral-based integration of programs and services.

*“At a program level, it would depend on the program of interest, but for example, if any of the NP clinicians at the NPLC are detecting, say, a communicable disease of interest, to public health interest, that would be one area that would trigger communication with our infectious disease program or potentially our sexual health program through program referrals. So, if we see individuals in our clinical or public facing programs that*

*might benefit from connection to the interdisciplinary team at the 360 clinic, that's another area where we would have communication.”*

## **5.2. Weaknesses:**

Weaknesses in public health care and social support systems that were brought up during the interviews include understaffing and burnout, fragmentation of services, difficulty sustaining collaboration, and the communication and partnership model.

### *Understaffing & Burn Out*

Understaffing in public health care was a concern brought up by most interviewees and so it is not surprising that burnout and being overwhelmed were also recurring topics in the interviews. While this has obvious implications for workplace wellness, the stretching-too-thin of human resources also has impacts on partnership and integration between organizations. When one interviewee was asked if they could think of anything to make their partnership more effective, their response was “*about 300 More NPs*”. Another interviewee described the current care model as “*islands unto themselves*”, in which all parties are overwhelmed and unable to focus outwards on partnerships, and fully function as supports for one another.

### *Fragmentation of Services*

Ideally, health care providers and social workers could come together and facilitate a seamless continuum of care. While interviewees made it clear that partnerships are playing an instrumental role in reducing barriers and connecting clients to the services they need, all interviewees felt that there are still barriers to achieving ‘seamlessness’. In theory, a strong network would allow for organizations to be specialized in the services they provide, depending

on external partners to cover other bases, but in practice, this can create gaps in the health care and social support system, inefficiencies for the care providers, and barriers for patients (especially those with complex needs) to access health care.

*“In the absence of those services, we have to operate through referral pathways and as a constellation of providers, which is hard for the provider, but also for the person seeking care because they get bounced around from building to building.”*

So, while the NPLC itself does provide an extensive range of services under the same roof, and takes a holistic and integrated approach internally, this is not reflected more broadly in the healthcare system. Two interviewees described the ‘seamless continuum of care’ as a falsehood, one calling it *“a branding of a product that doesn't exist at all”* and another said it is *“just words around a fragmented system”*.

### *Sustaining Collaboration*

Some interviewees spoke about weaknesses in the partnerships themselves. Two interviewees talked about the role resources play in facilitating integration and collaboration, but also in drawing boundaries between partners. The lack of resources and short-term funding of some organizations makes it difficult for these organizations to focus resources on partnerships and engage in long-term collaborative projects with external partners.

*“For collaboration, one challenge is that we don't put resources towards collaboration. As an example of one entity is that Peterborough Drug Strategy, right? They rely on short-term grant-based funding and so they're always having to reinvent the wheel in*

*terms of keeping the lights on, keeping the doors open, by proposing new projects, chasing new funds, and that doesn't always allow you to pursue things.”*

Internal issues of underfunding and resource instability can block the creation of robust partnerships because the maintenance of such collaborative projects takes resources and long-term planning to sustain. While long-term and consistent collaboration are important for the achievement of shared goals, this may be hindered by the underfunding of community partners, and the NPLC itself.

Weaknesses in partnerships also arise when there is a lack of contact and collaboration between partners. In the absence of significant collaborative programs or services, boundaries in resource flows are created as each organization's resources must be focused internally. For example, one interviewee raised concern about the physical separation of Family Health Teams (FHTs) physicians, from the spaces and community that the NPLC works to support:

*“Right now, they're [FHTs] isolated in their clinics, our resources are dedicated to them, which makes it very hard to have a partnership within NPLC.”*

This interviewee and one other hoped to see more ‘on the ground’ collaboration in the future which could lower boundaries to resource flows between organizations, enhance the partnership, and ultimately help work towards shared goals.

#### *Communication and Partnership Model*

Communication and information sharing were generally regarded as adequate across interviews. Nonetheless, it is still worth noting that two interviewees felt that staff in non-managerial positions can be left out of collaborative processes, especially in the context of inter-

organizational information sharing.

*“I think they have a lot more flow of communication, the higher up, but the trickle-down effect is not as great. So we kind of tend to get most of our information from an email string that's been sent out, you know, an update that sort of thing.”*

Another interviewee mentioned that the nature of the payment models makes it difficult for physicians to be at the “*planning table*”, and so partnership with the NPLC is “*really management to management*”. While those in non-managerial positions are not necessarily always being completely excluded from lines of communication with external partners, this partnership model could be perceived as a weakness. One interviewee argued that ‘bottom up’ models of support networks tend to be most effective. If healthcare practitioners and other non-managerial staff do not play an active role in partnerships, that may result in a loss of connection with felt needs at the community level, due to the absence of frontline workers at the discussion table.

### **5.3 Opportunities:**

Numerous opportunities for the clinic’s partnership integration were expressed and should be understood as calls for enhancing the possibility of greater network facilitation toward a seamless continuum of care. Such opportunities include a tight-knit ‘ecosystem’ of care through informal and formal partnerships; and communication through a greater implementation of hybrid working models that involve a mix of in-office and remote work, amplified education and advocacy platforms and the possibility to create a neutral entity that mediates such network systems.

### *Informal & Formal Partnerships:*

The 'ecosystem of care' analogy provided by one of the interviewees was particularly useful in understanding overarching opportunities that are presented for the clinic's work niche in relation to other healthcare institutions and organizations. Differences in mandates were initially perceived as structural barriers hindering close collaboration. However, different organizations with divergent mandates each playing unique roles in the broader support system lead to new, more innovative spaces for collaboration that close existing gaps. Such initiatives begin as 'informal partnerships' whereby collaboration arises from independent initiatives. In such circumstances, a partnership is encouraged outside of organizational and structural payment model boundaries that would otherwise obstruct closer cooperation and resource sharing. An example of collaboration was identified by the Family Health Teams interviewee whose organization's mandates, practices and clientele are entirely separate from the clinic's. In this case, this space is enabled through initiatives such as compensation agreements and volunteer-centred outreach. Such projects would have long-term goals striving for increased inter-organizational partnership formality that would increase opportunities for advocacy and engagement.

### *Communication*

Opportunities to enhance effective collaboration were found by embracing different forms and levels of communication strategies. As previously mentioned, though each interviewee expressed having a different degree of communication and information sharing in their partnership with the NPLC, all interviewees expressed satisfaction in terms of communication practices based on the nature of their collaboration. Three interviewees made a distinction

between formal and informal communication strategies that serve different purposes and that simultaneously reflect the nature of their collaboration, but also provide different opportunities for increased integration and service enhancement. The existence of unilateral communication, for example, was not necessarily perceived as a limitation according to one interviewee. In their view, such a practice is not always a reflection of fractured communication and disjointed working environments, especially given the nature of their work in relation to the clinic. The existence of unilateral communication, however, does provide an opportunity to evolve into a stronger bilateral partnership whereby more information can be shared beyond email threads, resulting in the articulation of a more synchronized inter-organizational work and strategic efficiency that could lead to a more ‘seamless’ continuum of care for patients.

#### **5.4. Threats:**

Threats to the NPLC’s mandate and its strategic partnerships were core themes in all the interviews. Overarching themes identified include the payment model, government policies, and stigma and prejudice.

##### *Payment Model*

One interviewee expressed particular concern for the current physician’s payment model which:

*“Punishes the doctor financially. The more complex and individual they work with, see, it's roster based, so the physicians are paid for the number of people they have on their roster. So if you have really complex people, you're not going to be able to carry the same size roster as if you have a bunch of 25-year-olds”*

Given that this incentivizes physicians to give preference to already privileged patients, at the expense of access to health for those who are already marginalized, this payment model is in direct opposition to the NPLC's mandate, goals, and values. It actively worsens the health inequity that 360 NPLC works to reduce. This can limit inter-organizational alignment between the NPLC and Peterborough Family Health Teams, ultimately weakening the capacity for collaborative strategic action. Such payment models are also what make it difficult to get non-managerial (frontline workers) to be at the planning table for collaborative initiatives, because, again, it financially punishes them for giving time to partnership activities.

### *Government Policies*

Lack of human resources, shortage of healthcare workers, and lack of monetary and spatial resources are all issues which can be traced back to government funding—or rather, a lack of it. All interviewees raised concern about the government's role in shaping the healthcare system, especially with regards to funding, and privatization of health care.

Three out of the four participants repeatedly brought up insufficient government spending throughout their interviews. Most interviewees expressed their belief that the government's underfunding of healthcare is the root cause of weaknesses in the public healthcare system. When one interviewee was asked if they perceived any weaknesses or areas for improvement in the partnership and achievement of shared goals, they responded: *"It's more of a systemic thing, it's a funding issue, right? A lot of the work that we do is, is underfunded and, and undervalued"*. One interviewee said that they attribute funding cuts to the government prioritizing economic interests: *"Our denominator, ethically, should be that everyone deserves good care. But, uh,*

*when we bring market principles into the mix, it can sometimes distort our understanding of what the goals are*". Another interviewee said they believe that *"this government is intentionally strangling primary care"*, allowing public health care (especially primary health care) to fail so that privatized health care will be more justified in the public eye.

In two interviews, participants expressed concern for the future of health care in Ontario given the push for privatization. *"You've got the government turning the tap off. Well, it hasn't been on in years. But anyway, not turning it on, turning it on for private interests [...] there's over 1000 Private lobbyists at Queen's Park, on the health care file"*. Aside from the current crisis of primary care, two main concerns among interviewees regarding the privatization of healthcare can be identified: the inability to compete with private sector salaries and working conditions, resulting in increased staffing shortages in public health care, and worsened health inequity as many people will not be able to afford private care.

Most interviewees were critical of government 'solutions' to the public health care crisis for being ineffective, and in some cases disingenuous. As discussed in the weaknesses section, a 'seamless continuum of care' is difficult to achieve in the absence of sufficient resources. The OHT formation was particularly put under scrutiny by interviewees for this reason. One interviewee described the creation of OHT as *"just optics that everybody's working together and isn't the government doing a wonderful thing", when in fact, they do very little, there is no new funding*". In other words, the OHT can serve to cover up government inaction towards (or complicity in creating) the healthcare crisis.

Another participant expressed general concern for the government's advocacy of coordinated system responses and 'seamless delivery of care', not only because such government

prescriptions need to be supported by funding, but also because “*as they [the government] actually revise these things from the top-down, they don't provision them well because their main orientation is to cutting costs*”. While the literature review highlights the benefits of the network model for social support and healthcare systems, insights from the participants in this research indicate that the full realization of such benefits is dependent on adequate funding and bottom-up organizing. This is especially true for the 360 NPLC given that it is a small organization, and an outlier in the healthcare system both ideologically and in its mandate. When asked about the impacts of OHT on the NPLC’s advocacy and proposal leverage, this was one interviewee’s response: “*I think any friction, or anything where a voice isn't heard, it's because the hospitals are so big. It's a hospital-controlled Ontario Health Team*”. Unequal power dynamics within the OHT system—namely the dominance of the hospital—makes it difficult for the clinic and their patient’s interests to be represented in the broader network’s approach to health care.

### *Prejudice & Stigma*

While health inequity is largely a structural issue, pervasive ideologies of prejudice and stigma work to reproduce and ‘justify’ such structures that marginalize people. While all health care-providing institutions share the same core objective of preventing illness and improving quality and longevity of life, this does not apply equally to people. In response to a question regarding how the needs of marginalized communities are addressed within the Peterborough OHT, one interviewee highlighted the fact that “*the average lifespan of a homeless man is 50% less than their counterparts in higher income groups [...] If that issue is not front and center, then our health service is not serving people equitably*”. While the NPLC staff and most external

partners value all human life equally, this is not seen as reflective of values and attitudes in the health care system more broadly.

Prejudice against marginalized communities, and stigma surrounding poverty, homelessness, substance use and addiction, and mental illness is prevalent in Peterborough. As one interviewee stated, *“Its hard to convince people, especially when it costs a lot of money to support this [marginalized] population and to convince the people who are only looking at the medical from a financial standpoint that this is a population that matters”*. Such beliefs and values pose a considerable threat to the interests of the NPLC especially when they are held by people in government and positions of power within the OHT. The partner who spoke from the perspective of social work expressed particular concern about this issue: *“I think we've seen that large corporate medical facilities don't care about this population, so it would worry me that places like the NPLC would be drowned out”*. Throughout all interviews, it was conveyed in one way or another that those who advocate for health equity are ideological minorities within the system. One interviewee said that *“there's the few and far between [...] it's almost like we have to build our strength in all of these little pockets and then bring them together”*.

## **6. Discussion & Recommendations:**

The following table presents in summary form the key findings of our SWOT analysis.

### 6.1. SWOT Analysis Table

| Strengths   | Weaknesses   |
|---|--|
| <p><i>Internal:</i></p> <ul style="list-style-type: none"> <li>Staff values and attitudes</li> <li>Education and training</li> <li>Evaluation and strategic action</li> </ul> <p><i>External:</i></p> <ul style="list-style-type: none"> <li>Advocacy and Education</li> <li>Safe environment and quality of care</li> <li>Synergic partnerships</li> </ul> <p><i>Overlapping themes:</i></p> <ul style="list-style-type: none"> <li>Adaptability and responsiveness</li> </ul> | <p><i>Internal:</i></p> <ul style="list-style-type: none"> <li>Work stressors</li> <li>Resource limitations (human, spatial, financial)</li> </ul> <p><i>External:</i></p> <ul style="list-style-type: none"> <li>Fragmentation of services</li> <li>Sustaining collaboration</li> <li>Communication and partnership model</li> </ul> <p><i>Overlapping themes</i></p> <ul style="list-style-type: none"> <li>Staff Burnout and Understaffing</li> </ul> |
| Opportunities   | Threats  |
| <p><i>Internal:</i></p> <ul style="list-style-type: none"> <li>Partnerships</li> <li>Indigenous-led health care</li> </ul> <p><i>External:</i></p> <ul style="list-style-type: none"> <li>Informal and Formal Partnerships</li> <li>Communication</li> </ul>  | <p><i>Internal:</i></p> <ul style="list-style-type: none"> <li>Barriers to funding</li> <li>Sector competitiveness</li> </ul> <p><i>External:</i></p> <ul style="list-style-type: none"> <li>Payment model</li> <li>Government policies</li> </ul> <p><i>Overlapping themes:</i></p> <ul style="list-style-type: none"> <li>Community stigma and prejudice</li> <li>Structural and Political factors</li> </ul>  |

## 6.2. Assessment of Strategic Goals

By assessing the current success and limitations of the former strategic plan, we can answer our second research question: *what are the implications for 360 Degree NPLC's strategic planning exercise?* Together, the two above SWOT analyses provide a comprehensive assessment of the 360 NPLC's operational activities and strategic partnerships, from both internal and external perspectives. Overlapping themes between both old and new datasets give a strong indication of what current strategies should be reproduced, and what issues need to be addressed. But, to inform the next strategic plan, it must be understood what implications these SWOT analyses have on each of the strategic goals. Since all four overarching goals intersect with one another and are, to a great degree, interdependent, many of the themes brought out in the SWOT analyses encompass more than one goal at a time. Here, a condensed and synthesized assessment of each goal—based on the two SWOT analyses—will be provided with regard to the level of achievement, potential weaknesses, external threats, and areas deserving further attention in the next strategic plan.

- ❖ *Equity & Inclusion:* This goal has been upheld to a high degree, with strengths in patient satisfaction, reaching and serving vulnerable populations, and cultural safety training. Moving forward, in upholding the clinic's commitment to Equity and Inclusion, new and enhanced Indigenous programming and partnerships should continue to be sought after. Some threats, however, do present themselves, most notably, attitudes of prejudice in the community, and stigma surrounding poverty, mental illness, homelessness, and addiction. Addressing such threats will likely require further advocacy efforts, and community

education campaigns to break down harmful ideologies, and foster a culture of care and support in Peterborough.

- ❖ *Enhanced Services & Access*: There are considerable successes as well as weaknesses within this goal. Notable strengths include the variety of services and programs offered at the same location; the implementation of a digital health tool which became particularly instrumental in the context of the pandemic; and the capacity for data collection and operational evaluation to continuously monitor emerging community needs. The clinic continues to have a long wait list, making the NPLC inaccessible to many who are in need. Funding limitations appear to be the most significant threat to the fulfillment of this goal as identified in this research. Continued advocacy for increased funding and outreach efforts for new community partnerships and employee prospects are recommended as means of striving for greater accessibility and services.
  
- ❖ *Workplace Wellness*: Efforts in the promotion of, and improvements in staff well-being, and the fostering of a healthy work environment are noticeable over the four-year period. While staff retention has indeed been a struggle, it appears to be stabilizing or at least improving. Strategies including team communication and knowledge sharing; optimization of human resources to support manageable workloads; team building and bonding; and peer debriefing should continue to be utilized and supported. Staff still report burnout and high levels of stress. This appears to be largely because of resource limitations within the clinic causing human resources to be stretched too thin, and the many gaps in the health care system that the clinic is constantly working to fill. Increased

funding for the clinic and increased accessible services available in Peterborough outside of the clinic would likely have a positive impact on the 360 NPLC staff by alleviating workload. Moreover, an enhancement of digital tools to allow for a hybrid model, when necessary, may benefit staff by creating further flexibility in working hours.

- ❖ *Improved System Integration:* The clinic has been quite successful in the attainment of this strategic goal. Progress is identified in the areas of nurturing community partnerships and integration, and in particular advocating for improved patient access to harm reduction and addiction treatment services. Progress was also evident in public awareness of the NPLCs team and excellent health care provision. However, clear areas for improvement were also found in partnership integration, communication strategies and online presence. Though the clinic has been successful in various collaborative efforts with local partners, participation in the Ontario Health Teams network has come with its challenges. Primarily evident by the structural barriers OHT was found to reproduce, given the fact that it is a hospital-run system with little government funding to ensure a more equitable platform for smaller healthcare organizations. Recommendations in this section include embracing informal partnerships and the development of an enriched hybrid model that would boost communication within and across organizations at all levels. This could result in greater collaboration opportunities, and system and resource integration reinforcing a healthy ecosystem of care, while an enhanced online presence and communication at all sectoral levels could aid in increased service delivery, heightened collaborative efficiency and social media exposure.

## **7. Conclusion:**

The NPLC fills an important niche in the ‘ecosystem of care’ and does so with commendable accomplishments. But, to maintain a healthy and functioning ecosystem, the environment—or in a literal sense, the social, political, and economic context—must actively nurture it. The SWOT analysis undertaken here highlights the clinic's success in providing high-quality care and adapting to community needs, as well as advocating for harm reduction services in Peterborough. However, what has also been made overwhelmingly clear is that an inequitable systemic structure, underfunding, and pervasive ideology of prejudice and stigma, pose considerable risks to the clinic's interests. Several opportunities have been identified to address challenges faced, including using innovative employment and partner outreach strategies, prioritizing partnership-centered approaches to care networks, advocating for increased funding and reform of physician payment models, engaging in initiatives to tackle prejudice and stigma, and developing and using digital tools to increase work hour flexibility. The research highlights the need for partnerships with like-minded community members that have aligned values and goals. While existing literature generally suggests that organizations should strive for formal inter-organizational partnerships and networks, this research shows the importance of informal ties in the process of building bottom-up networks of care. Future research is also needed to support the clinic's strategic actions, including exploring opportunities to increase Indigenous-led healthcare approaches and partnerships and develop outreach and advocacy strategies.

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## Appendices:

### Appendix A: 360 Nurse Practitioner-Led Clinic's Strategic Plan (2019-2022)

[https://www.360nursepractitionerledclinic.ca/wp-content/uploads/2019/11/Peterborough-360-Degree-Nurse-Practitioner-Led-Clinic-Strategic-Plan\\_with-appendices\\_regPrinter.pdf](https://www.360nursepractitionerledclinic.ca/wp-content/uploads/2019/11/Peterborough-360-Degree-Nurse-Practitioner-Led-Clinic-Strategic-Plan_with-appendices_regPrinter.pdf)

### Appendix B: Semi-Structured Interview Questions (SSIs)

**Q1.** Can you tell us a little bit about the work you do and how long have you been working in collaboration with the NPLC?

-how would you describe the state of your partnership with the NPLC?

probe: long-term/short term, level of integration/structure of partnership?

**Q2.** How would you describe the communication between your self/organization and the NPLC? What would you say is the primary mode of communication and data sharing between you and the NPLC? For example, are there any forms of formalized communication (ie meetings, shared online communication platform)?

Follow up: do you find this effective?

Follow up: Do you think there are any ways for communication to be improved?

**Q3.** We understand that there exist differences between organizations in regard to institutional and governmental structures, ideologies and mandates that guide their work and the constituencies they serve. These differences give rise to possible boundaries in the partnership and these differences between organizations may create barriers for deeper integration and “seamless” networks of care.

How do you see these differences play out with regards to the NPLC, their partnerships and the broader support network that they are part of? Do you think these differences between organizations act as inherent barriers to strong partnerships and ultimately, to strong community support networks?

Do these differences between organizations give rise to opportunities for stronger partnerships?

Probe:

Could you think of any examples?

**Q4.** There are four overarching goals outlined by the NPLC's strategic plan: equity and inclusion, enhanced services and access, workplace wellness, and improved system integration. We would like to get an understanding of the role your partnership plays in the achievement of these goals. If you would like any clarity on what each goal entails as we ask the following questions feel free to ask.

-What impact would you say your partnership has on equity and inclusion of the NPLC and/or of your own organization?

-What impacts, if any, would you say your partnership has on the quantity and quality of services and access to services provided by the NPLC and/or your own organization?

Probe: location?

-What impact would you say your partnership has on workplace wellness for staff of the NPLC and/or within your own workplace?

Probe: workload?

-What impacts, if any, would you say your partnership has on system integration?

-How do the goals of your organization strive for compared to those of the NPLC? Do they overlap, or are they different, do they align?

If there are unaligned goals, do they conflict?

**Q5.** Can you describe any successful on-going or past projects that you have collaborated with the NPLC on? and what made/makes them successful? For example, programs or services within the ptbo drug strategy as you mentioned earlier

- Chris, pandemic, patient (tara)
- CTS site

Follow up: are there any other strengths this partnership presents that you would like to shed light on that were not necessarily showcased by [this] example?

Follow up: in your opinion, are there any weaknesses or places of improvement of the partnership itself and the achievement of shared goals?

**Q6.** Has the pandemic affected the nature of the work you do with the NPLC or how you work with the NPLC?

Follow up: Do you think the pandemic has been a barrier to the achievement of the partnership's shared goals?

Follow up: Have these barriers been to some degree overcome? How?

Follow up: Aside from the pandemic, do you see any other threats to this partnership or the achievement of your shared goals?

**Q.7** OHT:

We first came across OHT through the clinic's strategic plan, in there it OHT appeared to strive for a 'seamless' continuum of care however, as we went through the raw data, we could see some issues such as power struggles and the clinic appeared to struggle with having their voice heard.

You mentioned the public health's role of advocacy to fight structural barriers

- Do you think these conglomerates provide leverage to NPLC in their advocacy and proposals to help to serve marginalized peoples?
- Do you think OHT provides some form of alleviation to this lack of coordination in healthcare organizations
- To what degree is the network in the form of the OHT achievable in this context?

**Q8.** Where do you see this partnership going in the future or where do you *hope* to see this partnership going in the future? What role would each actor play in this evolution?

**Q9.** Are there any other points that you didn't have space to touch on that you think would be important to make with regard to any of the themes we've covered today?

