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**Exploring the Role and Turnover among Heart Health Coordinators
In the Ontario Heart Health Program: A Qualitative Study**

By

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**Thesis submitted to the
Faculty of Graduate and Postdoctoral Studies
In partial fulfillment of the requirements
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**School of Nursing
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Abstract

The Ontario Heart Health Program has completed Phase I of a province-wide cardiovascular disease prevention program that employs community-based coalitions. Full-time heart health coordinators support the coalitions, but many coordinators left during Phase I, reducing coalition membership and compromising functioning. This thesis employed focused ethnography to explore the role, and turnover among heart health coordinators. A selective document review and thirteen telephone interviews with coordinators, chronic disease managers and coalition members from five different health units, found coordinators were challenged by: (1) an atypical job, (2) a lack of knowledge/experience (3) overwork, (4) a lack of support and recognition, and (5) coalition responsibilities. Coordinators required an understanding of the organizational structures, mandates, and funding requirements of the health unit, and the Ministry of Health and Long Term Care so they could mediate conflict, build relationships and advocate for heart health coalitions. Implications for education, practice, research and policy are discussed.

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Table of Contents

Abstract	i
Acknowledgements	ii
Table of Contents	iii
Chapter 1 Introduction	1
1.1 International Trends in Cardiovascular Disease Prevention	1
1.2 The Canadian Heart Health Initiative	2
1.3 The Ontario Heart Health Program	3
1.4 Implementation of Phase I of the Local Ontario Heart Health Program	4
1.5 The Heart Health Coordinator	5
1.6 The Issue of Heart Health Coordinator Turnover	6
1.7 Rationale for Exploring the Role and Turnover of Heart Health Coordinators	8
1.8 Overview of Thesis	8
Chapter 2 Literature Review	9
2.1 Search Strategy	9
2.2 Community Coalitions	9
<i>Rationale for Coalitions</i>	10
<i>Stages of Coalition Development</i>	12
<i>Coalition formation</i>	12
<i>Implementation and maintenance</i>	13
<i>Sustainability</i>	13
<i>Collaboration: How Successful Coalitions Do Business</i>	13
<i>Factors that Influence the Collaborative Process</i>	14
<i>Characteristics of Effective Coalition Leadership</i>	15
2.3 Public Health Nursing	17
2.4 Job Satisfaction and Turnover of Nurses	19
<i>Factors that Influence Job Satisfaction</i>	20
<i>Supportive managers and peers</i>	20
<i>Organizational Climate</i>	21
<i>Respect and status</i>	22
<i>Other factors</i>	22
<i>Burnout</i>	23
<i>Turnover</i>	24
2.5 Job Satisfaction and Turnover in Public Health Nursing	25
2.6 Summary of Literature Review	27
2.7 Rationale for Study Derived from the Literature Review	28
Chapter 3 Methods	29
3.1 Research Design	29
3.2 Research Questions	31

3.3 Participant Recruitment and Informed Consent	31
<i>Sampling</i>	31
<i>Recruitment Strategy</i>	32
3.4 Interviews and Data Collection	35
<i>Interview Guide</i>	35
<i>Transcription of Interviews</i>	36
3.5 Ethics	36
3.6 Data Analysis	37
3.7 Selected Ontario Heart Health Program Document Review	37
3.8 Research Timeline	38
3.8 Summary	39
Chapter 4 Findings	41
4.1 Participant Demographics	41
4.2 Heart Health Coordinator Roles and Responsibilities	44
<i>Facilitating the Work of the Coalition</i>	44
<i>Community Development Roles and Responsibilities</i>	48
<i>Administrative Roles and Responsibilities</i>	49
<i>Additional Health Unit Responsibilities</i>	49
<i>Essential Heart Health Coordinator Leadership Skills and Personal Qualities</i>	50
4.3 Rewards of the Heart Health Coordinator Job	51
4.4 Provincial Challenges	52
<i>Ontario Heart Health Program: Phase II Funding Announcement Delays</i>	52
<i>Limited Project Scope</i>	53
<i>Challenges of Working at the Interface</i>	54
<i>Structural and Funding Challenges</i>	55
4.5 Local Challenges	55
<i>Challenge #1: Some Heart Health Coordinators Lacked Knowledge and Experience for an Atypical Public Health Job</i>	56
<i>Challenge #2: Heart Health Coordinators were Overworked Which Led to Burnout</i>	57
<i>Challenge #3: Heart Health Coordinators Lacked Influence with Health Units and the Ministry of Health and Long Term Care</i>	58
<i>Challenge #4: Low Heart Health Coalition Membership and Participation</i>	59
<i>Challenge #5: Heart Health Coordinators Lacked Sufficient Remuneration and Status within the Health Unit</i>	60
<i>Challenge #6: Failure to Adapt Ontario Heart Health Program to Smaller Rural Health Units</i>	61
4.6 Heart Health Coordinator Turnover	61
4.7 Managing Heart Health Coordinator Job Challenges	65
4.8 Mediating Relationships between Unequal Partners with Conflicting Agendas	66
<i>Heart Health Coalitions: Supporting a Fragile Entity</i>	66
<i>Managing Complex Relationships</i>	67
<i>Heart Health Coordinators: A Buffer between the Health Unit and the Coalition</i>	68
<i>Impact of Heart Health Coordinator Turnover on Managing Complex Relationships</i>	68

4.9 Summary	70
Chapter 5 Discussion	73
<i>Mismatch between Skill Level and Job Requirements</i>	<i>73</i>
<i>Remuneration.....</i>	<i>74</i>
<i>Access to Power</i>	<i>74</i>
<i>A Key Role</i>	<i>75</i>
<i>The Issue of Heart Health Coordinator Turnover</i>	<i>76</i>
<i>Similarities and Differences in Turnover</i>	<i>76</i>
<i>Why Not Leave the Job</i>	<i>77</i>
<i>Results of Heart Health Coordinator Turnover.....</i>	<i>78</i>
5.1 Public Health System Challenges	79
<i>Amalgamation.....</i>	<i>79</i>
<i>Fiscal Restructuring in the Public Health System</i>	<i>80</i>
<i>Restructuring of Public Health Nurse Positions</i>	<i>80</i>
5.5 Trustworthiness and Authenticity of Data	81
<i>Triangulation</i>	<i>81</i>
<i>Trustworthiness.....</i>	<i>82</i>
<i>Reliability.....</i>	<i>82</i>
<i>Field Research</i>	<i>82</i>
5.6 Limitations.....	83
5.7 Implications and Recommendations	83
<i>Practice.....</i>	<i>84</i>
<i>Mentoring</i>	<i>85</i>
<i>Manager support</i>	<i>85</i>
<i>Understanding health unit fiscal rules</i>	<i>86</i>
<i>Administrative support.....</i>	<i>86</i>
<i>Improved pay</i>	<i>86</i>
<i>Education.....</i>	<i>87</i>
<i>Research</i>	<i>88</i>
<i>Policy.....</i>	<i>91</i>
5.8 Conclusion	91
References.....	93

Figures

Figure 3.1 Recruitment Strategy.....	34
Figure 3.2 Research Timeline.....	39
Figure 4.1 Participation in Study.....	42
Figure 4.2 Communication and Fiscal Accountability Relationships in the Ontario Heart Health Program.....	46

Tables

Table 5.1 Recommendations.....	84
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Appendices

Appendix A	Categorization of Health Units.....	108
Appendix B	EMail Requesting Permission to Contact Heart Health Coordinator	109
Appendix C	Recruiting Speech Requesting Participation in the Study	111
Appendix D	Health Unit Screening Tool.....	114
Appendix E	Sample Request for Background Information.....	115
Appendix F	Participant Information Letter	116
Appendix G	Research Summary.....	118
Appendix H	Heart Health Coordinator Consent Form	119
Appendix I	Interview Guide (Heart Health Coordinator in Coalition <i>with</i> Turnover).....	122
Appendix J	Interview Guide (Heart Health Coordinator in Coalition <i>without</i> Turnover).....	123
Appendix K	Interview Guide (Chronic Disease Manager in Coalition <i>with</i> Turnover).....	125
Appendix L	Interview Guide (Chronic Disease Manager in Coalition <i>without</i> Turnover).....	126
Appendix M	Interview Guide (Coalition Member in Coalition <i>with</i> Turnover).....	128
Appendix N	Interview Guide for Coalition Member in Coalition <i>without</i> Turnover	129
Appendix O	Diagram of Heart Health Coordinator Relationships and Questions	131
Appendix P	Ethics Certificate from University Ottawa.....	133
Appendix Q	Renewal of Ethics Certificate	134
Appendix R	Sample Categorization of Interview Data	135
Appendix S	Sample Matrix.....	136
Appendix T	Ontario Heart Health Program Selective Document Review	137

Chapter 1 Introduction

This chapter briefly describes international, federal, provincial and local efforts to reduce cardiovascular disease and the evolution of the Ontario Heart Health Program. Heart health coordinators support the Ontario Heart Health Program at the local level. The problem of heart health coordinator turnover is briefly described and a short description of each thesis chapter is outlined.

1.1 International Trends in Cardiovascular Disease Prevention

Cardiovascular disease has reached epidemic proportions and has rapidly expanded in severity and breadth to become the leading cause of death, disability, and rising health care costs throughout the world....It would be largely preventable through a public health approach to cardiovascular disease. (World Health Organization, 2004, p. v)

Five international declarations on cardiovascular disease prevention and one international declaration that focused specifically on cardiovascular disease and women encapsulate an evolution in the understanding, and approach to cardiovascular disease prevention. The Victoria Declaration identified cardiovascular disease as an international problem and recommended that health promotion and disease prevention strategies be employed to reduce the problem (World Health Organization, 1992). The Catalonia Declaration described specific cardiovascular disease prevention strategies and environmental supports for health promoting behaviors (World Health Organization, 1995). The Singapore Declaration recognized that countries must have the capacity to address cardiovascular disease, noting that in order to develop capacity, countries require a scientific base, the necessary infrastructure, a desire to improve cardiovascular health, and strong leadership (World Health Organization, 1998). A second Victoria Declaration described

how cardiovascular disease differed in women (World Health Organization, 2000). The Osaka Declaration explored how sectors other than health influence cardiovascular disease (World Health Organization, 2001). Most recently, the Milan Declaration discussed cardiovascular disease reduction technologies including health promotion, disease prevention, food, medical technologies and biotechnologies (World Health Organization, 2004). These international declarations continue to inform recent Canadian efforts to reduce cardiovascular disease (Health Canada, 2001).

1.2 The Canadian Heart Health Initiative

Established in 1986, the Canadian Heart Health Initiative aimed to build capacity for cardiovascular disease prevention programs at national, provincial and local levels (Health Canada, 2001). Capacity refers to “the actual knowledge, skill sets, participation, leadership and resources required by community groups to effectively address local issues and concerns” (Ontario Provincial Clearinghouse, 2002, p. 1). The Canadian Heart Health Initiative was a federal government program that employed population health strategies to address modifiable risk factors for cardiovascular disease among Canadians (Health Canada). Public participation and collaboration by health and other sectors were important components of the project. The six strategies that were promoted by the Canadian Heart Health Initiative included: “(1) public education, (2) community mobilization, (3) healthy public policy, (4) strengthening preventative health services, (5) research and evaluation, and (6) public health system leadership” (Health Canada, p. 5). This capacity building approach to cardiovascular disease prevention matched federal government funds with provincial money. The Ontario segment of the Canadian Heart Health Initiative in Ontario was known as the Ontario Heart Health Program (Health Canada).

1.3 The Ontario Heart Health Program

Five demonstration projects that ran from 1990 to 1996 have informed the Ontario Heart Health Program (Riley, d'Avernas, Edwards, 2002). These demonstration projects developed knowledge and expertise in community-based cardiovascular disease prevention through a project research component. A provincial Heart Health Resource Centre supported the demonstration projects and continued in the same role after the program expanded province-wide (Riley, Edwards, & d'Avernas, 2004).

In 1998 the Ontario Heart Health Program began Phase I of a 15 year initiative designed to reduce the incidence of cardiovascular disease in Ontario residents (Riley et al., 2004). Each phase was planned to last five years, but Phase I was extended an additional year to permit completion of a formal evaluation. The provincial government provided \$3.4 million dollars for each year of Phase I (Riley et al., p. viii), but funding for Phase II and Phase III was not guaranteed at the beginning of the program. There was a long period of fiscal uncertainty during the last few years of Phase I. After the Phase I evaluation was completed, it was recommended that the Ontario Heart Health Program be continued. Funding was announced for Phase II in November 2003, and began in April 2004 when all Ontario health units but one received provincial heart health funds. The Health Promotion and Wellness Division of the Public Health Branch of the Ministry of Health and Long Term Care have had responsibility for the Ontario Heart Health Program at the provincial level since the final year of Phase I (Riley et al.).

An important goal of the Ontario Heart Health Program is to improve the capacity of health units, communities, and heart health coalitions to address cardiovascular disease and support environmental changes that promote the reduction of modifiable cardiovascular disease risk factors in the population (Riley et al., 2004). Over time the Ontario Heart

Health Program expects to: (1) reduce the number of people smoking, (2) increase the level of physical activity in the population, and (3) improve diet, but it was not anticipated that these long term goals would be attained during Phase I. As Phase I of the Ontario Heart Health Program was implemented, communities formed local heart health coalitions that were established to plan and implement cardiovascular disease prevention strategies (Riley et al.).

To set the context for the Ontario Heart Health Program, it is essential to understand that important structural and fiscal changes occurred in Ontario at the same time as the program was initiated. These changes included: (1) the amalgamation of some municipal and health unit organizational structures (Association of Public Health Epidemiologists in Ontario, n.d.), (2) the downloading to municipalities of full responsibility for public health funding (Falk-Rafael, Fox, & Bewick, 2005; Riley et al., 2004), and (3) the reduction of health unit human resources (Falk-Rafael et al.). These significant province-wide changes occurred at the onset of the Ontario Heart Health Program, one of the largest prevention initiatives designed to reduce cardiovascular disease in Ontario residents.

1.4 Implementation of Phase I of the Local Ontario Heart Health Program

Provincial funding of the local Ontario Heart Health Program was contingent on community involvement in the form of heart health coalitions (Riley et al., 2004). In most cases, these coalitions developed after provincial funding was in place. Public health involvement with heart health coalitions is congruent with other community-based public health initiatives that have enlisted coalitions to address issues such as injury prevention, alcohol and drug use prevention, child health enhancement, and teen pregnancy prevention (Ontario Ministry of Health, 1997).

With one exception, individual public health units became the lead agency around which the local Ontario Heart Health Program was organized (Riley et al., 2004). Funding of the local Ontario Heart Health Program was a shared responsibility, as together the health unit and community partners provided two dollars in-kind for every dollar contributed by the Ministry of Health and Long Term Care. Local health units were responsible for administering heart health funds from the province and tabulating in-kind health unit and community contributions. The Boards of Health of individual health units were fiscally accountable to the Ministry of Health and Long Term Care for heart health funds. An important in-kind contribution by each health unit was the community leadership provided by a staff member who took on the role of the heart health coordinator (Riley et al.).

1.5 The Heart Health Coordinator

Each public health unit was mandated by the Ministry of Health and Long Term Care to assign one full time equivalent staff member as heart health coordinator during Phase I (Riley et al., 2004). Coordinators assisted coalitions to plan and implement heart health initiatives and were responsible for maintaining detailed records of coalition work that are routinely reported to the Ministry of Health and Long Term Care (Riley et al.).

Many heart health coordinators are public health nurses. This leadership position is appropriate for public health nurses because they understand health promotion and illness prevention; have a holistic approach to health and can support the development of community partnerships (Bolton, Georges, Hunter, Long, & Wray, 1998; Kang, 1995). Facilitating community participation to improve the health status of a community is an important role for public health nurses because working with partnerships is part of the Mandatory Health Programs and Services Guidelines for Local Boards of Health (Ontario Ministry of Health, 1997). Chambers et al. (1994) surveyed 1,849 public health nurses and

found they were functioning as “facilitators/ communicators/collaborators and community developers” (p. 177). Coalition leaders such as heart health coordinators require these types of skills (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001).

1.6 The Issue of Heart Health Coordinator Turnover

The problem of heart health coordinator turnover first became apparent in a study of Ontario heart health coalitions by Dunkley, Michelin, and Stewart (2001) and in the Preliminary Ontario Heart Health Evaluation (Riley et al., 2002). The mixed methods study by Dunkley et al. suggested that heart health coalitions required the support of stable heart health coordinators. During Phase I of the Ontario Heart Health Program turnover of coordinators was especially problematic because coalitions were in the early stages of development and partners relied on the coordinator to help them communicate with each other. Each heart health coalition had important tasks during the early stages of Phase I that included the development of: (1) a four-year long term plan, and (2) a sustainable coalition infrastructure. Turnover of heart health coordinators resulted in a lack of leadership which made these tasks more difficult (Dunkley et al.). Several other problems that resulted from coordinator turnover were documented by Riley et al. (2004) as: (1) limited development of interpersonal relationships among coalition partners, (2) an absence of the leadership necessary to help the coalition develop, (3) an absence of a collective identity among coalition members, (4) poor communication, and (5) an absence of coordination for all aspects of coalition functioning. It is clear that coordinator turnover significantly impeded the development of heart health coalitions during Phase I of the Ontario Heart Health Program (Riley et al.).

Considering the critical leadership requirements for heart health coalitions during Phase I, it is significant that there was a high rate of heart health coordinator turnover. Riley

et al. (2004) discovered that there were a total of 110 coordinators for the 37 health units during Phase I. This averaged 2.7 heart health coordinators per coalition. Some communities had as many as seven heart health coordinators during the five year period. When coordinators turned over there was, on average, a 3.6 month gap period (range zero to 26 months) without a coordinator in place (Riley et al. p. 23).

A few possible reasons for coordinator turnover have been identified. Dunkley et al. (2001) suggested that coordinator roles and responsibilities differed from those of other health unit employees. In addition, coordinators faced difficulties because the Ontario Heart Health Program did not always conform to existing heart health program policies. Dunkley et al. commented:

A striking feature of the findings across the province was the degree to which coordinators found their job stressful and demanding, in no small part due to the conflicting demands from three 'bosses': health unit, ministry and community. Clarity and accountability [in choosing] which policies to follow was sometimes lacking. (p. 20)

The qualitative section of the Preliminary Evaluation of Phase I by Riley et al. (2002) also suggested that the demanding nature of the heart health coordinator position may have caused coordinators to leave the job. In addition, these authors suggested that the coordinator position attracted skilled candidates who used the position as a means to move into management positions. While there is evidence that coordinators had a difficult job and turned over, and that turnover had a negative effect on coalitions, no research has studied the role of heart health coordinators, nor the problem of their turnover in depth.

1.7 Rationale for Exploring the Role and Turnover of Heart Health Coordinators

The Ontario Heart Health Program is an important health promotion initiative at the population health level because it offers the opportunity to build community capacity to address cardiovascular disease prevention, and thereby improve the health of Ontario residents (Health Canada, 2001). The Ministry of Health and Long Term Care, health units and community members have invested significant resources and time into this model of cardiovascular disease prevention, but heart health coordinator turnover during Phase I of the Ontario Heart Health Program has compromised heart health coalition membership and functioning (Riley et al., 2004). Job turnover can be symptomatic of job dissatisfaction (Irvine & Evans, 1995; Tang, 2003) and low organizational commitment (Acorn, Ratner, & Crawford, 1997). Therefore, it is important to explore the roles and turnover of heart health coordinators in order to understand why some leave and why others manage to stay.

1.8 Overview of Thesis

This thesis explores the role and turnover among heart health coordinators in the Ontario Heart Health Program. Chapter 2 reviews the literature on community coalitions, coalition leadership, and reasons for job turnover in nursing. Chapter 3 explains the study methodology and Chapter 4 describes study findings. Chapter 5 discusses the findings, implications and limitations of the study and makes recommendations for practice, education, policy and future research.

Chapter 2 Literature Review

The literature review described in this chapter examines the rationale for community coalitions, outcome success, stages of coalition development, and collaboration. It outlines factors that promote successful community partnerships and highlights the importance of coalition leadership. Factors influencing job satisfaction and burnout are discussed in sections on public health leadership and nursing turnover and the effect of turnover on organizations is reviewed. The quality of research examining coalitions, job satisfaction and turnover is discussed.

2.1 Search Strategy

The search strategy for this thesis used MEDLINE, CINAHL, HEALTHSTAR databases, Proquest electronic journals, and Ontario Scholars Portal for the years 1980 to 2006. Terms searched individually and in combination included: “cardiovascular disease prevention,” “coalition,” “community coalition,” “coalition + leadership,” “community capacity building,” “community capacity,” “community collaboration,” “nursing turnover,” “nursing job satisfaction,” “organizational commitment,” “public health nursing,” “public health nursing turnover,” and “public health nursing job satisfaction.” Relevant systemic reviews were identified through the Effective Public Health Practice Project, the Cochrane Collaboration and the databases identified above. Reference lists of retrieved articles were reviewed for relevant articles. Additional search strategies included online searches for authors known to publish in these areas including Butterfoss, Kreuter and Laschinger, and grey literature.

2.2 Community Coalitions

The Ontario Heart Health Program engaged communities in planning and implementing heart health initiatives by involving them in heart health coalitions (Riley et

al., 2004). This section describes: (1) the rationale for coalitions; (2) the stages of coalition development; (3) how coalitions collaborate to address complex community health problems, and (4) factors that influence coalition functioning including the role of coalition leaders in facilitating collaboration.

Rationale for Coalitions

Community coalitions are “formal, multi-purpose and long-term alliances or community organizations of individuals or interest groups to achieve common goals” (Kumpfer, Turner, Hopkins, & Librett, 1993, p. 360). Coalitions address problems too large to be solved by one organization working alone (Butterfoss, Goodman, & Wandersman, 1993; Roussos & Fawcett, 2000). Diverse coalition membership provides coalitions with access to multiple skills and resources which improves the likelihood that a coalition will succeed. A review of 34 coalition studies by Roussos and Fawcett determined that intersectoral partnerships permit coalitions to develop multifaceted interventions necessary to address complex issues. Health problems such as alcohol and drug use, tobacco use prevention, cancer prevention, heart disease and diabetes have been successfully addressed by community-based coalitions (Butterfoss, Morrow, Webster, & Crews, 2003).

Government agencies have often stipulated coalitions as a funding requirement for many community-based projects (Florin, Mitchell, & Stevenson, 1993; Kreuter, Lezin, & Young, 2000; Mayer et al., 1998; Health Canada, 2001; Riley et al., 2004; Weiss, Anderson, & Lasker, 2002). Coalitions have provided direction to community initiatives (Jasuja et al., 2005) and have served as catalysts spurring community change (Fawcett et al., 1997).

Coalitions maximize the use of scarce resources and facilitate coordinated interventions by reducing duplication of effort (Butterfoss et al., 1993; Kegler, Steckler, McLeroy, & Malek, 1998; Gottlieb, Brink, & Gingiss, 1993).

The widespread use of community coalitions is supported by an ecological model of health that recognizes the influence of environmental factors on individual behavior (Stokols, 1996; Stokols, Grzywacz, McMahan, & Phillips, 2003). While three review papers have concluded that coalitions often do not demonstrate significant health status changes, there are reasons that these changes may not be evident in the short term (Kreuter et al., 2000; Kuhn, Doucet, & Edwards, 1998; Roussos & Fawcett, 2000). Kreuter et al. suggested that coalition development takes time and resources, so improvements in community health status may not be evident in the early stages. Coalitions may attempt to improve the health of a population by addressing health problems which are the result of long standing previous exposure to risk factors. As a result, behavioral and environmental changes made now will not demonstrate an improvement in health status until the future (Kreuter et al.). Researchers now often identify intermediary outcomes as early evidence of population health changes (Cheadle, Sterling, Schmid, & Fawcett, 2000; Crowley, Yu, & Kaftarian, 2000).

There are some gaps in the study of coalitions because the complexity and long term duration of coalitions makes the cost of studying them prohibitive and complicated (Kreuter et al., 2000). Much of the research on coalitions has utilized case study methods that examine individual coalitions without comparison groups (Armbruster, Gale, Brady, & Thompson, 1999; Fodayemi, 2001; Mulroy, 1997; Snell-Johns, Imm, Wandersman, & Claypoole, 2003). The lack of comparison groups has made it difficult to evaluate the degree to which coalition efforts result in community change. No consistent outcomes for coalitions have been developed to ease comparisons across studies (Roussos & Fawcett, 2000). However, several researchers have identified that coalitions evolve through various

stages of development as they address community issues (Butterfoss et al., 1993; Kreuter et al., 2000).

Stages of Coalition Development

There is a lack of consistency in the descriptions of coalition development. What is clear is that coalition development has been categorized as: (1) coalition formation, and (2) coalition maintenance (Butterfoss et al., 1993; Granner & Sharpe, 2004; Kreuter et al., 2000). In other words, descriptions are given of the processes and tasks associated with (1) starting and developing a coalition, and (2) with maintaining or keeping it going.

While each individual coalition develops differently; the stages of development are similar (Butterfoss et al., 1993; Granner & Sharpe, 2004; Kreuter et al., 2000). Butterfoss et al. described the stages of coalition development as: "formation, implementation, maintenance and accomplishment of goals" (p. 319). Kreuter et al. further refined these stages by incorporating a "preformation stage" (p. 52) during which the coalition lays the groundwork for the project. Studies by Florin et al. (1993) and Bracht et al. (1994) discussed sustainability or the continued existence of coalitions after they finish addressing the primary issue that brought the coalition together.

Coalition formation. Both Butterfoss et al. (1993) and Kreuter et al. (2000) described similar tasks for the formation stage. Kreuter et al. suggested that during the formation stage coalitions must "clarify the mission, recruit members and formalize rules, roles and procedures" (p.53). The development of a common vision was described as the foundation for working together and an important factor in coalition success (Roussos & Fawcett, 2000). Another significant task for this stage was learning to deal with conflict (Kreuter et al.).

Implementation and maintenance. During these stages the coalition must progress from an assessment phase in which members define the issue and set priorities, to an active stage where they develop plans and implement strategies to address the problem (Kreuter et al., 2000). During this period, the coalition may identify gaps in their skill set and require technical assistance in order to develop sufficient expertise (Florin et al., 1993).

Sustainability. Much effort goes into forming and maintaining coalitions. Both Florin et al. (1993) and Bracht et al. (1993) examined the issue of sustainability of three community-based heart health coalitions after funding ceased. The authors found that coalitions can become institutionalized and continue to exist after they complete their initial tasks by moving on to address new community problems.

Throughout the stages of coalition development, retaining coalition membership and recruiting new members is vital (Foster-Fishman et al., 2001). Effective leadership is a critical component for coalition development as leaders assist members to coalesce into a coalition capable of developing a unified plan and implementing interventions that address community problems (Joffres, Langille, Rigby, & Langille, 2002; Kuhn et al., 1998; Mitzrahi & Rosenthal, 2001; Riley et al., 2004; Zukoski & Shortell, 2001). As coalitions progress through the stages, coalition partners learn to collaborate or work together (Butterfoss et al., 1993; Kreuter et al., 2000).

Collaboration: How Successful Coalitions Do Business

Collaboration “is a mutually beneficial relationship between two or more parties who work together toward common goals by sharing responsibility, authority and accountability for achieving results” (Chrislip & Larson, 1994, p. 5). Foster-Fishman et al. (2001) conducted a qualitative analysis of 80 articles on coalitions and discovered that the ability of coalitions to collaborate is dependent upon the development of collaborative capacity.

Collaborative capacity refers to the skills and abilities required by coalition members to work effectively together (Goodman et al., 1998). Foster-Fishman et al. found that coalitions must build collaborative capacity in four areas: (1) member relationships, (2) external relationships, (3) organizational capacity, and (4) programming. Alter and Hage (1992) described three levels of collaboration that progressively become more complex. During the obligational stage members exchanged information and communicated superficially, but by the second stage members developed a promotional network that identified a common problem, and devised ways to address it. A systemic network developed during the final stage, and permitted the coalition to address complex problems that required additional resources. Organizations participating in the coalition became less concerned with their organizational mandate and more aligned with coalition needs (Alter & Hage).

Factors that Influence the Collaborative Process

Developing collaborative capacity requires significant time, resources, energy, and is challenging because diverse coalition members must develop a common understanding of the problem and identify solutions to it (Kreuter et al., 2000; Roussos & Fawcett, 2000). Many factors have been identified that influence the ability of coalition members to collaborate effectively. While factors influencing collaboration may not influence coalition outcomes, they are important because they keep coalition partners working together to address a common goal (Foster-Fishman et al., 2000; Kreuter et al.). It is important to note that many coalitions dissolve before they successfully address community issues. Therefore factors that promote coalitions to remain intact and collaborate are important (Weiss et al., 2002).

Although factors influencing coalition function were identified in the literature, researchers have commented that many tools measuring these factors are not published and have not reported on validity or reliability (Granner & Sharpe, 2004; Roussos & Fawcett, 2000). Factors identified that influenced coalition functioning include: (1) a sustainable infrastructure (Cramer, Atwood, & Stoner, 2006; Florin et al., 1993; Kegler et al., 1998; Rogers et al., 1993), (2) a collective identity (Dunkley et al., 2001), (3) a formal statement of purpose (Butterfoss et al., 1993), (4) commitment to the cause (Anderson et al., 2004), (5) systematic communication (Butterfoss et al.; Dunkley et al., Rogers et al.), (6) an explicit method of decision making (Dunkley et al., Kegler et al.), (7) technical training and support (Florin et al.), (8) benefits that accrued to members from participation in the coalition offset the cost of involvement (Butterfoss et al.; Dunkley et al.; Kegler et al.), (9) the presence of a champion who supports the work of the coalition (Dunkley et al.), and (10) the use of a monitoring and evaluation system (Francisco, Paine, & Fawcett, 1993). The most important factor that has been shown to consistently influence effective coalition function is leadership (Alexander, Zakocs, Earp, & French, 2006; Butterfoss, Goodman, & Wandersman, 1996; Christlip & Larson, 1994; Granner & Sharpe; Joffres et al., 2001; Kreuter et al., 2000; Kumpfer et al., 1993; Mitzrahi & Rosenthal, 2001; Riley et al., 2004; Roussos & Fawcett).

Characteristics of Effective Coalition Leadership

In a review of 34 studies that used quantitative and/or qualitative methods, Roussos and Fawcett (2000) reported that leadership was the factor most often associated with coalition effectiveness and creating community change. Strong empowering coalition leadership has been shown to assist coalitions to develop conflict resolution strategies, work through conflicts and foster the development of collaborative capacity (Dunkley et al., 2001; Kumpfer, et al., 1993; Weiner, Alexander, & Shortell, 2002).

A small exploratory quantitative study by Kumpfer et al. (1993) discovered that coalition leaders use strong communication, conflict resolution, and administrative skills to foster collaboration among coalition partners. A mixed methods study by Mizrahi and Rosenthal (2001) found that effective coalition leaders possessed: (1) relationship building skills such as facilitation, negotiation and vision, and (2) competence skills that included analytical and communication abilities. In order to build and maintain coalition partner relationships, the leaders cultivated vital partner skills and capabilities required for collaboration, and maintained coalition members' interest and involvement in the project (Foster-Fishman, 2001). A quantitative exploratory study by Weiss et al. (2002) discovered that effective leaders promoted synergy within the coalition. Synergy was described as "combining the perspectives, knowledge and skills of diverse partners to: (1) think in new ways..., (2) plan more comprehensive, better programs, and (3) strengthen its relationship to the broader community" (p. 684). A large cross-sectional study by Weiner et al. (2002) indicated that conflict resolution strategies used by coalition leaders must result in outcomes that are perceived as fair by coalition members. Grass roots coalition leaders engaged members in the issue, while more formal, funded coalition leaders often administered the program and resources (Roussos & Fawcett, 2000). Diekemper, SmithBattle and Drake (1999) suggested that development of these complex coalition leadership skills require years of experience and support from mentors and colleagues.

In some cases coalitions hired a project manager to run the program (Alexander et al., 2006; Joffres et al. 2003; Riley et al., 2004). Alexander et al. compared ethnographic studies of eight coalitions to identify the attributes of effective project directors. The authors found that project leaders, who shared leadership with coalition membership, built bridges to and within the community and were community insiders developed more successful

coalitions (Alexander et al.). A case study by Fawcett, et al. (1997) found that community change was compromised when no leader was in place. A correlational study by Gottlieb et al. (1993) surveyed fifty coalitions to identify variables associated with coalition effectiveness. The researchers determined that turnover of both coalition leadership and membership was detrimental to coalition functioning. Energy was focused on socializing new members rather than coalition development and initiatives (Gottlieb et al.). No other literature was found that examined the relationship of leadership consistency to coalition functioning. As leaders of coalitions, public health nurses have played a significant role in community development.

2.3 Public Health Nursing

Community coalitions are a widely used public health strategy for improving community health status. Public health nurses have embraced opportunities to act as leaders of coalitions that support community-based approaches to health issues. This section examines: (1) the roles and activities of Ontario Public Health Nurses, and (2) challenges inherent within the job.

Several studies have examined the roles and activities of Ontario Public Health nurses (Chambers et al., 1992; Falk-Rafael et al., 2005). Chambers et al. (1992) surveyed 1,849 Ontario public health nurses to determine whether public health nurse roles and responsibilities described in the 1990 Canadian Public Health Association report applied to public health nurse practice. Most public health nurses stated that while they worked as “social marketers, facilitators/communicators/ collaborators, and community developers,” (p. 177) they felt less prepared for this role than for direct patient care. This had changed when Falk-Rafael et al. (2005) reported on the results of a 1999 descriptive survey of Ontario Public Health Nurses that was designed to understand the scope and nature of public

health nursing practice. In this later survey, most nurses indicated that they were using a population health approach to health promotion and illness prevention. Public health nurses ranked the most frequently used public health nursing strategies as: 2nd group health promotion, 3rd interagency collaboration, 4th community development, and 7th coalition development (Falk-Rafael et al.). A qualitative phenomenological study by Leipert (1996) of community health nurses from a large urban public health department in Canada described the activities nurses valued in their job. Nurses attached importance to collaborative activities that promoted health and prevented illness as well as individual and family visiting.

While many public health nurses have indicated that they like their jobs, it is evident that both American and Canadian public health nurses are facing significant challenges (Cumbe & Alexander, 1998; Gebbie & Hwang, 2000; Haugh & Laschinger, 1996). Studies have repeatedly described how the fast pace of change within the public health system has challenged nurses (Armstrong-Stassen & Cameron, 2005; Cumbe & Alexander; Gebbie & Hwang; Haugh & Laschinger). A qualitative study for the Canadian Nurses Association by Underwood (2003) described how fragmented Canadian community nursing services have contributed to a poor understanding of the public health nurse role by nurses, the public, and politicians. Another explanation of why nurses may feel challenged is that while both Canadian and American public health nurses were well educated about public health nursing theory, they may have lacked sufficient clinical experience during their educational preparation to understand the realities of this type of nursing (Gebbie & Hwang; Underwood).

The public health nurse job can be challenging because nurses may not have sufficient managerial support. Many Ontario public health units lack nurses in upper level

management positions (Falk-Rafael et al., 2005). Underwood (2003) discovered that Canadian public health nurses may have managers from another health discipline who find it difficult to understand the scope of nursing. Managers may also be weighed by heavy job demands that make it difficult for them to provide adequate support to nurses (Underwood). This could mean that some Ontario public health managers lack sufficient power to help their staff garner the necessary resources to do the job (Haugh & Laschinger, 1996).

In light of the challenges within the public health sector and because public health nurses occupy heart health coordinator positions, it is important to examine the literature around nursing job satisfaction and turnover to determine whether or not any of these factors might have influenced heart health coordinator turnover. While a literature review of nurse turnover by Hayes et al. (2006) found that it is difficult to both define and quantify turnover Strachota, Normandin, O'Brien, Clary, and Krukow (2003) consider it to be voluntarily leaving a job.

2.4 Job Satisfaction and Turnover of Nurses

Most of the studies on job satisfaction and turnover in nursing were American and have been conducted within the hospital sector (Campbell, Fowles, & Webber, 2004; Cumbe & Alexander, 1998; Jones, 2005; Larrabee et al., 2003). Job satisfaction is "an affective feeling that depends on the interaction of employees, their personal characteristics, values and expectations with the work environment and the organization" (Cumbe & Alexander, p. 41). Personal feelings that relate to job satisfaction fluctuate as individual characteristics and perceptions of the job change (Cumbe & Alexander). A Canadian study concluded that high levels of job satisfaction correlate to low levels of turnover (Lum, Kervin, Clark, Reid, & Sirola, 1998). This was also found by a Chinese researcher (Tzeng, 2002). Shields and Ward (2001) found that job satisfaction was a more important factor for

British nurses in job turnover than the lure of other opportunities and therefore an understanding of the factors that influence levels of job satisfaction may shed light on factors that influence turnover. A Dutch team, Janssen, de Jonge, and Bakker, (1999) found that nurses may become so overwhelmed by their job that they burnout. Burnout was related to increased job turnover. This section discusses: (1) factors that influence job satisfaction, (2) burnout, and (3) the cost of turnover.

Factors that Influence Job Satisfaction

A study by Aiken et al. (2001) compared job satisfaction levels of nurses in five different countries. The authors found that 32.9% (p. 46) of Canadian nurses were dissatisfied with their present job. Canadian rates for nursing job dissatisfaction were lower than those for nurses in the United States, England, and Scotland, but were higher than in Germany (Aiken et al.). Nurses have identified many factors that positively influence job satisfaction including: (1) supportive managers (Irvine & Evans, 1995; Larrabee et al., 2003; Strachota et al., 2003; Upenieks, 2003), (2) a positive organizational climate (Irvine & Evans), (3) respect and status (Cowin, 2002), and (4) personal factors (Lacey, 2003; Shields, & Ward, 2001).

Supportive managers. Supportive managers improved nursing job satisfaction (Irvine & Evans, 1995; Larrabee et al., 2003; Strachota et al., 2003; Upenieks, 2003). In a mixed methods study, Upenieks compared American magnet and non-magnet hospitals to determine whether nursing job satisfaction was linked to effective management. Nurses had higher job satisfaction levels when they had managers who made themselves available; supported autonomous nurse decision-making; and provided nurses with access to opportunities, information, and resources (Upenieks). However, Aiken et al. (2001) found that only 34.9% (p. 47) of Canadian nurses thought that administration listened and

responded to their concerns while 39.7% (p. 47) felt that nurses participated in policy decisions. Only 39.3% (p. 47) of Canadian nurses felt that nursing contributions to patient care were acknowledged (Aiken et al.). Yet, Aiken et al. found that Canadian nurses were more satisfied than most even though they perceived they were not being listened to by administration. This suggests that other factors may have been more relevant to nurse job satisfaction among Canadian nurses.

Using a descriptive, correlational survey design, Kluska, Laschinger, and Kerr (2004) surveyed 112 staff nurses in Ontario teaching hospitals to examine the relationship between nurses' perceived effort and reward, and their level of empowerment. The researchers found that easy access to resources (information, support, and opportunity) that were required to do the work, improved nurse levels of empowerment. Access to resources was viewed as an important factor in job satisfaction (Upenieks, 2003). High levels of empowerment were associated with low job stress and high levels of job satisfaction (Kluska et al.). Similar results were found in a Canadian study by Laschinger, Finegan, Shamian, and Wilk (2001). Aiken et al. (2001) discovered that only 35.2% (p.47) of Canadian nurses believed that there were sufficient registered nurses to provide quality patient care, and only 37.4% (p. 47) of Canadian nurses felt hospitals were adequately staffed.

Organizational climate. A meta-analysis of 21 studies by Irvine and Evans (1995) explored the relationship between job satisfaction and turnover, and discovered that job satisfaction levels were determined more by organizational climate than by remuneration. A longitudinal Australian study by Cowin (2002) surveyed fourth year nursing students' and hospital nurses' levels of satisfaction and turnover intent at two points in time, eight months apart. At the time of the second survey, the nursing students had graduated. The second survey had a qualitative component which asked the nurses for comment on their nursing

experiences. Only 35% (p. 287) of the new graduates were satisfied with their pay, whereas 64% (p. 287) of experienced nurses were satisfied with their pay. For the recently graduated nursing students, the debt load from their education was also a concern. Several experienced nurses felt that nursing salaries compared poorly to those of similar professions such as teachers particularly given the high level of responsibility handled by nurses (Cowin). Aiken et al. (2001) found that 69% (p. 47) of Canadian hospital nurses were satisfied with their salaries. This was the highest percentage when compared to American, English, Scottish and German nurses.

Respect and status. An American longitudinal study by Ulrich, Buerhaus, Donelan, Norman, and Dittus (2005) examined how 1,783 registered hospital nurses viewed their work environment at two year intervals. The researchers found that the level of respect from both supervisors and management influenced nursing turnover. Participants in the study indicated that if nurses received more respect from managers and management, it would be more likely that they would remain in their present job. The researchers suggested that more research needs to be done to identify exactly what respect means to staff nurses (Ulrich et al.). In an Australian study by Cowin (2002) over 90% (p. 288) of nursing students and experienced nurses identified professional status as a source of satisfaction and an important contributor to their decision to remain in nursing. A Canadian study by Underwood (2003) interviewed 11 participants to explore the value of community nurses practising in a variety of settings. Participants commented that they felt the general public was unaware of the roles and responsibilities of community health nurses unless they had received service, and that community health nurses were invisible to the public (Underwood).

Other factors. New British nurses were more likely to have low job satisfaction than older nurses (Shields & Ward, 2001). American nurses were more likely to leave their job

during the first three years of employment (Lacey, 2003). An American study by Gardner (1992) found that while strong career commitment may reduce nursing turnover, this did not hold true for new nurses possibly because new nurses may not have developed sufficient career commitment to remain in the job. An international study by Aiken et al. (2001) found that nurses under the age of thirty were more likely to state that they wished to leave their job than nurses over the age of thirty. Highly educated Chinese nurses were more likely to turnover in order to advance their careers (Yin & Yang, 2002). In both China and Canada workplace and family balance has been found to be critical to job satisfaction (Hung, 2002; Kane, 1999). According to a Canadian study dissatisfied nurses may not leave the position because external factors such as closure of a major industry, spousal employment, or the opportunity for another job may dictate the employee's decision to remain working or leave a position (Betkus & MacLeod, 2004). Nurses who become overwhelmed by their job may be subject to burnout.

Burnout

Dutch researchers found that an overwhelming workload can lead to burnout among workers (Janssen et al., 1999). Burnout occurs when workers become emotionally exhausted resulting in the depersonalization of clients and a reduced sense of personal accomplishment (Leiter & Spence Laschinger, 2006). Canadian studies identified burnout as a precursor to physical health problems and depression (Jamal & Baba, 2000; Kerr, Laschinger, Severin, Almost, & Shamian, 2005; Laschinger & Finegan, 2005). Employees who experience burnout are more likely to leave the job (Janssen et al.). A Canadian descriptive study by Kerr et al. (2005) found that rapid changes in the healthcare system have caused increased workplace stress for nurses. A heavy workload, too much overtime, and acutely ill patients were identified as important stressors. Participants in the study also reported that nurses

who were not involved in decision-making, lacked peer social support and had difficulties accessing technology were more likely to experience burnout (Kerr et al.). According to an American study, overtime, weekend and night duty tend to increase job turnover among nurses (Strachota et al., 2003). Nurses who experience low levels of job satisfaction or burnout may be inclined to change jobs. However, the costs of turnover to an organization are high (Hayes et al., 2006).

Turnover

Turnover is costly for organizations both financially and in the loss of corporate memory. Organizations experiencing turnover: (1) lose experienced staff, (2) must recruit and orient new staff, and (3) must cope during the transition period between the old staff member and the new person hired (Hayes et al., 2006). In an American study by Jones (2005) the cost to a hospital in US dollars of one nurse turning over was estimated to be \$62,100 - \$67,100 (p. 42). These costs reflect (1) advertising, (2) temporary nurses to fill the vacancy, (3) hiring costs, orientation, the reduced productivity by the new employee, (4) reduced productivity for the nurse leaving the hospital, and (5) termination expenses (Jones). American and Canadian hospital studies have also associated turnover with reduced capacity to provide quality patient care (Larrabee et al., 2003; Shields & Ward, 2001). The aging workforce of nurses and reduced number of nurses entering the field has led to concern in many countries because organizations will be competing for nursing human resources (Aiken et al., 2001; Betkus & MacLeod, 2004; Jones; Registered Nurses Association of Ontario & Registered Practical Nurses Association of Ontario, 2000; Ulrich et al., 2005). It is important to compare the literature describing hospital and public health nurse job satisfaction and turnover to understand similarities and differences.

2.4 Job Satisfaction and Turnover in Public Health Nursing

While most of the studies of job satisfaction have been done with hospital nurses, several studies have examined this issue among Canadian public health nurses (Best & Thurston, 2006; Betkus & MacLeod, 2004). A mixed methods study by Betkus and MacLeod (2004) found that while public health nurses in rural British Columbia were moderately satisfied with their jobs, this did not mean they intended to remain in their present job. Factors such as demographics, personal circumstances and opportunities influenced turnover. Higher levels of job satisfaction are found among public health nurses who are (1) involved in decision making (Campbell et al., 2004; Cumbey & Alexander, 2004), (2) have increased organizational rules (Cumbey & Alexander), (3) experience working in public health (Cumbey & Alexander), and (4) in a job which offers autonomy (Best & Thurston). Technology and the work environment did not influence job satisfaction (Cumbey & Alexander). Ontario public health nurses and nurse managers did not perceive themselves as powerful (Falk-Rafael et al., 2005; Haugh & Laschinger, 1996). No studies were found documenting actual numbers of Canadian public health nurses turning over.

A cross-sectional descriptive field study by Armstrong-Stassen and Cameron (2005) surveyed community health nurses to compare how work-related concerns, job satisfaction and retention varied between Ontario public health nurses, home care nurses, and community care access centre nurses. The researchers concluded that while public health nurses were more satisfied with their job than other community nurses, they found that public health nurses had concerns with low staffing, and challenges dealing with vulnerable families with complex needs who were sometimes difficult. This is similar to the findings by Aiken et al. (2001) who discovered that many hospital nurses felt staffing was inadequate. Other issues that public health nurses raised were the difficulties dealing with

constant change and the instability of programming (Armstrong-Stassen & Cameron). This was the only study that compared job satisfaction among different community health nursing specialties.

Two studies of American public health nurses by Campbell et al. (2004) and Cumbey and Alexander (2004) found that job satisfaction increased when nurses were included in the decision-making process by both peers and managers. This is similar to findings in the American hospital sector by Upenieks (2003). Job satisfaction also improved with increased organizational rules and regulations (Cumbey & Alexander). This contrasted with findings from the hospital sector that identified organizations with formal structures as reducing job satisfaction (Upenieks). Experienced public health nurses had higher rates of job satisfaction, but technology and the work environment did not influence job satisfaction (Cumbey & Alexander). It must be remembered that these American studies reflect a different workforce than in Canada because the public health nurses in the United States do not all have baccalaureate degrees and some of the participants who were surveyed were registered practical nurses.

An exploratory comparative study by Haugh and Laschinger (1996) surveyed a convenience sample of 46 Ontario public health nurses and ten nurse managers to understand their perceptions of empowerment. Neither the managers nor the public health nurses ranked themselves as highly powerful. Managers perceived that the public health nurses had more power than the public health nurses perceived they had. While the public health nurses rated themselves as receiving support and opportunities they consistently identified themselves as lacking information and resources (Haugh & Laschinger). Falk-Rafael et al. (2005) found a similar perception of powerlessness among Ontario public health nurses. Since two Canadian studies found that feelings of empowerment and access to information

and resources are associated with increased job satisfaction, this finding is important (Kluska et al., 2004; Laschinger et al., 2001).

While both Canadian and American studies have described how public health nursing has evolved to address health issues using population-based approaches, it must be remembered that the two systems function extremely differently. One problem with research studies examining turnover is that no consistent definition of turnover is used throughout the literature. Many facilities do not differentiate between staff layoffs and voluntary turnover which makes cross comparisons difficult (Hayes et al., 2006; Irvine, & Evans, 1992). Assessing the reasons for turnover has proven difficult because information obtained from exit interviews may not be an honest representation of nurse concerns about the job because they want a positive reference (Fottler, Crawford, Quintana, & White, 1995). Many researchers examining turnover have used surveys to elicit information from participants, but only a few qualitative studies have been done. Qualitative studies might provide a richer understanding of the issue of turnover (Fottler et al.; O'Brien-Pallas, Duffield, & Hayes, 2006). Few studies were longitudinal and cross sectional studies may fail to capture the predicted relationship between job satisfaction and turnover (Hayes et al., 2006). In spite of these research limitations, these studies shed light on issues that may affect the turnover of heart health coordinators.

2.6 Summary of the Literature Review

This literature review described how community-based coalitions can unite diverse organizations and individuals to solve community problems. While coalitions have demonstrated intermediary and environmental changes, evidence supporting coalitions' impact on community health status is lacking. Coalitions progress through different stages as coalition members develop collaborative skills. Effective coalition leaders help

coalitions: (1) address challenges such as recruiting and retaining membership, (2) facilitate collaboration by coalition members, and (3) guide coalition activities. In order to be successful, coalition leaders must facilitate the development of relationships among members and engage coalition members by involving them in decision-making.

Research on job satisfaction and turnover with public health nurses is sparse because most of the research in this area has been conducted with hospital nurses. High levels of job satisfaction meant nurses were less likely to turnover. Both hospital nurses and public health nurses have similar factors that relate to job satisfaction including: (1) managerial support, (2) involvement in decision-making, (3) access to resources, (4) remuneration, and (5) respect and status. New nurses within the hospital setting perceived that pay was related to job satisfaction, but this was not the case with more experienced nurses. Personal factors such as employment of a spouse and job opportunities were sometimes a factor in nursing job turnover. Since many heart health coordinators were nurses, it is important to understand whether the same factors played a role in heart health coordinator job satisfaction and possibly turnover.

2.7 Rationale for Study Derived from the Literature Review

While job turnover of nurses costs organizations financially, a more critical issue is the loss of experienced personnel. This is especially important when nurses are involved in complex programs such as the Ontario Heart Health Program. Without effective leadership, heart health coalitions have been shown to lose members and be unable to function effectively. Thus, the Ontario Heart Health Program is a good exemplar because it is a complicated program with a high rate of leadership turnover. In light of this literature review, it is important to understand what caused heart health coordinators who are in the key position of coalition leadership to turn over.

Chapter 3 Methods

The following chapter describes how focused ethnography was used to explore the role and impact of turnover among heart health coordinators. The sample, recruitment of participants and ethical review are discussed. Data collection methods, analysis procedures, and evaluation of the trustworthiness of the data are outlined. Findings from the document review are integrated throughout the findings.

3.1 Research Design

This thesis employed the qualitative research method of focused ethnography to explore the role and turnover of heart health coordinators in five health units during Phase I of the Ontario Heart Health Program. Qualitative research has been used in the health and social sciences because some aspects of human experience such as relationships, values and culture are difficult to quantify (Streubert Speziale & Carpenter, 2003). Ethnographic research seeks to understand people by learning from them (Roper & Shapira, 2000). Rooted in anthropology, ethnographic researchers attempt to understand how people use their culture to frame their behaviour and interpret their experiences (Munhall & Oiler, 1986). Leininger (1985) has a long history of applying anthropological research methods to nursing issues. Focused ethnography which explores a distinct problem with a smaller number of individuals, is also known as miniethnography (Leininger) and microethnography (de Laine, 1997; Polit & Hungler, 1999). In focused ethnography, the researcher examines smaller, more manageable groups and concentrates on answering a small number of specific questions, thus shortening the timeframe required for study when compared to the traditional ethnographic approach (Roper & Shapira). Focused ethnography was an appropriate research method for this health services research because it enabled the researcher to

understand the role and turnover of heart health coordinators from the perspective of those most involved with the issue (Streubert Speziale & Carpenter).

Three fundamental characteristics of ethnographic research are: (1) a focus on culture, (2) researcher immersion in the culture, and (3) reflexivity (Streubert Speziale & Carpenter, 2003). Researchers must understand both the cognitive aspects, and the behavioural aspects of culture (Roper & Shapira, 2000). As the researcher becomes immersed in the culture, a tension or reflexivity develops between the research role and the researcher's immersion in the culture (Streubert Speziale & Carpenter). Ethnographic researchers seek to illuminate both the emic and etic views of a particular culture. The emic perspective represents the insiders' view of the world (Roper & Shapira; Streubert Speziale & Carpenter; Spradley, 1980). The etic view reflects the researchers' interpretation of the culture and is obtained through analysis of the data and setting it in context. Both emic and etic viewpoints are necessary to understand culture. Three data collection methods may be used to develop cultural understanding: (1) participant observation, (2) document review, and (3) interviews (Munhall & Oiler, 1986; Roper & Shapira). This thesis obtained an emic perspective from:

1. Semi-structured telephone interviews with heart health coordinators, chronic disease managers, and heart health coalition members from five Ontario health units, and
2. A selective review of relevant Ministry of Health and Long Term Care documents (two published and one unpublished) relating to the Ontario Heart Health Program. These documents reflect an insider viewpoint because they incorporate interviews and focus groups with participants in the Ontario Heart Health Program.

Because of the retrospective nature of this study, the researcher did not directly observe heart health coalition meetings or heart health initiatives, but was able to draw on her experience

working with coalitions within the public health sector. To overcome potential bias from inferences based on her own experiences, the researcher immersed herself in the study and kept field notes describing all decisions made during all aspects of the research process.

3.2 Research Questions

The purpose of this study was to understand the role of heart health coordinators and to explore factors influencing turnover. The research questions are:

1. What is the role of the heart health coordinator in an Ontario heart health coalition?
2. What is the relationship between the heart health coordinator and the local health unit?
3. What are the reasons for and consequences of heart health coordinator turnover?
4. How is a heart health coalition that experiences heart health coordinator turnover similar or different to one that does not?
5. What could be done to reduce the problem of heart health coordinator turnover?
6. What is the best way to manage heart health coordinator turnover?
7. Are there any differences in heart health coordinator leadership or turnover in non-northern rural, non-northern urban or northern areas¹ of Ontario?

3.3 Participant Recruitment and Informed Consent

Sampling

Participants with a rich understanding of heart health coordinator roles and responsibilities and experience with the issue of turnover during Phase I of the Ontario Heart Health Program were selected for this study. Participants were purposively chosen with varied backgrounds and experiences to maximize viewpoints on the thesis topic (Polit &

¹ Non-northern rural, non-northern urban and northern categories of health unit location were used in the Ontario Heart Health Program: Preliminary Evaluation Report 2002. Northern health units were either primarily rural or had an urban centre with rural surroundings.

Hungler, 1999). Health units were identified as non-northern urban, non-northern rural and northern from a list of health units in each of these categories identified by Riley et al. (2002) in the Ontario Heart Health Program: Preliminary Evaluation Report (see Appendix A). Health units from non-northern urban, non-northern rural and northern areas were further subdivided into those with and without heart health coordinator turnover during Phase I. Health units with turnover were defined as:

1. health units with more than two heart health coordinators during Phase I, or
2. health units with one or more heart health coordinators who remained in the position for less than one year during Phase I.

The heart health coordinator was the point of contact for each selected health unit. If a coordinator agreed to participate in the study she was then asked to contact the chronic disease manager and two heart health coalition members to obtain their verbal consent to have the researcher contact them regarding their participation in the study. If verbal consent was obtained, then the researcher contacted the chronic disease manager and the coalition members by email or phone to book an interview and answer questions. If the coordinator refused to participate, then no one else at the health unit was contacted and the next health unit on the list was chosen.

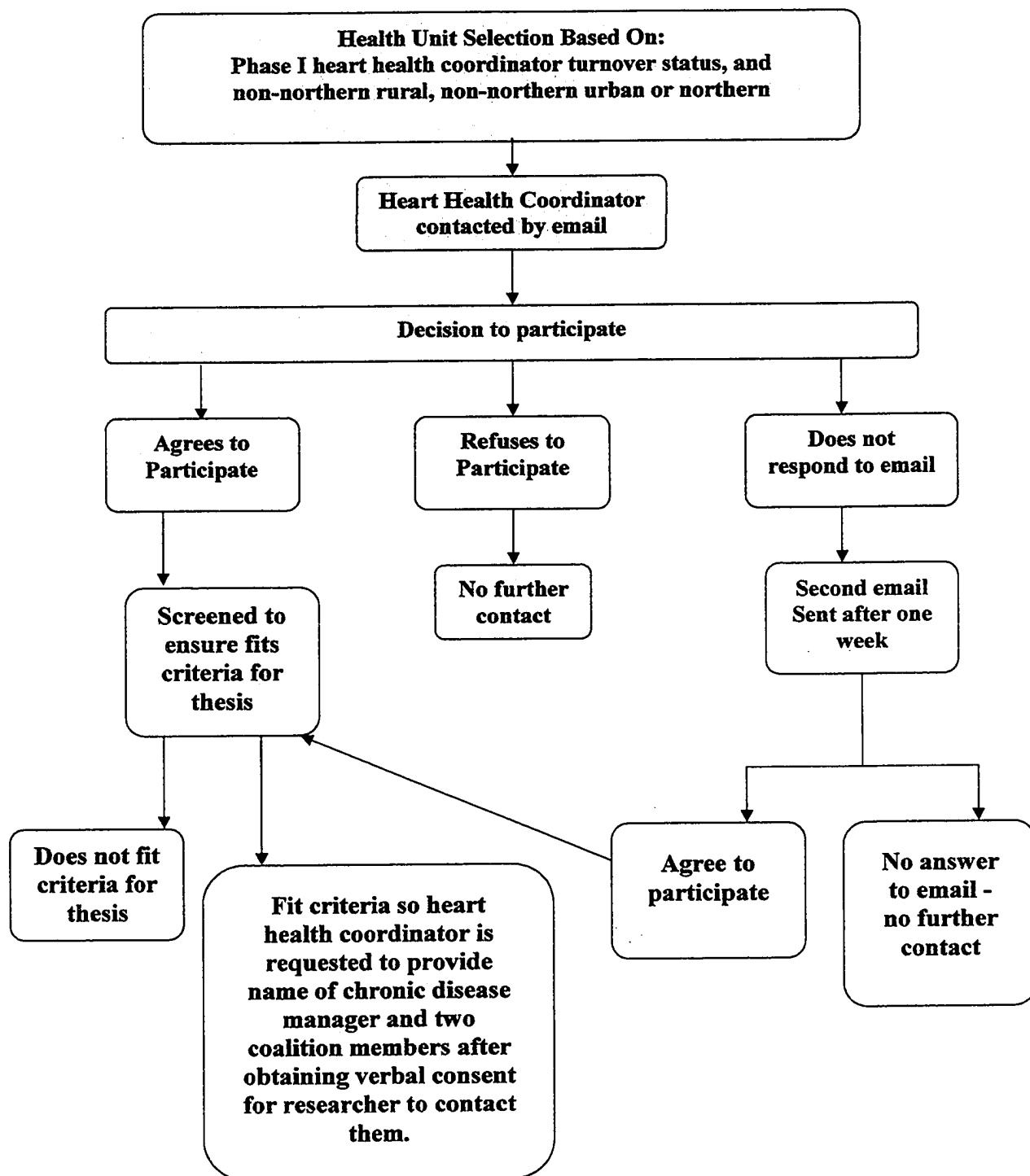
Recruitment Strategy

The recruitment strategy is shown in figure 3.1. Health units were contacted through the heart health coordinator currently in the position. Heart health coordinators were the entry point for the study because their names were in the public domain on the Heart Health Resource Centre website. The Heart Health Resource Centre was emailed to obtain an up-to-date list of heart health coordinators. Coordinators were asked to participate in the study by email using a standard letter of invitation. This letter briefly explained the research and

asked whether or not they would like further information about the study (see Appendix B). An identical email was sent a week later if there was no reply to the first email. If no reply to the second email was received, the health unit was deemed a refusal and a heart health coordinator from the next health unit on the list was contacted. If the heart health coordinator expressed an interest in participating, she was telephoned and read the script (see Appendix C). This phone call provided an opportunity to screen the health unit, and verify that it fit criteria for the thesis (see Appendix D); obtain participant background information (see Appendix E); and answer any questions. If the health unit was deemed eligible, it was included in the sampling frame. Recruitment of health units was purposeful with the aim of getting at least one non-northern rural, one non-northern urban and one northern health units that had experienced coordinator turnover.

After the phone call participants were sent a package that included: Participant Information Letter (see Appendix F), summary of the study (see Appendix G), consent form (see Appendix H), list of interview questions (see Appendices I – N), and request to draw a diagram (see Appendix O). A time convenient time for the participant was booked for a taped telephone interview approximately 30 minutes in length. Figure 3.1 illustrates the recruitment strategy.

Figure 3.1: Recruitment Strategy



3.4 Interviews and Data Collection

The questionnaire and probes and the diagram exercise were pilot tested with an individual familiar with the Ontario Heart Health Program. After pilot testing, revisions were made to the interview questions to improve clarity. This pilot data is not included with the main study findings.

A total of thirteen taped phone interviews were completed in English with heart health coordinators, chronic disease managers, and coalition members from five different Ontario health units. Participants received the interview schedule, including probes, prior to the interview. In advance of the interview, all participants were asked to draw a diagram of heart health coordinator relationships to the Ministry of Health and Long Term Care, the health unit and the heart health coalition. The diagram and signed consent were faxed to the researcher prior to the interview.

Interview Guide

There were six versions of the interview schedule tailored to each of the following groups of interviewees: heart health coordinators in coalitions with and without heart health coordinator turnover; chronic disease managers in coalitions with and without turnover; and coalition members in coalitions with and without heart health coordinator turnover. For example heart health coordinators, chronic disease managers and coalition members whose coalition had experienced heart health coordinator turnover were asked 'why do you think your particular coalition experienced heart health coordinator turnover' while participants whose coalition had not experienced turnover were asked 'why they felt their coalition had not experienced heart health coordinator turnover?' A few questions were added as interviews progressed. Participants interviewed at a later stage were asked whether or not

the heart health coordinator position should be front line or managerial. The interview guide was used to ensure topics were covered and to provide probes when required.

Transcription of Interviews

All interviews were taped directly from the telephone. All interviews were completed, but there were problems with three tapes. One tape finished just prior to completion of the interview while two tapes had garbled language in several sections. All three interviews were kept in the study. The researcher transcribed the audiotapes verbatim with minor editing to remove repetition of words and pauses. Tapes were listened to several times to ensure accuracy of transcription. Three tapes were incomplete so notes taken during the interviews were used to supplement the transcripts.

3.5 Ethics

Ethics approval was obtained from the Health and Social Sciences Ethics Review Board, University of Ottawa (see Appendix P). All heart health coordinators interested in participating were requested to provide the researcher with information about health unit ethical requirements prior to the interview. Separate ethics approval was obtained from two health units. The latter ethics approval forms are not included in the thesis to maintain confidentiality of the health units. Participation was voluntary and participants could withdraw at any time. One participant withdrew permission prior to the interview and all notes, the consent form and diagram were destroyed. One participant did not wish to be quoted and this request was respected. Privacy, confidentiality, and anonymity of the participants were maintained during data collection, data analysis and reporting phases of the study. All transcripts had identifying information removed and were labeled with an identifying number.

3.6 Data Analysis

Transcripts were read and reread immersing the researcher in the data. Each transcript was analyzed utilizing a paper-based process. Transcripts were organized using a colour scheme with different colours denoting a different research question topic. Each coloured section was assembled into a long list and through an iterative process data in the lists were clustered according to topic. For example, the research question that explored the reasons for heart health coordinator turnover resulted in a table that addressed various categories of provincial and local challenges that faced heart health coordinators (see Appendix R). Further analysis was done to create matrices that cross-referenced categories of participants or types of health units with various issues raised by the participants (see Appendix S). The clusters of data were gradually amalgamated into themes. Tables were refined as new data was gathered and or reexamined throughout the research process. The researcher utilized the original transcripts to obtain relevant quotations to support categories and themes. Some transcript data were labeled 'unsure of category' because it did not fit identified categories. Data in this category was revisited regularly to see if it was possible to place it in a more specific category. Transcription of the tapes and the paper data analysis fully immersed the researcher in the data.

During the next stage, the researcher returned to the literature to see if the research findings built on existing information about the role and turnover of heart health coordinators. Data from the transcripts and the tables were examined for evidence confirming or refuting themes.

3.7 Selected Ontario Heart Health Program Document Review

Three documents were selected for review because: (1) they examined Phase I of the Ontario Heart Health Program at different points in time, (2) they were research-based, (3)

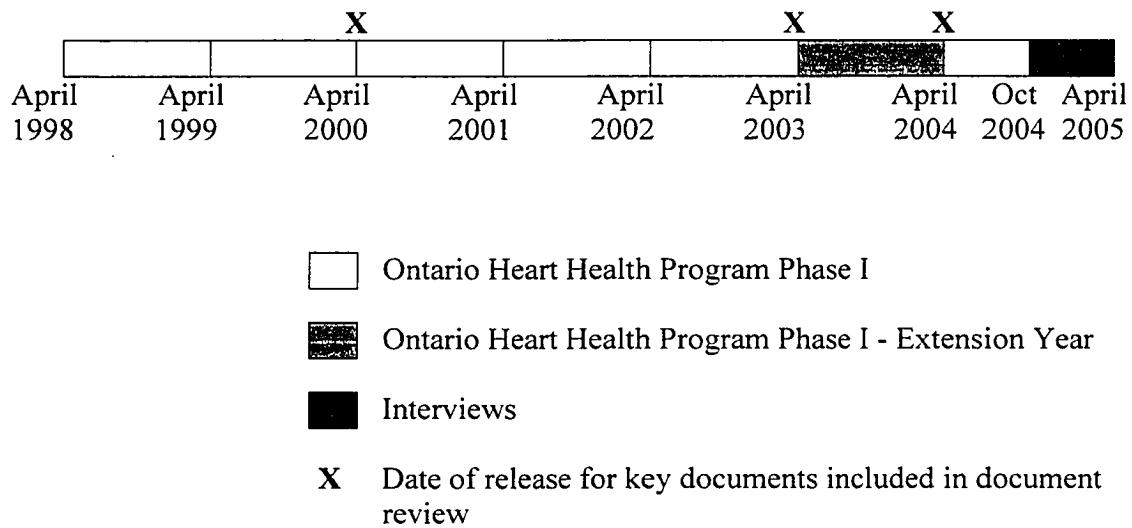
they spoke about heart health coordinators, and (4) they covered a broad spectrum of other issues in the Ontario Heart Health Program. The full document review is found in Appendix T. The documents included in the review were:

1. Dunkley, G., Michelin, L.R., & Stewart, M., (2001). *Towards benchmarking heart health coalitions: Developing a systematic process for documenting and enriching community/health unit partnerships*. Retrieved on June 20, 2006 from <https://www.benchmarking-publichealth.on.ca/cfdocs/Documents/HHCoalitionFinalreport.pdf>
2. Ontario Heart Health Network, (2002). *Continuation plan for 2003 and beyond*. Retrieved on June 20, 2006 from http://www.opc.on.ca/english/our_programs/hlth_promo/project_ini/strk_prevent/2003_and_beyond.pdf
3. Riley, B, Edwards, N, and d'Avernas, J. (2004). *Ontario Heart Health Program – Final evaluation report: Informing future directions for healthy living and chronic disease prevention in Ontario*. Unpublished report to the Ministry of Health and Long Term Care, Public Health Branch, Health Promotion and Wellness.

The document review was used to confirm or disconfirm participant findings and also yielded relevant contextual information that added insight into the roles and turnover of heart health coordinators.

3.8 Research Timeline

To illustrate the retrospective nature of this research, a timeline has been included that shows Phase I of the Ontario Heart Health Program, the extension year for Phase I, the timing of the interviews and the year that the documents were issued (see figure 3.2).

Figure 3.2 Research Timeline

3.9 Summary

Focused ethnography was used to explore the role and turnover of heart health coordinators in five health units of the Ontario Heart Health Program. Two published documents and one unpublished document from the Ontario Heart Health Program were selected for review. Semi-structured telephone interviews were conducted with heart health coordinators, chronic disease managers and heart health coalition members. The point of contact was through the heart health coordinator because coordinator names were accessible through the heart health resource centre website. Coordinators were responsible for informing their chronic disease manager and two coalition members of the study and requesting verbal permission for the researcher to contact them. Ethical approval was obtained from the Health and Social Sciences Ethics Review Board, University of Ottawa and two health units. Interviews were taped and the researcher transcribed the tapes. Transcripts were analyzed manually and data were categorized through an iterative process using the research questions as a guide. Matrices were created comparing types of health units or participants to the categories and gradually themes emerged. A selective review of

Phase I Ontario Heart Health Program documents provided additional understanding of the issues. During the next stage, the researcher returned to the literature to see if the research findings built on existing information about the role and turnover of heart health coordinators.

Chapter 4 Findings

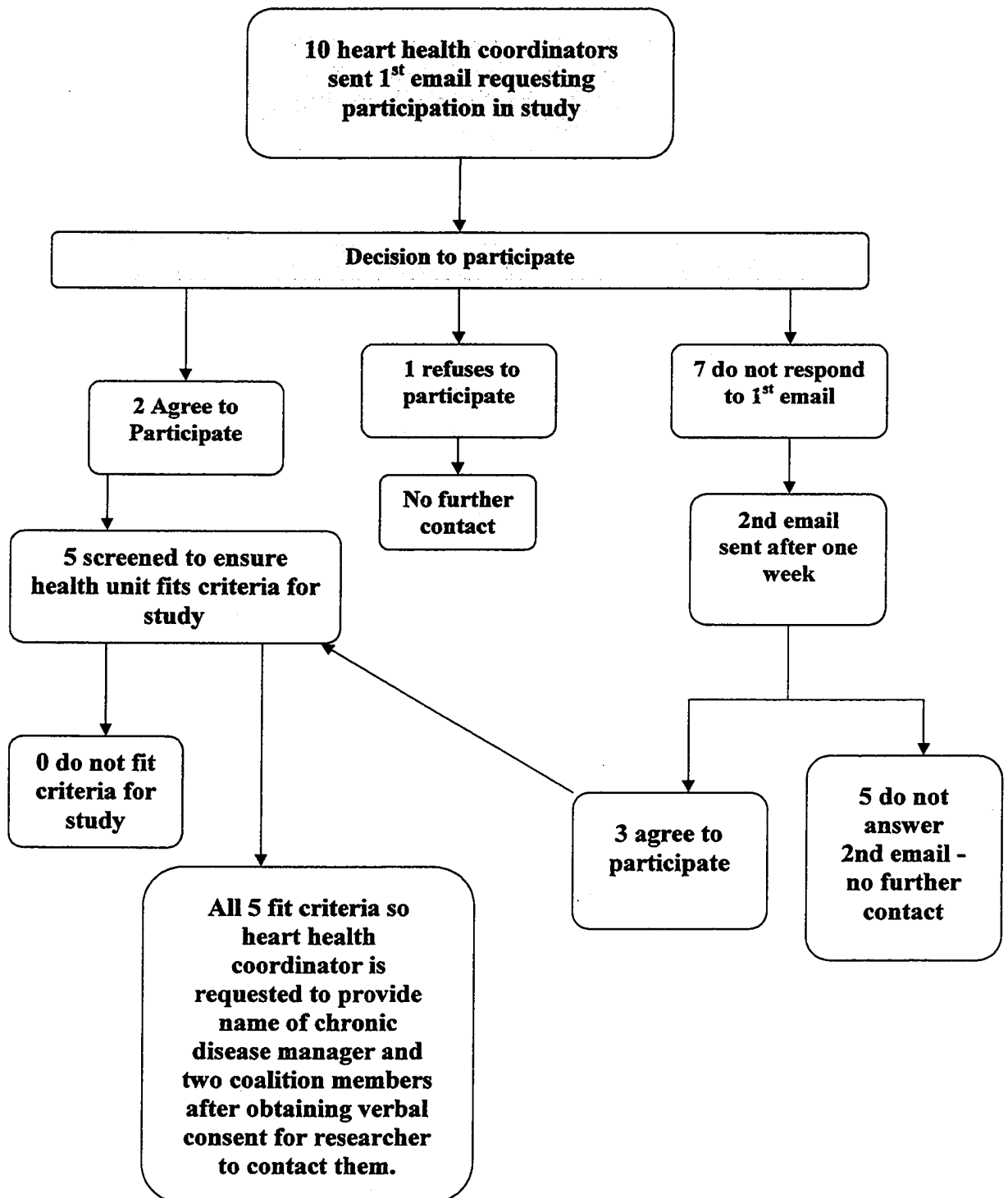
The purpose of this study was to explore the role and turnover of heart health coordinators in the Ontario Heart Health Program. This chapter integrates the review of selected Ontario Heart Health Program documents with the findings from interviews with study participants. The demographics of the participants, roles and responsibilities, and challenges faced by the heart health coordinator are described. The role of the heart health coordinator in mediating relationships between unequal partners with conflicting agendas is discussed. Data is presented in diagrams and in the participants' own words.

4.1 Participant Demographics

This study focuses on Phase I of the Ontario Heart Health Program. A total of 10 health units were invited and five agreed to participate. Two rural non-northern health units, two non-northern health units and one northern health unit participated. Heart health coordinator turnover experiences in participating health units ranged from one health unit with no heart health coordinator turnover to one health unit with six heart health coordinators. The ratio of one in five health units without heart health coordinator turnover was similar to the general situation during Phase I of the Ontario Heart Health Program. A summary of participant recruitment is found in Figure 4.1.

Twenty-two individuals were invited to participate in the study and 13 participants agreed. Two participants had experience working in two different heart health positions. One participant was a heart health coordinator who became a chronic disease manager; the other participant was a heart health coalition member who became a heart health coordinator. Three of the participating heart health coordinators were public health nurses and four were health promoters. Five of the coordinators interviewed had between one and

Figure 4.1 Participation in Study



two years experience with the Ontario Heart Health Program while two coordinators had more than five years of experience. All heart health coordinators were front line health unit staff. Four of the heart health coordinators were working as heart health coordinators at the time of the interview and three had left their position. One left to assume a managerial position at the same health unit, one left to take on new staff responsibilities and one had lost the position due to restructuring within the health unit. It was difficult to get in touch with heart health coordinators who had left their positions because of conflict. Either there was no information about their whereabouts because they had moved, or participating heart health coordinators were uncomfortable approaching them. However, participants in the study spoke openly about some of the issues and conflicts that arose with heart health coordinators who had left their positions.

Chronic disease managers from the five health units were invited to participate in the study, but only two agreed. One chronic disease manager who heard about this study prior to the interviews asked to participate because her health unit had had so much trouble with heart health coordinator turnover. In this situation both the heart health coordinator and the chronic disease managers were emailed invitations to participate in the study and both agreed. Both chronic disease managers had more than two years experience with the Ontario Heart Health Program.

Six coalition members from varied backgrounds participated in the study. None of the coalition members worked for the health unit. Four coalition members were no longer involved with the coalition while the rest had remained active in the coalition. Four coalition members had over five years of experience with the Ontario Heart Health Program, while two of them had two years of experience.

4.2 Heart Health Coordinator Roles and Responsibilities

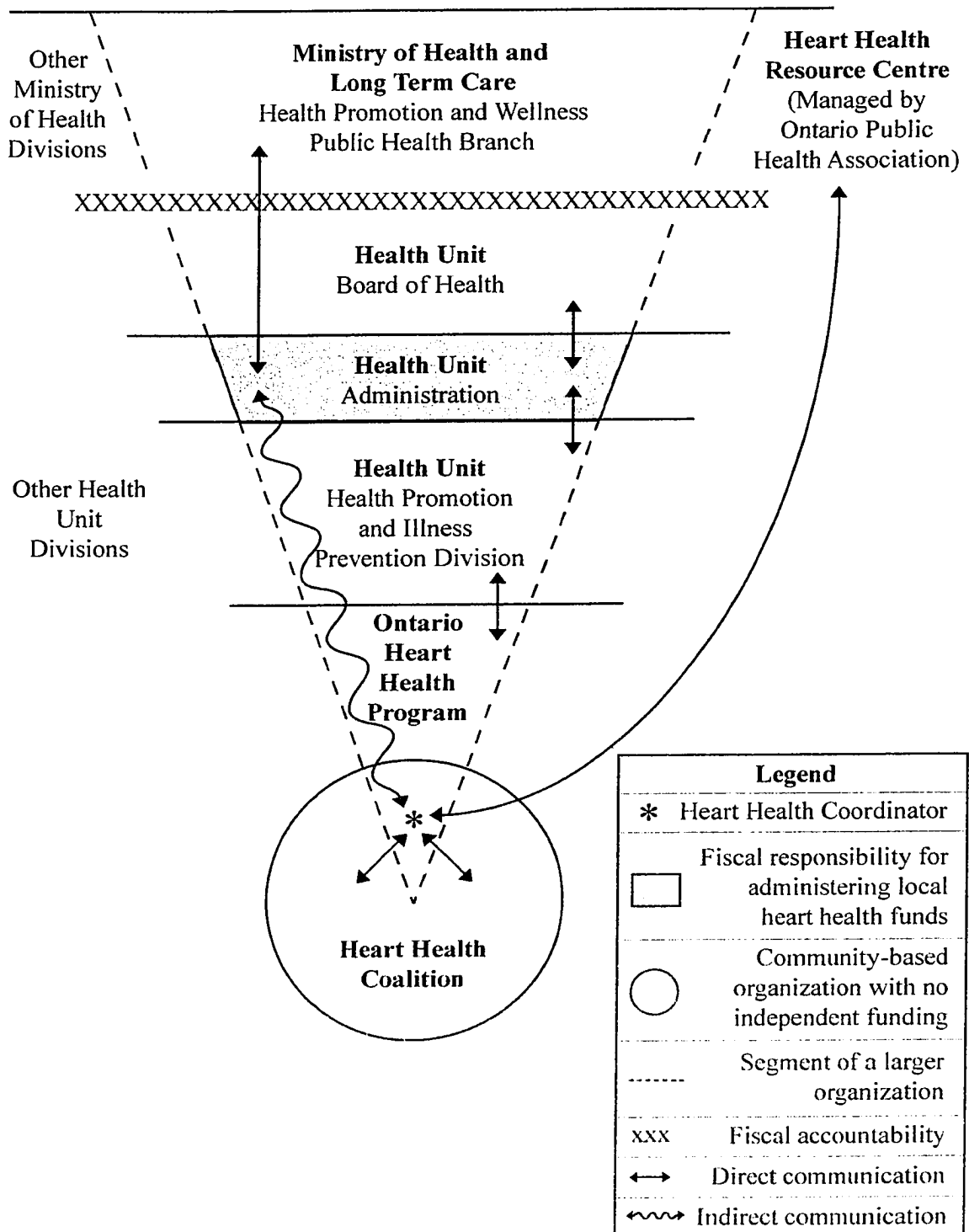
All participants described heart health coordinators as leaders of the local Ontario Heart Health Program. Roles and responsibilities of the coordinator were described as: (1) coordination, (2) community development, (3) administration, and (4) additional health unit responsibilities above and beyond the coordinator job. These are similar to the roles identified by Riley et al. (2004) who included “planning and administration, community mobilization and organization, and programming” (p. 18). Participants also described a variety of skills and personal qualities that enhanced the ability of coordinators to fulfill their job roles and responsibilities. Participants consistently identified the primary coordination role for the heart health coordinator as facilitating the planning and implementation of heart health initiatives by the heart health coalition.

Facilitating the Work of the Heart Health Coalition

The heart health coordinator facilitated the planning and implementation of heart health initiatives by interpreting Ministry of Health and Long Term Care directives, and assisting the coalition to access heart health funds that were housed for administrative and accountability reasons within the health unit. The health unit was important in the implementation of heart initiatives because it provided large numbers of staff who assisted with implementing heart health activities. “*We have twelve [members] whereas most of our organizations generally have only one or two individuals involved in the coalition.*” Over time, health units developed task groups comprised of both health unit staff and community members that were responsible for implementing specific heart health initiatives. For this reason heart health activities were integrated into health unit operational plans to ensure that that health unit funds were allotted to staff these heart health initiatives.

Heart health coordinators were a vital communication link between the heart health coalition, the Ministry of Health and Long Term Care, and the health unit. Figure 4.2 illustrates the communication and fiscal accountability relationships in the Ontario Heart Health Program.

Figure 4.2 Communication and Fiscal Accountability Relationships in the Ontario Heart Health Program



Heart health coalitions were isolated, and as such relied on coordinators to provide them with information from both the Ministry of Health and Long Term Care and the health unit. Some heart health coordinators received communication directly from the Ministry of Health and Long Term Care, while other coordinators received information indirectly, after materials were reviewed by their chronic disease manager. One coordinator explained that while she and her chronic disease manager received information from the Ministry at the same time, her manager was too busy to keep abreast of it. Consequently she would inform the manager of the details. Heart health coordinators were more than just conduits for information, they were also responsible for interpreting and distilling Ministry of Health and Long Term Care directives and then communicating them to the coalition membership. Coordinators had to *"digest information [from the Ministry,] translate it, and interpret what would be appropriate information for our local community."*

Based on both Ministry directives and community needs, the coalition planned heart health initiatives. In order to access the heart health funds which were held by the health unit, the heart health initiative suggestions were conveyed by the coordinator to the health unit chronic disease manager who sent the recommendation through the health unit hierarchy to the health unit administration. A decision was made by health unit administrators to accept or reject coalition recommendations and the decision was sent down through the hierarchy to the chronic disease manager who informed the heart health coordinator of the decision. The coordinator then informed coalition members of whether or not the funding was approved. The health unit Board of Health was formally accountable for the heart health funds, but did not figure significantly in day to day heart health funding decisions.

A key support for heart health coordinators and coalition members was the Heart Health Resource Centre. Participants explained that new coordinators were oriented to

provincial aspects of the program through the Centre. It also facilitated networking through regular Heart Health Network meetings in which coordinators from similar geographical locations health units would meet to learn from each other. The resource centre also provided Ministry of Health and Long Term Care consultants who offered help with specific coalition needs. Documents by Riley et al. (2004) and the Ontario Heart Health Network (2002) also reinforced the important role of the Heart Health Resource Centre in supporting heart health coordinators as they facilitated the work of the coalition.

Community Development Roles and Responsibilities

Another important role for heart health coordinators was facilitating community and partnership development. During this lengthy, involved process, coordinators assisted coalition partners to develop relationships both within and external to the coalition. As the only person in the local Ontario Heart Health Program whose primary job responsibilities were solely focused on heart health, coordinators had the most time to devote to informing both partners and the community of the importance of their input and participation in heart health initiatives.

An important role for heart health coordinators was recruiting members to the heart health coalition and keeping them at the table. Many heart health coalitions had widely fluctuating membership. *"When I came we only had one coalition member that would come to the table ... now we have about twelve."* Dunkley et al. (2001) explained that it was important to have a balance between renewal and retention of coalition members because individuals and organizations could become burned out when there were insufficient new members in the coalition. In order to retain coalition members, coordinators had to discover what had motivated coalition members to become involved in the coalition, and then ensure that members were able to meet those needs. *"Partners will come in and join because they*

have something they need to address and if you are not perceptive and accepting of it then they're not going to show up." Coalition members had many responsibilities other than the coalition so it was important that coordinators not make *"any big demands – I don't want to scare anybody off."*

Administrative Roles and Responsibilities

Most of the participants commented that heart health coordinators were responsible for a large number of administrative tasks that were not directly associated with planning and facilitating heart health initiatives. These tasks involved chairing meetings, paperwork and jobs such as booking rooms, calling coalition members about meetings, filling out purchase requisitions for the health unit, completing reports for the Ministry of Health and Long Term Care, and sending out agendas and minutes from meetings. Participants attributed the bulk of the administrative burden to bureaucratic demands from the health unit and the reporting requirements of the Ministry of Health and Long Term Care. One coordinator explained that a large portion of her time was spent on administrative tasks and went on to say, *"ideally, the heart health coordinator is the person who facilitates strategic work within the partnership ... but unfortunately I would say the main role has become administration."* Participants also commented that *"administrative tasks are not very satisfying."*

Additional Health Unit Responsibilities

During Phase I, the Ministry of Health and Long Term Care directed that one full time health unit staff member be assigned to the heart health coordinator position (Riley et al., 2004). Some health units were unable to fulfill this directive. In one health unit, the heart health coordinator was designated as .8 of a full time equivalent position. Participants stated that heart health coordinators often shouldered additional health unit job

responsibilities, either routinely or in emergencies, above and beyond the heart health coordinator roles and responsibilities. For example some coordinators were assigned additional responsibilities such as physical activity planning, or car seat clinics in addition to their coordinator responsibilities. Several health units had to deal with serious community health crises during Phase I of the Ontario Heart Health Program. In these situations some health units required coordinators to assist with the emergency situation, while they still continued to have responsibilities for heart health. This was not a consistent practice throughout Ontario as some health units ceased heart health activities during emergencies. It was suggested by participants that continuing heart health programming during crises was unrealistic, because it created the expectation that heart health objectives would continue to be met.

Essential Heart Health Coordinator Leadership Skills and Personal Qualities

In order to be effective leaders of the local Ontario Heart Health Program, participants pointed out that heart health coordinators required strong project management and communication skills, as well as a variety of personal qualities that were essential for success. In the Phase I Ontario Heart Health Evaluation, Riley et al. (2004) made a similar observation, explaining that coordinators required “strong skills in community mobilization, facilitation, and volunteer management” (p. 18).

While participants seldom described the importance of project management skills, many identified related skills such as facilitation, organization, innovation and attention to detail. Coordinators required superior communication skills because they had to inform the heart health coalition of Ministry of Health and Long Term Care directives and convey the coalition requests to the health unit. Interpersonal skills were essential in developing and maintaining community partnerships within and external to the heart health coalition. To

this end, coordinators needed conflict resolution, diplomatic and political skills. Participants identified a variety of personal qualities required by successful heart health coordinators. Heart health coordinators had to be content coordinating the heart health program rather than being actively involved with heart health. *"I think that you have to be content not to be the doer ... Most people do prefer to have hands on direct [client] contact."* Coordinators had to be patient, persistent, self-directed, work well independently and be adaptable so that they could respond to the changing needs of the community.

4.3 Rewards of the Heart Health Coordinator Job

Participants made it clear that coordinators appreciated many aspects of the job and found it rewarding in many different ways. Three categories of reward emerged: (1) working with community partners, (2) working on a province-wide project, and (3) personal benefits.

Heart health coordinators derived satisfaction from working with community partners. *"I enjoy working on the fringe of things. A lot of coworkers don't have the same developed concept of what community health is or they've got a narrow perspective of it. We are dealing with a holistic approach...and that has a certain reward to it."* Coordinators appreciated that coalition members were volunteers who added heart health coalition responsibilities to an already busy schedule. A healthier community and successful initiatives were also identified as rewarding. For example one heart health coordinator described her pleasure when inactive community members took part in a free community skate. Many coordinators reported that heart health coalitions formally recognized heart health initiatives and supporters.

For some coordinators, participating in a large scale provincial program was exciting. A coordinator spoke at length of the benefits of participating in a provincial project as

opposed to focusing solely on local initiatives. She stated *"I like having a big picture of what is going on...and learning about what different coalitions are doing in different parts of the province."* She also enjoyed contact with colleagues from other health units.

Heart health coordinators received personal benefits from working in the job including the opportunity to learn new skills via training opportunities afforded them through the Ontario Heart Health Program. The leadership opportunities intrinsic to the heart health coordinator role were rewarding because coordinators had more autonomy than other health unit positions; were given high stature out in the community; and the job provided perks such as the opportunity to schedule one's own time.

4.4 Provincial Challenges

Many challenges described by participants encompassed larger issues that affected all of the five health units studied to some degree, while others were idiosyncratic or specific to certain health units. Provincial challenges arose from: (1) the late announcement of Phase II Ontario Heart Health Program funding, (2) a limited project scope, and (3) working at the interface of the health unit and the heart health coalition. The document review also identified significant provincial structural and funding challenges that affected Ontario health units during Phase I of the Ontario Heart Health Program.

Ontario Heart Health Program: Phase II Funding Announcement Delays

Funding for Phase II of the Ontario Heart Health Program was uncertain during the latter stages of Phase I. As there was no guarantee at the beginning of Phase I that Phase II and Phase III would receive funding, there was always the sense that this program could end after five years. Toward the final stages of Phase I and during the additional year during which the evaluation was being completed, participants noted a waning of interest and participation in the Ontario Heart Health Program by coalition members. Even though

efforts were made to keep the program intact by continuing the funding for an additional year in order to reduce the possibility of heart health coalitions disintegrating during the evaluation stage; the extended period of insecure funding negatively affected both heart health coordinators and coalitions. These findings were also noted by Riley et al. (2004). Coordinators were concerned about job security and the lack of secure funding meant coalitions could not plan for the long term. This was a significant problem because community development is a long-term process (Ontario Heart Health Network, 2003). According to both participants and Riley et al. there was a significant reduction in the planning and implementation of heart health initiatives during the last few years of Phase I.

Limited Project Scope

As a community-based program, the Ontario Heart Health Program was designed to develop initiatives targeted at reducing three risk factors for heart disease; poor diet, smoking, and physical inactivity (Riley et al, 2004). While some of these risk factors are common to other chronic diseases such as stroke, diabetes and cancer, directives put in place by the Ministry of Health and Long Term Care had restricted Phase I funding usage strictly to heart health initiatives. This made it difficult for heart health coalitions to attract and retain organizational representatives from agencies that addressed these same risk factors, but were not focused on heart health. This limited project scope frustrated heart health coordinators because they understood, *"the whole chronic disease prevention aspect ... our work does affect many things...but our guidelines are very strict in saying we can only deal with three risk factors and it has to be a heart health program."* These findings are similar to those by the Ontario Heart Health Network (2003) and Riley et al. (2004) who both noted that the narrow focus on heart health effectively limited organizational participation in heart health coalitions.

Challenges of Working at the Interface

Several participants suggested that the organizational structure of the Ontario Heart Health Program was problematic. Established by Ministry of Health and Long Term Care as a community-based initiative, the program directed a coalition of citizens and organizational representatives to plan and implement heart health initiatives. For reasons of convenience and fiscal accountability, the heart health funding flowed through the health unit which placed power and control of funding in the hands of health units, permitting them to accept or decline coalition recommendations for heart health initiatives. *"The funds are administered by the health unit and they have their own financial procedures...so the coalition...[doesn't] really function as a coalition...you are working toward something that is not really achievable. It's pretty discouraging."* This structure created a situation that was ripe for conflict between the two organizations and situated the coordinator between them where she could be subjected to pressure from all sides. A participant described this position as being caught in *"a tension and you are the interface."* Coordinators were required to explain the different requirements and different points of view to each organization and this could place her in a position where she received and had to deliver unpalatable information. When *"the community is screaming about things, they are not screaming at the Ministry of Health and Long Term Care [for the health unit], they are screaming at the coordinator."* As an employee of the health unit, coordinators were accountable to their employer and were required to support the health unit's stances on issues even if they felt otherwise. *"Being an employee of the health unit put her in a difficult position because our health unit put up a lot roadblocks for us so she had to listen to us complain, but be very careful [about] what she said."* It is clear that heart health coordinators were in an unenviable position between two

organizations with different perspectives of how the Ontario Heart Health Program should be implemented at the local level.

Structural and Funding Challenges

While participants in the study did not identify structural and funding challenges, they were mentioned as public health challenges in the Ontario Heart Health Program – Phase I Final Evaluation Report by Riley et al. (2004). Structural challenges included municipal amalgamations, welfare reform, education reform, health care renewal and a review of mandatory public health programming and monitoring requirements. Funding challenges included downloading of public health funding costs onto municipalities, no funding increases for public health, and provincial tax cuts. In addition, some health units experienced significant public health crises.

4.5 Local Challenges

Participants spoke at length of the challenges faced by coordinators while coordinating the planning and implementation of heart health initiatives at the local level. Expressions describing the heart health coordinator position as “*frustrating, complicated*” and “*a hard position*” suggest that these local challenges might have contributed to heart health coordinator turnover. The recurring challenges were: (1) a lack of knowledge and experience for an atypical public health job, (2) heavy job demands, (3) coordinators lacked influence with the health unit and the Ministry of Health and Long Term Care, (4) insufficient remuneration for the job demands and responsibilities, (5) challenges recruiting and retaining coalition members, and (6) failure to adapt the Ontario Heart Health Program to smaller rural health units

Challenge #1: Some Heart Health Coordinators Lacked Sufficient Knowledge and Experience for an Atypical Public Health Job

The heart health coordinator position was described as an atypical public health job because: (1) the program focused on coordination rather than implementation of initiatives, (2) the scope of the Ontario Heart Health Program was larger than other health unit programs, and (3) the program focused on community development. Role adjustment was required because coordinators had *"to be content not to be the doer."* Even though this coordination role was explained to new staff during job interviews, few fully understood the requirements prior to assuming the position.

The magnitude of the Ontario Heart Health Program added to the complexity of the job. New coordinators did not have much time to learn the required skills because of strict timelines imposed by funding requirements. Some coordinators left the position because they could not learn the necessary skills quickly enough. In addition to these challenges, some coordinators found their roles and responsibilities unclear. One rural coordinator explained that it took her two years to understand where she fit in the coalition and when she compared herself to other coordinators, she learned that this timeframe for adjustment was not unusual.

Many participants suggested that heart health coordinators lacked a background in working with coalitions that were part of a complex program. The document by the Ontario Heart Health Network (2003) made a similar observation when it described the problem as "an inappropriate match of people to the coordinator position" (p. 25). A rural chronic disease manager describing problems recruiting heart health coordinators with the necessary skills and knowledge said that many recruits were enthusiastic new graduates who found working with a large coalition daunting. Several participants described the heart health

coordinator position as an entry point into the health unit because coordinators moved into other front line positions as they became available or into managerial positions after they acquired the requisite skills.

Challenge #2 Heart Health Coordinators were Overworked which Led to Burnout

The coordinator job was demanding and difficult, and in some cases led to burnout. Participants described issues contributing to coordinator overwork and burnout as: (1) the job was overwhelming for one person, (2) coordinators had additional public health responsibilities, (3) coordinators lacked administrative and clerical support to manage large amounts of paperwork, and (4) there were time pressures.

The coordinator job was more demanding with more significant time pressures than other similar jobs in the health unit. One participant suggested that the *"the job is too many things for one person and it is difficult so people leave ...[to go back to] where all they have to deal with is smoking cessation."* Another participant explained that *"I know of three people who have gone back to other positions in the health unit [due to an inability to maintain the level of overtime]."*

Some heart health coordinators had health unit responsibilities above and beyond the coordinator job. One coordinator lobbied the health unit for a year to have her job split so she could focus on her heart health responsibilities. In some smaller health units *"coordinators have to keep their old jobs and duties while taking on the heart health work. Talk about workload."* Some managers did not understand the heart health coordinator role so they *"added responsibilities onto this person because they do this heart health thing and we don't really know what they do, but they've got to have some extra time so we'll put them on baby seat clinics."*

Administrative responsibilities were often downloaded on to heart health coordinators because no provincial funding was provided for clerical support. For reasons of accountability health units had complicated fiscal procedures that made these responsibilities difficult. Both non-northern rural and non-northern urban heart health coordinators found the regulations and bureaucratic paperwork governing access to funds frustrating and time consuming to navigate. One coordinator commented that, *"I can't get my money through the system"* while another stated *"it seemed like the restrictions or requirements around accessing the funds got stricter and stricter as the time went by and so it was always changing so we never knew if we did something last time if we could do it again."* A participant concluded *"what you hear from coordinators across the province is that they don't have the administrative support internally to get their work done."* Coordinators who had clerical support were able to focus on community development strategies rather than booking rooms and sending letters. The lack of administrative support seemed particularly acute in rural areas where there were fewer support staff.

Challenge #3 Heart Health Coordinators lacked Influence with Health Units and the Ministry of Health and Long Term Care

The lack of direct communication between heart health coordinators and health unit administrators made it difficult for coordinators to advocate for heart health coalition initiatives and influence the funding decisions for heart health initiatives made by administrators. If the health unit denied funding for a heart health initiative, heart health coordinators usually were not given the reasons for the decision. This was sometimes attributed to managers who were responsible for coordinators being overworked, and therefore unable to respond to coordinator requests in a timely manner. These delays made it difficult to get heart health paperwork through the health unit system quickly. New

coordinators found it difficult when they did not receive sufficient managerial support as they were learning a complex and challenging role.

Ten participants indicated that the Ministry of Health and Long Term Care did not always respond to heart health coordinators' expressed concerns. One coordinator commented that while coordinator input into Phase II of the Ontario Heart Health Program was solicited by the Ministry of Health and Long Term Care, she perceived that coordinator recommendations were not reflected in the Phase II guidelines. Input on decision-making was given by coordinators to *"inform the guidelines that came out for this round of funding, but [the Ministry] deleted it."* These study findings contrast with Riley et al. (2004) who stated that changes for Phase II were reflective of input from coordinators.

Challenge #4 Low Heart Health Coalition Membership and Participation

All health units were required to develop heart health coalitions as an essential component of the local Ontario Heart Health Program. This proved difficult for health units both with and without turnover and in northern, non-northern rural and non-northern urban centers. As many participants explained, it was very difficult to recruit and retain heart health coalition partners. One health unit that experienced a lot of coordinator turnover was unable to develop a heart health coalition and utilized a series of smaller task groups that individually planned and implemented specific heart health strategies. The study findings were similar to the general situation found by Riley et al. (2004) across Ontario. The authors discovered that all heart health coalitions in all five years of Phase I of the Ontario Heart Health Program had difficulty attracting and retaining members. This was partly due to the volunteer nature of coalition partners who had other jobs. *"The problem is that the coalition is really made up of people who have full time jobs doing other things and they really can't help this public health person out."*

This problem was even more acute in smaller coalitions which often lacked sufficient human resources. In rural areas it was difficult for heart health coalitions to attract and retain coalition members because organizations interested in heart health usually had only one paid staff member who had many other responsibilities. Coalition members who did get involved often became burned out and ultimately left the coalition. The limited pool of human resources meant fewer coalition members participated in the planning and implementation of heart health initiatives. In some cases the coalition assumed an advisory role and the work of implementing heart health initiatives fell back onto the heart health coordinator. In other cases coalition members simply assumed that coordinators would implement heart health initiatives.

Some coalition members found it difficult to understand why they were required to provide a lot of detailed information regarding their participation in the program for the Phase I evaluation. It was incumbent upon the coordinator to explain the need for coalition input into the evaluation process. Some coalition members questioned the need for such detailed information and for some these extra responsibilities reduced their participation.

Challenge #5 Heart Health Coordinators Lacked Sufficient Remuneration and Status within the Health Unit

With the heavy demands of the job, some coordinators were bitter at being paid the same salary as other front line public health employees. *"The toughest part is that I probably carry twice the workload. And you look at your counterparts within the health unit and there is no compensation for that. It's a big issue for us internally. We get paid the same."* This payment issue was not consistent throughout the Ontario Heart Health Program because some coordinators were placed in a management position, and thus health units were able to pay them a higher salary. Some coordinators were not permitted by health

unit administrators to use the term heart health coordinator because it referred to a managerial position within the health unit.

Challenge # 6 Failure to Adapt Ontario Heart Health Program to Smaller, Rural Health

Units

Participants from smaller health units suggested that the Ministry of Health and Long Term Care did not understand the unique challenges of implementing the Ontario Heart Health Program in smaller, rural settings which were geographically spread out with small populations. Rural areas had a smaller population base which made it more difficult to attract participation in the heart health coalition. The geographic expanse made meeting as a group difficult and expensive. Smaller rural health units had fewer staff to help look after administrative work generated by the Ontario Heart Health Program.

Furthermore the financial costs of paying the entire coordinator salary was a bigger burden for small health units than larger ones. The Ontario Heart Health Network (2003) suggested that while larger health units with bigger budgets could easily afford the expense of a full time salary for the heart health coordinator, it was unrealistic for smaller health units to cover this cost. In some cases the salary expense was perceived as diminishing health unit resources (Ontario Heart Health Network). Participants explained that coordinators functioned differently in non-northern urban centres than in non-northern rural areas *"In the large cities [they] were really able to spread the work out more...the coordinator should be just that – a coordinator...whereas it really didn't work that way for ours."*

4.6 Heart Health Coordinator Turnover

To some degree heart health coordinator turnover was inevitable and it happened in two different ways. In some health units, the previous coordinator remained at the health unit and was available as a resource to the new coordinator. In other health units, the

coordinator resigned, and left the health unit with a void. When there was no one in the position, the health unit usually temporarily filled the gap with health unit staff while a new coordinator was hired. The Ontario Heart Health Program Phase I Evaluation found that gap periods ranged from 0 – 26 months without a new coordinator, with an average time between coordinators of 3.6 months (Riley et al., 2004). While the gap period reflects the actual time without a coordinator, the time required for the new coordinator and the coalition to adjust to the transition was considerably longer as it involved the development of strong interpersonal relationships. It is unclear what strategies new coordinators had to employ following a situation of turnover in order to reinvigorate the coalition so that it could continue to plan and implement heart health strategies.

Some heart health coordinators were unable to handle the significant overtime requirements and the job demands and left the position for other positions elsewhere in the health unit with fewer and less complex responsibilities. Other coordinators obtained managerial positions using the skills they acquired as coordinators. Whatever the reasons, heart health coordinator turnover had a very real impact on the health unit, the heart health coalition and heart health coordinators themselves. When the coordinator left, the health unit was still responsible for helping the coalition implement heart health activities and for reporting to the Ministry of Health and Long Term Care on heart health activities. Some health units experienced gap periods until the position was filled. During these gap periods, health unit managers or staff members were often required to assume coordinator responsibilities. Replacement coordinators could find themselves under the scrutiny of the coalition, and were not always welcomed particularly if the heart health coordinator left the position because of conflict. In health units with frequent coordinator turnover, communication patterns developed that left coordinators out of the communication loop. As

one coordinator explained, repeated turnover was *"a real challenge...because there hadn't been a coordinator for four months so there was a lack of communication [between the coalition and] the coordinator."*

Turnover also damaged coalitions by reducing membership and slowing coalition momentum. This was evident in the Ontario Heart Health Program Phase I Final Evaluation which found that coalitions experiencing turnover were: (1) slow to develop a collective identity or collaborative partnership, (2) had few partners accepting responsible positions such as chair or on committees, (3) had limited development of interpersonal relationships, and (4) were slow to make progress toward goals (Riley et al., 2004).

Participants described similar findings to those by Riley et al. (2004) and explained what occurred as coordinators turned over. During transition periods between coordinators, the emphasis was placed on team building rather than on developing and implementing heart health initiatives. This transition period was characterized by a period of cautiousness as the new coordinator took over and became established. Some heart health coalitions with turnover were described *"as falling apart – we lost partners because their personal connection with that coordinator was the thing that kept them involved."* In some health units, individual working groups continued to carry out heart health activities, but the lack of a consistent heart health coordinator meant that a strong coalition had never developed. In another health unit, coordinator turnover meant that the coalition only existed in a major centre and had not been able to expand into the outlying areas.

Participants also reported that coalition functioning was also affected by turnover which caused the *"coalition to slow down a bit. You don't spend as much time discussing issues ... there is a lull period where some partners might be a bit apprehensive."* Heart health coordinator turnover also reduced the corporate memory of the coalition. Problems

resulting from heart health coordinator turnover were compounded by coalition member turnover.

Participants described how heart health coordinators left their positions for a variety of reasons, but commented that transitions were easier when the new coordinator was eased into the position. Coordinators who were originally coalition members and emerged from the coalition facilitated the transition process because they already possessed an understanding of the community and the history of the heart health coalition. Transitions between coordinators were also less complicated when the outgoing coordinator remained with the health unit and was available to mentor the new coordinator. Supportive health unit colleagues and managers were also important in the adjustment process. Participants indicated that resources from the Ministry were helpful in orienting new coordinators. The Heart Health Resource Centre familiarized new coordinators with the Ontario Heart Health Program and provided ongoing support through mentorship programs with coordinators from other health units. The Ministry provided consultants and facilitated regularly scheduled regional heart health meetings that gave coordinators the opportunity to discuss common concerns. Regional meetings were an important source of support because *“there is a lot of need that gets satisfied with people who are newer [who have the opportunity] to pick the brains of people who have been around for awhile.”*

It is interesting to note that the rate of heart health coordinator turnover was reduced to nine in year five from a high of 21 in year two (Riley et al., 2004, p. 23). This suggests that factors at play that caused a lot of turnover during year two might have mediated during the last year of the Ontario Heart Health Program.

4.7 Managing Heart Health Coordinator Job Challenges

Participants identified personal strategies used to cope with the stress generated by the heart health coordinator job, and made a series of recommendations for organizational changes that would improve coordinator job satisfaction. Personal strategies used by coordinators included patience, realism, and a focus on the positive. Participants suggested that new coordinators avail themselves of mentoring and consultant services offered by Heart Health Resource Centre staff.

Participants suggested that the Ministry of Health and Long Term Care fund the heart health coordinator position so that salaries could be more competitive. Riley et al. (2004) recommended that funding for heart health coordinator salaries be explored and that provincial guidelines be developed to clarify coordinator roles and responsibilities. While some participants felt that the coordinator should be a mid-level management position, others strongly felt that the heart health coordinator should remain in a frontline health unit position.

Participants described how coordinators were caught at the interface between provincial guidelines for the Ontario Heart Health Program established by the Ministry of Health and Long Term Care, the rules and regulations of the health unit, and heart health initiatives recommended by the coalition. To counteract this problem, some participants suggested that both the coordinator and heart health coalition be given more fiscal autonomy to plan and implement heart health initiatives. However, some other participants recommended that the heart health coalition become an advisory body with the final decision for heart health financial expenditures resting with the health unit.

In some health units, heart health coordinators had clerical support to help them run the program and coordinators found this to be advantageous. Smaller health units found it

difficult to provide this support from their existing resources, and it was recommended that the Ministry provide funding for clerical support. Based on the experience of coordinators in Phase I of the Ontario Heart Health Program, the Ontario Heart Health Network (2003) recommended that a consultation process examine the supports required by the coordinator and the coalition.

Participants suggested that provincial heart health messages and resources be developed by the Ministry of Health and Long Term Care for use by all coalitions. Respondents indicated this would facilitate more efficient delivery of heart health messages. The Ontario Heart Health Network (2003) made a similar suggestion and recommended that a local logo be added to foster community program identity.

4.8 Mediating Relationships between Unequal Partners with Conflicting Agendas

Heart health coordinators were caught at the interface between three dissimilar organizations, all of which had differing visions of how the Ontario Heart Health Program should be implemented. The health unit, the Ministry of Health and Long Term Care and the heart health coalition each had differing structural arrangements, funding levels, mandates, and levels of power (Riley et al., 2004). In spite of differences, these organizations were required to work together to implement the Ontario Heart Health Program at the local level. Heart health coordinators were responsible for supporting a fragile coalition, fostering relationships among these organizations and managing the differing power dynamics. This required that coordinators be skilled at diffusing the tensions which might arise.

Heart Health Coalitions: Supporting a Fragile Entity

Heart health coalitions were more informal and more loosely structured organizations than either the Ministry of Health and Long Term Care, or the health unit. Coalition

membership was voluntary so that members could leave at any time and there was frequent turnover of organizational representation. Coalition membership and functioning was enhanced in the absence of coordinator turnover. Heart health coalitions addressed risk factors for cardiovascular disease that were common to other chronic diseases. However, some organizations that addressed the same risk factors did not join or did not retain membership in the coalition because they had no interest in heart health. While it was documented by Riley et al. (2004) that all coalitions found it difficult to attract and retain coalition members, participants indicated that rural health units perceived that they had specific challenges due to their large geographic areas and smaller population base.

Heart health coordinators actively supported the recruitment and retention of coalition membership by ensuring that coalition members had their organizational needs met. They reduced the demands on coalition members and assisted the coalition to function by performing many of the administrative tasks associated with the work of the coalition and advocating for heart health funds on behalf of the coalition.

Managing Complex Relationships

Heart health coordinators assisted coalitions to plan and implement heart health initiatives by balancing: (1) rules and regulations for the Ontario Heart Health Program established by the Ministry of Health and Long Term Care, (2) requirements of individual health units for financial accountability, and (3) recommendations by the coalition for community-based heart health initiatives. To ensure accountability, health units had developed complex fiscal regulations governing the spending of heart health funds that sometimes confused heart health coalition members. Heart health coordinators were responsible for ensuring that the heart health coalition had a voice to advocate for coalition recommendations in terms that met health unit fiscal regulations. An important role for the

coordinator was to “*help the coalition figure out how to follow all the rules that were set up and still try and accomplish something.*” These coordinator responsibilities were complicated by the fact that most coordinators were frontline health unit employees with no direct access to health unit administrators. Although heart health coordinators were advocating for the recommendations of the coalition, they were obliged to follow health unit policies and procedures.

Heart Health Coordinators: A Buffer between the Health Unit and the Coalition

The Ministry established the Ontario Heart Health Program as a community-based project to implement cardiovascular disease prevention strategies, but placed the responsibility for administration of heart health funds in the hands of the health unit. Heart health coordinators required political skills and acumen to advocate and support the work of the heart health coalition. This meant that coordinators had to trade on good relationships and insider knowledge of how the organizations worked in order to understand where each was coming from, and their motivation and goals. In some cases, coordinators positioned themselves outside the sphere of the health unit so that coalition members did not see them as part of unpopular health unit funding decisions. This strategy was also recommended by the Ontario Heart Health Network (2003). As the only link between the heart health coalition and the health unit, the heart health coordinator acted as a buffer between the two organizations and mediated this unequal relationship.

Impact of Heart Health Coordinator Turnover on Managing Complex Relationships

New heart health coordinators had to quickly develop an understanding of the organizational structures, mandates, funding requirements and the community in order to develop the skills, confidence and knowledge necessary to successfully advocate on behalf of the heart health coalition. This was challenging for new heart health coordinators because

the job was atypical and it was difficult to learn these skills quickly. Heart health coordinator turnover made a break in the communication link between the Ministry of Health and Long Term Care, the health unit and the coalition.

Health units handled the absence of heart health coordinators in two ways. In some cases, managers assumed coordinator responsibilities. This was difficult because many participants reported that managers were already very busy with administrative responsibilities. In other cases, participants indicated that health units placed temporary staff members in the coordinator position. This meant that coalitions had a person advocating for heart health funding who may have lacked knowledge of both the history and desires of the coalition, and health unit funding rules and regulations.

Time during the transition period was spent building relationships between the new coordinator and the coalition instead of developing and implementing heart health initiatives. It is not surprising that many coalitions had reduced membership and efficacy when there was coordinator turnover. Most heart health coalitions were established after provincial funding for Phase I was issued in 1998 (Riley et al., 2004). Yet the Ministry expected heart health coalitions to develop extensive four year plans shortly after the program began (Ontario Heart Health Network, 2003). Coalitions found developing these plans was difficult because they were still at the stage of building relationships among the partners, and there often was a lack of local expertise in the planning process. Dunkley et al. (2001) maintained that during the early stages coalitions were still developing a collective identity and could not be expected to develop complex, long term plans. As the coalitions continued to evolve, heart health coordinators were a vital communication link between partners and provided expertise and help with the planning phase. Coordinators also informed the coalition of Ministry directives in language that coalition members could understand. With

heart health coordinator turnover, the person in the leadership position had much less knowledge of all of the vital information required to facilitate the work of the heart health coalition. Thus, coordinator turnover made it difficult for the coalition to develop a collective identity and complicated the planning process.

Interpersonal skills were critical so that heart health coordinators could build relationships among heart health coalition members. With the turnover of heart health coordinators, coalitions lost some members and time had to be spent developing relationships, rather than implementing heart health initiatives. This reduced the opportunities for the coalition to implement successful heart health ventures.

4.9 Summary

A selective review of three key documents provided insight into Phase I of the Ontario Heart Health Program. Dunkley et al. (2001) described problems in some health units because the heart health coalition perceived the program as health unit driven thus marginalizing other community partners. The Ontario Heart Health Network (2002) recommended implementing a chronic disease strategy by amalgamating programs addressing stroke prevention, diabetes prevention and cancer prevention by building on health unit and community capacity developed in the Ontario Heart Health Program. Riley et al. (2004) documented successes and gaps in Phase I and recommended continuing provincial funding for Phase II of the Ontario Heart Health Program. All three documents described problems with heart health coordinator turnover.

Thirteen taped phone interviews were completed with heart health coordinators, chronic disease managers and heart health coalition members from five health units. Participating health units were from non-northern rural, non-northern urban and northern

areas of Ontario. Participating health units experienced a range of heart health coordinator turnover from none to six coordinators during Phase I of the Ontario Heart Health Program.

Participants identified a variety of heart health coordinator roles and responsibilities. In order to fulfill these roles and responsibilities, coordinators required communication and interpersonal skills, project management skills and personal qualities suited to the Ontario Heart Health Program.

While heart health coordinators were able to identify rewards from the job such as working with community partners, working in a large province-based program and personal benefits, they were challenged by both provincial and local issues. Provincial challenges included a structure that required coordinators to act as a buffer between the health unit and the heart health coalition, dealing with Ontario Heart Health Program Phase II funding delays, and a limited project scope. Locally, coordinators faced challenges including: (1) a lack of knowledge and experience and a steep learning curve for an atypical public health job, (2) overwork leading to burnout, (3) a lack of influence with the health unit and the Ministry of Health and Long Term Care, (4) insufficient remuneration and a lack of support and recognition, (5) low heart health coalition membership and participation that forced many coordinators to assume coalition responsibilities, (6) a failure by the Ministry of Health and Long Term Care to adapt the Ontario Heart Health Program to smaller, rural health units.

Heart health coordinator turnover had an impact on the health unit, the heart health coalition and coordinators themselves. Health units had to manage turnover and gap periods between coordinators. Turnover caused heart health coalitions to experience reduced membership and less than optimal function. Heart health coordinators had difficulties assuming the coordinator role in coalitions that experienced a lot of turnover. Participants

recommended that new coordinators seek support from experienced coordinators and the Heart Health Resource Centre, and identified personal and organizational strategies to reduce turnover.

The health unit, the heart health coalition and the Ministry of Health and Long Term Care all had to work together to implement the Ontario Heart Health Program at the local level. Heart health coordinators used political skills to manage these complex relationships and buffered an often difficult relationship between the health unit and the heart health coalition. This was complicated by the fragile nature of the coalition which often had difficulty attracting and maintaining members. Heart health coordinator turnover made it more difficult for coalitions to develop collaborative capacity and plan and implement heart health initiatives.

Chapter V Discussion

This chapter examines the findings from the participant interviews and document review in light of relevant literature. Strengths and limitations of the study are described. The implications of the findings for clinical practice, education, future research and policy are considered.

This is one of the first studies to examine the issue of turnover of public health staff working with coalitions in complex provincial programs. Heart health coordinators played a pivotal leadership role in the local implementation of the Ontario Heart Health Program. As coordinators were the key link between the health unit and the heart health coalition, their turnover was a problem.

Findings suggest that an array of individual and organizational factors challenged heart health coordinators during Phase I of the Ontario Heart Health Program and possibly contributed to turnover. Most prominent among these were: (1) a mismatch between skill level and job requirements, (2) remuneration issues, and (3) access to power.

Mismatch between Skill Level and Job Requirements

Heart health coordinators had an atypical, fast-paced and complicated job. Consequently, new coordinators faced a steep learning curve with little time to learn the skills. According to the findings, it was often difficult to find health unit staff with the necessary qualifications and experience required for the position. This is not surprising given the unique and complicated nature of the job. Diekemper et al. (1999) suggested that complex coalition leadership skills are developed over many years of experience. With the complexity of the program, the heavy workload and constant time pressures, new coordinators may not have had adequate time to master these skills. There may have been a mismatch between skill level and job requirements, contributing to turnover.

Remuneration

While participants suggested that the complexity and responsibilities of the heart health coordinator job merited higher pay, these findings contrast with those of Armstrong-Stassen and Cameron (2005) who found that public health nurses were more satisfied with their pay than other community health nurses. Pay was also not considered to be a reason for job dissatisfaction among most hospital nurses other than those who were new graduates (Cowin, 2002). A possible reason for some coordinator dissatisfaction with their salary may have been that the coordinator position was frequently an entry point into the health unit. Many coordinators began their public health career in that job and these new coordinators would have been at the lower end of the public health pay scale, yet in a job that demanded a high skill level. Irvine and Evans (1995) indicated that organizational climate is a more important factor in job satisfaction than remuneration. However, this may not always be the case because both Kluska et al. (2004) and Laschinger et al. (2001) concluded that the balance between effort and reward contributes to job satisfaction. The findings from this study bear this out because in order to be paid more for similar responsibilities, some coordinators used the skills they acquired as coordinators to move into managerial positions with higher pay.

Access to Power

Structural issues may have made it more difficult for heart health coordinators to fulfill their job responsibilities. For instance, an important role for coordinators was to advocate on behalf of the coalition for heart health funds necessary to implement heart health initiatives. However, as front line health unit staff, coordinators had limited access to higher levels of health unit administration responsible for heart health funding decisions.

It is likely that coordinators relied on chronic disease managers to push forward heart health coalition requests for funding to health unit administrators. Literature identifying nurse job satisfaction in hospitals identifies the importance of managers in helping nurses gain access to resources, particularly those that made the job easier (Upenieks, 2003). Haugh and Laschinger (1996) reported that nurses relied on managers having enough power to support them. Participants in this study described an uneven level of managerial support for heart health coordinators which may have made it more difficult for them to access heart health funds. Managers may have been too busy to help coordinators understand health unit fiscal rules and regulations so that coordinators could interpret these for the coalition. This finding is supported by Falk-Rafael et al. (2005) who reported that public health nurses rated themselves as the second least influential group within the health unit - just above community members. These authors also explained that public health units in Ontario have lost high level positions such as Directors of Nursing. The absence of these positions might have further limited coordinators from direct access to health unit administrators.

A Key Role

An important responsibility for heart health coordinators was to facilitate the work of the heart health coalition. This meant that when the local program was not functioning effectively because there were difficulties recruiting and retaining heart health coalition members, or because the coalition and health unit had trouble working together - the coordinator was viewed as responsible. The problems some coalitions had with membership and functioning is well documented. As can be seen from the findings, some of these problems may have occurred because of systemic and structural problems and not necessarily because the coordinator was a poor leader. However, the perception of

leadership failure may have caused some coordinators to leave the job. Coordinator turnover may have been symptomatic of the problems with a new and complicated program.

The Issue of Heart Health Coordinator Turnover

Heart health coordinators were the only individuals working full time in the local heart health program. In essence, they were the only people who understood in totality how the local heart health program worked because all other organizations and individuals involved had more limited roles and responsibilities. It stands, therefore, that coordinator turnover was a serious problem because it meant that the only person who could really facilitate community-based programming was unavailable. The highly interpersonal nature of community-partner collaboration made leadership consistency an important factor for coalition success. It is not surprising that turnover exacerbated problems with coalition development and functioning. This aspect of coalition leadership is under represented within the literature and is important for future research. The balance between ideas brought by a new leader and the corporate memory retained by a well established leader needs to be explored further. In essence, how much leadership turnover is necessary for a well functioning coalition versus how much turnover causes problems for a coalition?

Similarities and Differences in Turnover

Many of the similarities and differences in heart health coordinator challenges across participating health units were reflective of experiences with heart health coordinator turnover and geographical differences. The findings from this study indicate that heart health coordinator turnover reduced the membership and functioning of heart health coalitions. Coordinators in health units with little or no heart health coordinator turnover were able to initiate and maintain heart health coalitions. One health unit that experienced frequent heart health coordinator turnover was never able to develop a functional coalition.

Instead this health unit relied on a system of small task groups to carry out individual heart health initiatives.

More rural health units had geographical challenges which when combined with coordinator turnover also meant that coalitions might develop only in larger centers rather than expanding to outlying areas. Smaller communities had fewer organizational representatives and community members to draw upon to support the heart health coalition. Those who did participate in the coalition often became tired and some eventually left the coalition. Smaller heart health coalitions often resulted in coordinators assuming more responsibility for heart health initiatives and this added to an already demanding coordinator job and may have contributed to turnover.

Why Not Leave the Job?

It is important to remember that not all heart health coordinators were unhappy with the job. In spite of choices that coordinators sometimes made to leave or to move to other positions, they also identified many job rewards including working with community partners, prestige within the community, job autonomy, and making positive community changes. Coordinators had more autonomy and enjoyed more perks such as setting their own schedule than other front line health employees. Ulrich et al. (2005) found that status and prestige were associated with higher levels of job satisfaction and were more important than monetary rewards. Prestige particularly within the community may have had a positive influence on job satisfaction, thus moderating coordinator turnover.

There is a difference between the intent to leave a job and actually acting on the intent (Mor Barak, Nissly, & Levin, 2001). One participant wanted to leave the position, but could not because of family reasons. Often employees will remain or leave a job because of factors completely separate from the job itself. Gender, age, family situation or the closure

or opening of a significant community industry can reduce or exacerbate a person's ability to act on their intent to leave (Betkus & MacLeod, 2004; Sousa-Poza & Henneburger, 2004). Few studies with inconsistent results have examined whether or not alternative job opportunities increase job turnover (Krausz, Koslowsky, Shalom, Elyakim, 1995; Strachota et al., 2003). Participants indicated that heart health coordinators left the job for both personal and organizational reasons, but this study was unable to untangle whether coordinators left the position for personal reasons or because organizational factors made the job too difficult. This study points to a gap in the literature examining the interplay of personal factors and work-related factors that influence staff choices to stay in their position.

Results of Heart Health Coordinator Turnover

Heart health coordinator turnover was costly both to coalitions that lost a key leader and to health units that bore the cost of hiring and retraining a new staff person for the position. Perhaps the most critical problem stemming from coordinator turnover was the uneven development of workforce capacity with the expertise and skills necessary to implement the Ontario Heart Health Program. Heart health coordinators did not always stay in the job long enough to master the knowledge and skills required to effectively broker recommendations from the heart health coalition with the fiscal rules and regulations required by the health unit. Consequently, there was a limited pool of coordinators with long-term expertise of how to implement the Ontario Heart Health Program. This may have established a cycle whereby some coordinators turned over because they did not have the necessary support systems.

Study findings associated heart health coordinator turnover with reduced coalition membership and functioning. Several participants stated that heart health coalitions that experienced turnover functioned poorly because good coalition function was dependent upon

strong interpersonal relationships between the coordinator and the coalition. In the only literature describing the importance of coalition leadership consistency, Gottlieb et al. (1993) explained that frequent turnover required coalition members to spend their time developing interpersonal relationships rather than implementing projects.

5.1 Public Health System Challenges

The period before and during heart health coordinator turnover was characterized by tremendous change across the Ontario public health system that occurred during Phase I of the Ontario Heart Health Program. While this study did not ask participants questions about these issues, the document review identified some of these factors. It is possible that these factors may have had an adverse effect on implementation of the Ontario Heart Health Program and possibly influenced heart health coordinator turnover. During the past decade, public health has evolved from primarily service-based individualized care to improving the health of populations (Butterfoss et al., 2003; Falk-Rafael et al., 2005; Haugh & Laschinger, 1996; Ontario Heart Health Network, 2002; Veazie et al., 2001; Zahner & Gredig, 2005a, 2005b). Studies have repeatedly shown how constant changes within the public health system have often overwhelmed nurses (Cumbey & Alexander, 1998; Gebbie & Hwang, 1999; Haugh & Laschinger). In Ontario significant changes occurred either just before or during Phase I of the Ontario Heart Health Program that: (1) altered municipal and health unit organizational structures, (2) affected public health funding arrangements, and (3) reduced health unit human resources.

Amalgamation

In 1998, the provincial government compelled several cities and a number of rural areas to amalgamate in order to reduce duplication of services and costs (Association of Public Health Epidemiologists in Ontario, n.d.). The system of Ontario health units was not

immune to this process, and consequently was reduced from 43 to 37 health units. The newly formed health units required time to adjust and reorganize their organizational structures and reporting mechanisms. These changes may have made it more difficult for some heart health coordinators early in Phase I of the Ontario Heart Health Program to negotiate through the changed administrative system in order to help the heart health coalition to obtain funds for initiatives.

Fiscal Changes in the Public Health System

Both Falk-Rafael et al. (2005) and Riley et al. (2004) described important fiscal changes in the public health system. Prior to 1998, the province assumed 75% of the cost of public health services while local municipalities were responsible for 25%. In 1998 the Ontario government legislated downloading of the entire cost of public health services onto the municipalities. This was amended in 1999 with the municipality and the province each assuming responsibility for fifty percent of the costs. These funding changes were significant because municipalities rely solely on property taxes for revenue, and the public health system now competed for dollars against municipal infrastructure expenses such as roads, police and fire services. Heart health coordinators may have found the health unit to be more cautious about releasing funds for heart health programming.

Restructuring Public Health Nurse Positions

Public health nurse roles and responsibilities also changed during this period. In a study of 1665 Ontario public health nurses carried out in 1999, Falk-Rafael et al. (2005) discovered that nurses had increased the amount of time they spent in community and coalition development. However, when public health nurses ranked their activities, coalition development was seventh indicating that many nurses might not have had experience with

coalition leadership (Falk-Rafael et al.). This supports the heart health coordinator's contention that coordinators had an atypical public health job.

In summary, amalgamation, fiscal downloading and restructuring of public health nurse jobs may have compromised the financial and organizational stability of the public health system. During a period of great change, health units were also responsible for implementing Phase I of the Ontario Heart Health Program at the local level, providing new funding to support the heart health coordinator position and generating in-kind funds from community organizations. These challenges may have had an impact on how health units reacted to the implementation of the Ontario Heart Health Program within Ontario. This study did not ask participants direct questions about the effects of amalgamation, fiscal restructuring and changes in public health nursing jobs. However, information regarding these issues might have helped further illuminate challenges faced by heart health coordinators. These changes within the Ontario Public Health system may have provided additional challenges that reduced coordinator job satisfaction and potentially increased turnover during this period.

5.2 Trustworthiness and Authenticity of Data

Triangulation

Triangulation is the use of multiple sources of data in one research project. It is used to reveal a more accurate picture of phenomena and confirm findings and conclusions. It also lends richness to data and can fill in gaps from one source (Roper & Shapira, 2000; Streubert Speziale & Carpenter, 2000). This study employed both a document review and semi-structured telephone interviews with participants from non-northern rural, non-northern urban and northern health units. Participating health units had a range of heart health coordinator turnover from none to six coordinators. Participants interviewed included: heart

health coordinators in the position, heart health coordinators who had left the position, chronic disease managers and coalition members. Matrices were created to understand the differences and similarities among the different types of respondents and different types of health units.

Trustworthiness

The researcher is described as the research instrument in qualitative research and as such is subject to bias (Roper & Shapira, 2000). As the researcher attempts to understand the insider or emic viewpoint, it is possible to become biased in favour or against the viewpoints of particular participants. The researcher must maintain an outsider or etic perspective to prevent this from occurring. Efforts to minimize bias have been made by the researcher examining her thoughts and feelings about the issue of heart health coordinator turnover in regular meetings with her thesis supervisor, and keeping field notes during data gathering, data analysis and writing of the thesis. The researcher attempted to remain non-judgmental and attentive during interviews to encourage disclosure.

Reliability

Reliability refers to the use of data collection methods that are consistent and repeatable (Roper & Shapira, 2000). A semi-structured interview guide provided a list of key questions asked by the interviewer. While there were some wording changes during the interviews, the interviewer followed the question guide and used probes developed for the questions when necessary.

Field Research

This study used information gained from semi-structured interviews with participants as the primary data source. The researcher also endeavored to obtain participants from a variety of geographical areas, different size health units and different backgrounds in order

to provide a variety of viewpoints to illuminate the issues. The researcher wrote field notes as a means of tracking decision making throughout the study.

5.3 Limitations of the Study

This focused ethnographic study aimed to identify issues surrounding the roles and responsibilities of heart health coordinators and turnover. While the study was limited to thirteen participants from five Ontario health units, perspectives on the issues were identified that may be relevant to other health units. All interviews were conducted in English which might have limited the participation of individuals more comfortable expressing themselves in French. Participants recalled information from Phase I of the Ontario Heart Health Program which lasted six years, and thus there may be problems with recall. The researcher had limited experience with interviewing, so early interview transcripts were reviewed with the researcher's supervisor, and strategies were devised that helped the researcher probe more effectively as the interviews progressed.

Some perspectives were not obtained because heart health coordinators were the entry point into the study. If coordinators were not interested in participating, then no one else from the health unit took part in the study. Only two chronic disease managers participated and no non-northern urban or northern health units without heart health coordinator turnover took part. Data saturation was not achieved with these groups. It proved impossible to locate or gain access to heart health coordinators who left the position because they were unhappy, but insight into this issue was gleaned from other participants in the study who described conflicts and problems.

5.4 Implications and Recommendations

A number of implications and recommendations are discussed under the topics of practice, education, research and policy. These recommendations are based on study

findings and are supported by the literature. A summary of these recommendations is provided in Table 5.1.

Table 5.1 Recommendations

Practice 1. Hire experienced public health staff for heart health coordinator positions 2. Support new staff by: • Mentoring new staff • Providing managerial support • Educating staff about health unit fiscal rules • Providing administrative support • Improving pay scale for heart health coordinators
Education 1. Educational institutions must teach policy development in courses designed to educate nurses in both the theoretical and practical aspects of coalition leadership 2. Encourage nurses to obtain credentials such as Community Health Nursing Certification
Research 1. Conduct a study to explore more fully how heart health coordinators who have a good working relationship with the coalition successfully move issues forward 2. Conduct a study to explore what is the optimal length of time heart health coordinators should remain in the job 3. Conduct a longitudinal study to understand whether or not the roles and responsibilities and turnover of heart health coordinators changed during Phase II and Phase III of the Ontario Heart Health Program
Policy Ministry of Health and Long Term Care policies must be developed that • Describe the roles and responsibilities of heart health coordinators • Provide adequate funding for heart health coordinator salaries • Provide funding for administrative support for heart health coordinators

Practice

Heart health coordinators had a difficult job as they attempted to implement a complicated coalition-based program to reduce the incidence of cardiovascular disease. Several things might help their practice. It is critical to hire experienced public health staff for heart health coordinator positions who understand the workings of health units and coalitions. Experienced coordinators who are in their positions longer term provide the heart health coalition with stability permitting it to focus on planning and implementing heart health initiatives.

Mentoring. Experienced coordinators are a source of expertise and can serve as mentors for new coordinators. Experienced heart health coordinators help provide a support system that assists new heart health coordinators to learn the skills required and adjust to a demanding, atypical public health job. Nurses who are mentored are more likely to stay in their current position because mentorship helps link theory with nursing practice and “is a key recruitment and retention strategy for nurses” (Registered Nurses Association of Ontario, Mentorship, n.d., para 4). Mentoring new heart health coordinators may ease the transition of a new coordinator into the role ultimately reducing turnover. It also provides a means by which coordinators can share their experiences and knowledge, thus enhancing heart health coordinator capacity.

Manager support. It was clear that public health managers were an important factor in the ability of heart health coordinators to access funds from health unit administrators. However, this study found that many managers were too busy to help the heart health coordinator in a timely manner. Some managers lacked a clear understanding of public health nurse roles and functions. To facilitate manager support, it is recommended that the workload of managers be evaluated with a view to making it more manageable. This would

assist managers to respond to the needs of heart health coordinators in a timely manner. The findings from this study provide a clear description of the roles and responsibilities of the heart health coordinator and should be used to assist managers to understand the complexities of the coordinator role. These roles are consistent with the Canadian Community Health Nursing Standards of Practice (Community Health Nurses Association of Canada, 2003). It would be useful to disseminate these standards to give managers a clear description of the scope of practice for public health nurses.

Understanding health unit fiscal rules. One of the factors that may have made it difficult for the heart health coalition and the health unit were the complex and changing health unit fiscal rules. While some coalition members perceived the health unit as blocking community-based heart health initiatives, they did not always understand the reasons for the denial of funding initiatives. It would be helpful for health unit administrators, the heart health coordinator and the coalition to meet and openly discuss the health unit fiscal rules, thereby increasing transparency. The knowledge generated by this meeting might assist the coalition to plan initiatives that take into account health unit rules.

Administrative support. Overwork can contribute to low job satisfaction, emotional exhaustion and eventually burnout (Jamal & Baba, 2000; Jansen, Kerkstra, Abu-Saad, & van der Zee, 1996). Many participants in this study described an onerous amount of paperwork that heart health coordinators were required to complete. These administrative tasks took time away from community development efforts. Health units should provide clerical support to allow the coordinator's workload to focus more on community development. The Ontario Ministry of Health and Long Term Care funding would need to assist smaller health units to provide this support.

Improved pay. Several coordinators described their frustration because they received the same pay as their peers for a more difficult and skilled job. This situation was not consistent throughout Ontario as some health units addressed this issue by making the coordinator a managerial position. While salary has not been identified as an important factor in job satisfaction; the link between effort and reward and job satisfaction has been shown (Kluska et al., 2004; Laschinger et al., 2001). Heart health coordinator salaries and positions should be reviewed by the Ministry of Health and Long Term Care to establish a baseline salary with incremental increases. Additional funding from the Ministry would assist health units to establish salaries reflective of the skills required and the demands of the job and might reduce the number of heart health coordinators leaving to assume other public health jobs or managerial positions with higher pay and status. Riley et al. (2004) made a similar suggestion in the Ontario Heart Health Program Phase I Evaluation.

Education

Increasingly, public health nurses will be leading complex coalitions similar to those in the Ontario Heart Health Program, with a large number of partners addressing a variety of public health issues. The newly released report on Revitalizing Ontario's Public Health Capacity reinforces the need to develop leadership skills within the public health sector (Ontario Ministry of Health and Long Term Care, 2006). Similarly a draft version of Core Public Health Competencies has been developed that describe coalition leadership (Federal/Provincial/Territorial Public Health Human Resources Joint Task Group, 2004). It is critical that nurses in these leadership positions possess the requisite political skills and understanding of organizational behavior so that they can effectively make community-based changes that promote health. Therefore it is essential that public health nurse education provide a solid base in both the theory for this practice, as well as experience in

clinical placements that involve working with coalitions and within collaborative practice models (MacDonald & Schoenfeld, 2003; Zahner & Gredig, 2005a, 2005b). To ensure that public health nurses have the required skills, educators should be guided by the Canadian Community Health Nursing Standards of Practice (Community Health Nurses Association of Canada, 2003). Some universities have developed courses in policy development such as the one described by Reutter and Duncan (2002). The authors explained that students in the advanced practice masters of nursing program in community and public health nursing take a course that explore the issues surrounding policy analysis and policy advocacy. The role of the advanced practice nurse in intersectoral collaboration and public participation is strongly emphasized. Courses like these offer nurses the opportunity to develop the high level political skills and understanding of organizational behaviour necessary to lead complex coalitions with multiple partners.

For nurses currently practising in the public health field, the Canadian Nurses' Association has recently implemented a Community Health Nursing Certification Examination (Canadian Nurses' Association, n.d.). Practising public health nurses and new graduates should be encouraged to develop credentials demonstrating a specialized knowledge of community health nursing. Employers should be encouraged to support efforts by nurses to obtain these credentials.

Research

Several new research questions arise from this study and this thesis illuminates the need for a better understanding of the leadership of complex coalitions. While this study sheds light on both the roles and turnover among heart health coordinators, many areas are still unclear. Coordinators had trouble implementing the program because it was difficult to advocate on behalf of the heart health coalition. Research should be done with coordinators

in health units who have a good working relationship with coalitions and those that do not to compare strategies used by coordinators to move issues forward. It is important that this research reflect all geographic areas because this study pointed out that there are some differences across non-northern urban, non-northern rural and northern health units.

Turnover is described in the literature in negative terms because of the costs involved. However little is known about how much leadership turnover is essential to bring in new ideas and generate different strategies versus how much is detrimental to an organization. In order to understand turnover more fully, it would be useful to explore how long heart health coordinators should remain in the position in order to be effective. This would help define leadership turnover in terms of cost and benefit to the organization.

This study explored the role and turnover of heart health coordinators during Phase I of the Ontario Heart Health Program. This was early in the development of these coalitions so the role of the coordinator may be quite different as the coalition matures and begins to collaborate. It would also be useful to understand whether coordinators are continuing to turn over at a high rate and if so whether the reasons remain the same. A longitudinal study that explores the roles and responsibilities of heart health coordinators and turnover as the heart health program continues to evolve might help address this issue.

During Phase I of the Ontario Heart Health Program, Ontario health units experienced a lot of fiscal and organizational change. The document review discussed some of these factors, but participants were not questioned about these changes. It would be useful to understand whether any of these factors were implicated in heart health coordinator turnover. Further research should include questions about these issues.

Although coalitions in the Ontario Heart Health Program received funding, health units often provide leadership to other community coalitions that are not funded by the

Ministry of Health and Long Term Care. Exploring the similarities and differences between the leadership skills required for both funded and unfunded coalitions might help clarify whether a different skill set is required by public health leaders of unfunded coalitions.

Of the five health units studied, only one rural non-northern health unit did not have turnover. It would be useful to interview participants from non-northern urban and northern health units without turnover so that any differences in those groups could be identified.

Many participants in this study viewed health unit administrators as a roadblock to accessing heart health funding. Given that health unit administrators are subject to rules and regulations imposed by the Ministry of Health and Long Term Care, interviewing them might elicit issues that have an impact on the leadership of heart health coalitions.

Information about the timing and mechanisms for the release of funds from the Ministry of Health and Long Term Care, rules and restrictions pertaining to funding, and the effect of this on health unit and heart health coalition relationships are poorly understood.

Much of the research into nurse job satisfaction and turnover is focused on large teaching hospitals. This research suggests that different factors may be important in leading coalitions located in smaller health units. It would be useful to explore more fully the differences in coalition leadership between larger and smaller health units, and within non-northern urban and non-northern rural settings. While this research focused on the perspectives of those who left the coordinator job, it might be also be useful to understand it from the perspective of nurses who remain in the job.

Community coalitions are used throughout public health units in Canada to address health issues. No research was found that described heart health coalition leadership roles and responsibilities or turnover in other provinces. It would be useful to compare coalitions

in different provinces in order to understand if leadership practices and turnover differ elsewhere.

Much of the research relates nurse job satisfaction to organizational factors such as managerial support, pay and other tangible factors. Little has been written about the personal factors that influence job satisfaction. This would be an excellent area to research further.

Increasingly government funding is tied to community involvement in health promotion through the use of coalitions and it is critical that these financial resources not be wasted. If complex coalitions are going to function effectively, more must be learned about the leadership skills required to lead them.

Policy

Coalitions are an important vehicle for community involvement in heart health initiatives. Stable heart health coordinator leadership assists with maintenance of coalition membership and effective coalition functioning. Ministry of Health and Long Term Care policies must be developed that: (1) describe the roles and responsibilities of heart health coordinators, (2) provide adequate funding for heart health coordinator salaries, and (3) provide administrative support so that coordinators can facilitate community development. These policies are an essential support and will help build capacity within the Ontario Heart Health Program.

5.5 Conclusion

This study aimed to explore the roles and turnover among heart health coordinators in the Ontario Heart Health Program. Heart health coordinators occupy a complicated leadership role that is integral to the program. Heart health coordinator turnover compromises the ability of the Ontario Heart Health Program to implement an important

community based initiative to reduce cardiovascular disease and ultimately improve the health of Ontario citizens. Given the investment in human and fiscal resources, the issue of heart health coordinator turnover must be addressed at both local and provincial levels. During implementation of the Ontario Heart Health Program amalgamation, fiscal downloading and restructuring of public health nursing jobs may have compromised the financial and organizational stability of the public health system. Insights into leadership of public health coalitions and the issue of turnover found in this study may help guide coalitions in other health units and provinces. Future research should look at the roles and responsibilities of coordinators during Phase II of the Ontario Heart Health Program, and leadership of public health coalitions in other provinces. Findings described in this study have important similarities to findings by Riley et al. (2004) and Dunkley et al. (2001) and add important knowledge to illuminate the field of public health coalition leadership.

References

- Acorn, S., Ratner, P.A., & Crawford, M. (1997). Decentralization as a determinant of autonomy, job satisfaction, and organizational commitment among nurse managers. *Nursing Research* 46(1), 52-58.
- Aiken, L.H., Clarke, S.P., Sloane, D.M., Sochalski, J.A., Busse, R., Clarke, H., et al. (2001). Nurses' reports on hospital care in five countries. *Health Affairs* 20(3), 43-53.
- Alexander, M.P., Zakocs, R.C., Earp, J. A. L, & French, E. (2006). Community coalition project directors: What makes them effective leaders? *Journal of Public Health Management and Practice* 12(2), 201-209.
- Alter, C., & Hage, J. (1993). *Organizations working together*. Newbury Park, CA: Sage Publications.
- Anderson, D., Plotnikoff, R.C., Raine, K., Cook, K., Smith, C., & Barrett, L. (2004). Towards the development of scales to measure 'will' to promote heart health within organizations in Canada. *Health Promotion International* 19(4), 471-481.
- Armbruster, C., Gale, B., Brady, J., & Thompson, N. (1999). Perceived ownership in a community coalition. *Public Health Nursing* 16(1), 17-22.
- Armstrong-Stassen, M., & Cameron, S.J. (2005). Concerns, satisfaction and retention of Canadian community health nurses. *Journal of Community Health Nursing* 22(4), 181-194.
- Association of Public Health Epidemiologists. (n.d.). *Core indicators for public health in Ontario*. Retrieved June 5, 2006 from http://www.apheo.ca/indicators/pages/resources/geography_in_ontario.htm

- Best, M.F., & Thurston, N.E. (2006). Canadian public health nurses' job satisfaction. *Public Health Nursing* 23(3), 250-255.
- Betkus, M.H., & MacLeod, M.L.P. (2004). Retaining public health nurses in rural British Columbia. *Canadian Journal of Public Health* 95(1), 54-58.
- Bolton, L.B., Georges, C.A., Hunter, V., Long, O., & Wray, R. (1998). Community health collaboration models for the 21st century. *Nursing Administration Quarterly* 22(3), 6-17.
- Bracht, N., Finnegan Jr., J.R., Rissel, C., Weisbrod, R., Gleason, J, Corbett, J. et al. (1994). Community ownership and program continuation following a health demonstration project. *Health Education Research* 9(2), 243-255.
- Butterfoss, F.D., Goodman, R.M., & Wandersman, A. (1993). Community coalitions for prevention and health promotion. *Health Education Research* 8(3), 315-330.
- Butterfoss, F.D., Goodman, R.M., & Wandersman, A. (1996). Community coalitions for prevention and health promotion: Factors predicting satisfaction, participation and planning. *Health Education Quarterly* 23(1), 65-79.
- Butterfoss, F.D., Morrow, A.L., Webster, J.D., & Crews, R.C. (2003). The coalition training institute: Training for the long haul. *Journal of Public Health Management and Practice* 9(6), 522 -529.
- Campbell, S.L., Fowles, E.R., Weber, B.J. (2004). Organizational structure and job satisfaction in public health nursing. *Public Health Nursing* 21(6), 564-571.
- Canadian Nurses Association website. (n.d.). *Canadian Nurses Association Certification Brochure*. Retrieved on May 12, 2006 from http://www.cna-nurses.ca/CNA/documents/pdf/publications/Certification_brochure_2007_e.pdf

- Chambers, L.W., Underwood, J., Halbert, T., Woodward, C.A., Heale, J.A., & Isaacs, S. (1994). 1992 Ontario survey of public health nurses: Perceptions of roles and activities. *Canadian Journal of Public Health* 85(3), 175-179.
- Cheadle, A., Sterling, T.D., Schmid, T.L., & Fawcett, S.B. (2000). Promising community-level indicators for evaluating cardiovascular health-promotion programs. *Health Education Research* 15(1), 109-116.
- Chrislip, D.D., & Larson, C.E. (1994). *Collaborative leadership: How citizens and civic leaders can make a difference*. San Francisco, CA: Jossey-Bass.
- Community Health Nurses Association of Canada. (2003). *Canadian Community Health Nursing Standards of Practice*. Retrieved on May 22, 2006 from <http://www.chnac.ca/Standards/Standards%20Practice%20jun04.pdf>
- Cowin, L. (2002). The effects of nurses' job satisfaction on retention: An Australian perspective. *Journal of Nursing Administration* 32(5), 283-291.
- Cramer, M.E., Atwood, J.R., & Stoner, J.A. (2006). Measuring community coalition effectiveness using the ICE© instrument. *Public Health Nursing* 23(1), 74-87.
- Crowley, K.M., Yu, P., Kaftarian, S.J. (2000). Prevention actions and activities make a difference: A structural equation model of coalition building. *Evaluation and Program Planning* 23(3), 381-388.
- Cumbey, D.A., & Alexander, J.W. (1998). The relationship of job satisfaction with organizational variables in public health nursing. *Journal of Nursing Administration* 28(5), 39-46.
- Diekemper, M., SmithBattle, L., & Drake, M.A. (1999). Sharpening the focus on populations: An intentional community health nursing approach. Part II. *Public Health Nursing* 16(1), 11-16.

- Dunkley, G., Michelin, L.R., & Stewart, M. (2001). *Towards benchmarking heart health coalitions: Developing a systematic process for documenting and enriching community/health unit partnerships*. Retrieved on June 20, 2006 from <https://www.benchmarking-publichealth.on.ca/cfdocs/Documents/HHCoalitionFinalreport.pdf>
- Falk-Rafael, A., Fox, J., & Bewick, D. (2005). Report of a 1999 survey of public health nurses: Is public health restructuring in Ontario, Canada moving toward primary health care? *Primary Health Care Research and Development* 6, 172-183.
- Fawcett, S.B., Lewis, R.K., Paine-Andrews, A., Francisco, V.T., Richter, K.P., Williams, E.L., et al. (1997). Evaluating community coalitions for prevention of substance abuse: The case of Project Freedom. *Health Education and Behavior* 24(6), 812-828.
- Federal/Provincial/Territorial Public Health Human Resources Joint Task Group (2004). *The development of a draft set of public health workforce core competencies*. Retrieved June 24, 2006 from http://www.phs.utoronto.ca/SPH_Doc_and_Ref/Core_Public_Health_Competencies_Report_english.pdf
- Florin, P. Mitchell, R., & Stevenson, J. (1993). Identifying training and technical assistance needs in community coalitions: A developmental approach. *Health Education Research* 8(3), 417-432.
- Folayemi, B. (2001). Case story #1: Building the grassroots coalition. *American Journal of Community Psychology* 29(2), 193-197.

- Foster-Fishman, P.G., Berkowitz, S.L., Lounsbury, D.W., Jacobson, S., & Allen, N.A. (2001). Building collaborative capacity in community coalitions: A review and integrative framework. *American Journal of Community Psychology* 29(2), 241-261.
- Fottler, M.D., Crawford, M.A., Quintana, J.B., & White, J.B. (1995). Evaluating nurse turnover: Comparing attitude surveys and exit interviews. *Hospital and Health Services Administration* 40(2), 278-295.
- Francisco, V.T., Paine, A.L., & Fawcett, S.B. (1993). A methodology for monitoring and evaluating community health coalitions. *Health Education Research* 8(3), 403-416.
- Gardner, D.L. (1992). Career commitment in nursing. *Journal of Professional Nursing* 8(3), 155-160.
- Gebbie, K.M., & Hwang, I. (2000). Preparing currently employed public health nurses for changes in the health system. *American Journal of Public Health* 90(5), 716-721.
- Goodman, R.M., Speers, M.A., McLeroy, K., Fawcett, S., Kegler, M., Parker, E., et al. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior* 25(3), 258-278.
- Gottlieb, N.H., Brink, S.G., & Gingiss, P.L. (1993). Correlates of coalition effectiveness: The Smoke Free Class of 2000 Program. *Health Education Research* 8(3), 375-384.
- Granner, M.L., & Sharpe, P.A. (2004). Evaluating community coalition characteristics and functioning: A summary of measurement tools. *Health Education Research* 19(5), 514-532.

- Haugh, E.B., & Laschinger, H.S. (1996). Power and opportunity in public health nursing work environments. *Public Health Nursing 13*(1), 42-49.
- Hayes, L.J., O'Brien-Pallas, L., Duffield, C., Shamien, J., Buchan, J., & Hughes, F., et al. (2006). Nurse turnover: A literature review. *International Journal of Nursing Studies 43*(2), 237-263.
- Health Canada. (2001). *Canadian Heart Health Initiative: Process evaluation of the demonstration phase*. Ottawa, ON: Author.
- Heart Health Resource Centre. (n.d.). *About us*. Retrieved July 1, 2006 from <http://hhrc.net/about/index.cfm>
- Hung, R. (2002). A note on nurse self-scheduling. *Nursing Economics 20*(1), 37-39.
- Irvine, D.M., & Evans, M.G. (1995). Job satisfaction and turnover among nurses: Integrating research findings across studies. *Nursing Research 44*(4), 246-253.
- Jamal, M., & Baba, V. V. (2000). Job stress and burnout among Canadian managers and nurses: An empirical examination. *Canadian Journal of Public Health 91*(6), 454-458.
- Jansen, P. G. M., Kerkstra, A., Abu-Saad, H. H., & van der Zee, J. (1996). The effects of job characteristics and individual characteristics on job satisfaction and burnout in community nursing. *International Journal of Nursing Studies 33*(4), 407-421.
- Janssen, P.P.M., de Jonge, J., & Bakker, A.B. (1999). Specific determinants of intrinsic work motivation, burnout and turnover intentions : A study among nurses. *Journal of Advanced Nursing 29*(6), 1360-1369.

- Jasuja, G.K., Chou, C-P., Bernstein, K., Wang, E., McClure, M., & Pentz, M.A. (2005). Using structural characteristics of community-based coalitions to predict progress in adopting evidence-based prevention programs. *Evaluation and Program Planning* 28(2), 173-184.
- Joffres, C., Langille, D., Rigby, J., & Langille, D.B. (2002). Factors related to community mobilization and continued involvement in a community-based effort to enhance adolescents' sexual behaviour. *The Qualitative Report* 7(2). Retrieved January 29, 2003, from <http://www.nova.edu/ssss/QR/QR7-2/joffres.html>
- Jones, C.B. (2005). The costs of nurse turnover, Part 2: Application of the nursing turnover cost calculation methodology. *JONA* 35(1), 41-49.
- Kane, D. (1999). Job sharing: A retention strategy for nurses. *Canadian Journal of Nursing Leadership* 12(4), 16-22.
- Kang, R. (1995). Building community capacity for health promotion: A challenge for public health nurses. *Public Health Nursing* 12(5), 312-318.
- Kegler, M.C., Steckler, A., McLeroy, K., & Malek, S.H. (1998). Factors that contribute to effective community health promotion coalitions: A study of 10 Project ASSIST coalitions in North Carolina. *Health Education and Behavior* 25(3), 338-353.
- Kerr, M.S., Spence Laschinger, H. K., Severin, C.N., Almost, J.M., & Shamian, J. (2005). New strategies for monitoring the health of Canadian nurses: Results of collaborations with key stakeholders. *Nursing Research* 18(1), 67-81.
- Kluska, K.M., Spence Laschinger, H.K., & Kerr, M.S. (2004). Staff nurse empowerment and effort-reward imbalance. *Nursing Leadership* 17(1), 112-128.

- Krausz, M., Koslowsky, M., Shalom, N., & Elyakim, N. (1995). Predictors of intentions to leave the ward, the hospital and the nursing profession. *Journal of Organizational Behaviour* 16, 277-278.
- Kreuter, M.W., Lezin, N.A., & Young, L.A. (2000). Evaluating community-based collaborative mechanisms: Implications for practitioners. *Health Promotion Practice* 1(1), 49-63.
- Kuhn, M., Doucet, C., & Edwards, N. (1999). *Effectiveness of coalitions in heart health promotion, tobacco use reduction and injury prevention: A systematic review of the literature 1990-1998*. Ottawa, ON: Effective Public Health Practice Project for the Public Health Branch, Ontario Ministry of Health.
- Kumpfer, K.L., Turner, C., Hopkins, R., & Librett, J. (1993). Leadership and team effectiveness in community coalitions for the prevention of alcohol and other drug abuse. *Health Education Research* 8(3), 359-374.
- Lacey, L.M. (2003). Called into question: What nurses want. *Nursing Management* 34(2), 25-26.
- de Laine, M. (1997). *Ethnography: Theory and applications in health research*. Sydney, Australia: MacLennan & Petty Pty Limited.
- Larrabee, J.H., Janney, M.A., Ostrow, C.L., Withrow, M.L., Gerald, R., & Burant, C. (2003). Predicting registered nurse job satisfaction and intent to leave. *Journal of Nursing Administration* 33(5), 271-283.
- Leininger, M.M. (Ed.). (1985). *Qualitative research methods in nursing*. Orlando, FL: Grune & Stratton.

- Leipert, B. D. (1996). The value of community health nursing: A phenomenological study of the perceptions of community health nurses. *Public Health Nursing* 13(1), 50-57.
- Leiter, M.P., & Spence Laschinger, H.K. (2006). Relationships of work and practice environment to professional burnout: Testing a causal model. *Nursing Research* 55(2), 137-146.
- Lum, L., Kervin, J., Clark, K., Reid, F., & Sirola, W. (1998). Explaining nursing turnover intent: Job satisfaction, pay satisfaction or organizational commitment? *Journal of Organizational Behaviour* 19(3), 305-320.
- MacDonald, M.B., & Schoenfeld, B.M. (2003). Expanding roles for public health nursing: Numerous guidelines have been published in recent years as frameworks for public health, but are the concepts being translated into practice? Are front-line nurses supported as their roles expand? *The Canadian Nurse* 99(7), 18-22.
- Mayer, J.P., Soweid, R., Dabney, S., Brownson, C., Goodman, R., & Brownson, R.C. (1998). Practices of successful community coalitions: A multiple case study. *American Journal of Health Behaviour* 22(5), 368-377.
- Mitchell, S.M., & Shortell, S.M. (2000). The governance and management of effective community health partnerships: A typology for research, policy and practice. *The Milbank Quarterly* 78(2), 241-289.
- Mitzrahi, T., & Rosenthal, B.B. (2001). Complexities of coalition building: Leaders' successes, strategies, struggles and solutions. *Social Work* 46(1), 63-78.

- Mor Barak, M. E., Nissly, J. A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and meta-analysis. *Social Service Review* 75(4), 625-661.
- Mulroy, E.A. (1997). Building a neighbourhood network: Interorganizational collaboration to prevent child abuse and neglect. *Social Work* 42(3), 255-264.
- Munhall, P.L., & Oiler, C.J. (1986). *Nursing research: A qualitative perspective*. Norwalk, CT: Appleton-Century Crofts.
- O'Brien-Pallas, L., Duffield, C., & Hayes, L., (2006). Do we really understand how to retain nurses? *Journal of Nursing Management* 14(4), 262-270.
- Ontario Heart Health Network, (2002). *Continuation plan for 2003 and beyond*. Retrieved on June 20, 2006 from http://www.opc.on.ca/english/our_programs/hlth_promo/project_ini/strk_prevent/2003_and_beyond.pdf
- Ontario Ministry of Health. (1997). *Mandatory Health Programs and Service Guidelines for Local Boards of Health*. Toronto, ON: Queen's Printer.
- Ontario Ministry of Health and Long Term Care (2006). *Revitalizing Ontario's public health capacity: The final report of the capacity review committee*. Retrieved on June 24, 2006 from http://www.health.gov.on.ca/english/public/pub/ministry_reports/capacity_review06/capacity_review06.pdf
- Ontario Provincial Clearinghouse. (2002). *Capacity building for health promotion: More than bricks and mortar*. Retrieved April 23, 2006, from http://www.opc.on.ca/english/our_programs/hlth_promo/resources/capacity_building.pdf
- Polit, D.F., & Hungler, B.P. (1999). *Nursing research: Principles and methods* (6th ed.). Philadelphia: Lippincott.

Registered Nurses Association of Ontario and Registered Practical Nurses Association of Ontario (2000). *Ensuring the care will be there: Report on nursing recruitment and retention in Ontario*. Toronto, ON: Author.

Registered Nurses Association of Ontario website. (2003.). *Preceptorship and mentorship practice page 2(3)*. Retrieved on April 21, 2006 from http://www.rnao.org/Storage/15/983_Practice_Page_Mentorship.pdf

Reutter, L. & Duncan, S. (2002). Preparing nurses to promote health-enhancing public policies. *Policy, Politics and Nursing Practice* 3(4), 294-305.

Riley, B., d'Avernas, J., & Edwards, N. (2002). *Ontario Heart Health Program: Preliminary evaluation report*. Unpublished report to the Ministry of Health and Long Term Care, Public Health Branch, Health Promotion and Wellness.

Riley, B., Edwards, N., & d'Avernas, J. (2004). *Ontario Heart Health Program – Final evaluation report: Informing future directions for healthy living and chronic disease prevention in Ontario*. Unpublished report to the Ministry of Health and Long Term Care, Public Health Branch, Health Promotion and Wellness.

Rogers, T., Howard-Pitney, B., Feighery, E. C., Altman, D. G., Endres, J. M., & Roeseler, A. G. (1993). Characteristics and participant perceptions of tobacco control coalitions in California. *Health Education Research* 8(3), 345-357.

Roper, J.M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, CA: Sage Publications.

Roussos, S.T., & Fawcett, S.B. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health* 21(1), 369-402.

- Shields, M.A., & Ward, M. (2001). Improving nurse retention in the National Health Service in England: The impact of job satisfaction on intentions to quit. *Journal of Health Economics* 20, 677-701.
- Snell-Johns, J., Imm, P., Wandersman, A., & Claypoole, J. (2003). Roles assumed by a community coalition when creating environmental and policy-level changes. *Journal of Community Psychology* 31(6), 661-670.
- Sousa-Poza, A., & Henneberger, F. (2004). Analyzing job mobility with job turnover intentions: An international comparative study. *Journal of Economic Issues* 38(1), 113-137.
- Spence Laschinger, H.K., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding on Kanter's model. *Journal of Nursing Administration* 31(5), 260-272.
- Spence Laschinger, H.K., & Finegan, J. (2005). Using empowerment to build trust and respect in the workplace: A strategy for addressing the nursing shortage. *Nursing Economics* 23(1), 6-13.
- Spradley, J.P. & McCurdy, D.W. (1980). *Anthropology: The cultural perspective* (2nd ed.). New York: John Wiley & Sons.
- Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion* 10(4), 282-298.
- Stokols, D., Grzywacz, J.G., McMahan, S., & Phillips, K. (2003). Increasing the health promotive capacity of human environments. *American Journal of Health Promotion* 18(1), 4-13.

- Strachota, E., Normandin, P., O'Brien, N., Clary, M., & Krukow, B. (2003). Reasons registered nurses leave or change employment status. *Journal of Nursing Administration* 33(2), 111-117.
- Streubert Speziale, H.J., & Carpenter, D.R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative* (3rd ed.) Philadelphia: Lippincott Williams & Wilkins.
- Tang, J. H-C. (2003). Evidence-based protocol: Nurse retention. *Journal of Gerontological Nursing* 29(3), 5-14.
- Tzeng, H.M. (2002). The influence of nurses' working motivation and job satisfaction on intention to quit: An empirical investigation in Taiwan. *International Journal of Nursing Studies* 39(8), 867-878.
- Ulrich, B.T., Buerhaus, P.I., Donelan, K., Norman, L., & Dittus, R. (2005). How RNs view the work environment: Results of a National Survey of Registered Nurses. *Journal of Nursing Administration* 35(9), 389-396.
- Underwood, J. (2003). *The value of nurses in the community*. Ottawa: Retrieved May 20, 2006 from Canadian Nurses Association website: http://www.cna-nurses.ca/CNA/documents/pdf/publications/Nursing_Community_August_2003_e.pdf
- Upenieks, V.V. (2003). The interrelationship of organizational characteristics of magnet hospitals, nursing leadership and nursing job satisfaction. *The Health Care Manager* 22(2), 83-98.
- Veazie, M. A., Teufel-Shone, N., Silverman, G. S., Connolly, A.M. et al. (2001). Building community capacity in public health: The role of action-oriented partnerships. *Journal of Public Health Management and Practice* 7(2), 21-32.

- Weiner, B.J., Alexander, J.A., & Shortell, S.M. (2002). Management and governance processes in community health coalitions: A procedural justice perspective. *Health Education and Behavior* 29(6), 737-754.
- Weiss, E.S., Anderson, R.M., & Lasker, R.D. (2002). Making the most of collaboration: Exploring the relationship between partnership synergy and partnership functioning. *Health Education and Behaviour* 29(6), 683-698.
- World Health Organization (WHO). (1992). Bridging the gap: Science and policy in action. *The Victoria Declaration on Heart Health*. Retrieved May 10, 2006 from http://www.med.mun.ca/chhdbc/pdf/victr_e.pdf
- World Health Organization (WHO). (1995). Investing in heart health. *The Catalonia Declaration*. Retrieved on May 10, 2006 from <http://internationalhearthealth.org/Publications/catalonia1995.pdf>
- World Health Organization (WHO). (1998). Forging the will for heart health in the next millennium. *The Singapore Declaration*. Retrieved on May 10, 2006 from http://www.internationalhearthealth.org/Publications/Singapore_eng.pdf
- World Health Organization (WHO). (2000). Women, heart diseases and stroke, science and policy in action. *The 2000 Victoria Declaration: Women, Heart Diseases and Stroke*. Retrieved May 10, 2006 from http://www.cwhn.ca/resources/victoria_declaration/
- World Health Organization (WHO). (2001). Health, economics and political action:stemming the global tide of cardiovascular disease. *The Osaka Declaration*. Retrieved May 10, 2006 from http://www.phac-aspc.gc.ca/ccdpc-cpcmc/cindi/pdf/osaka_e.pdf

- World Health Organization (WHO). (2004). Positioning technology to serve global heart health. *The Milan Declaration*. Retrieved May 10, 2006 from http://who.int/cardiovascular_diseases/media/en/cvd_milan_declaration.pdf
- Yin, J.T., & Yang, K.A. (2002). Nursing turnover in Taiwan: A meta-analysis of related factors. *International Journal of Nursing Studies* 39(6), 573-581.
- Zahner, S.J., & Gredig, Q-N. B. (2005a). Public health nursing practice change and recommendations for improvement. *Public Health Nursing* 22(5), 422-428.
- Zahner, S.J., & Gredig, Q-N. B. (2005b). Improving public health nursing education: Recommendations of local public health nurses. *Public Health Nursing* 22(5), 445-450.
- Zukoski, A.P., & Shortell, S.M. (2001). Keys to building effective community partnerships. *Health Forum Journal* 44(5), 22-25.

Appendix A
Categorization of Health Units
(According to Non-Northern Rural, Non-Northern Urban and Northern Designation)

Northern	Non-Northern Rural	Non-Northern Urban
Algoma Muskoka-Parry Sound North Bay and District Northwestern Sudbury and District Thunder Bay District Timiskaming	Haliburton, Kawartha Pine Ridge District Niagara Regional Area Simcoe County District Wellington-Dufferin-Guelph Haldimand-Norfolk Regional Lambton Eastern Ontario Chatham-Kent Bruce-Grey-Owen Sound Elgin-St. Thomas Oxford County Renfrew County and District Huron County Windsor-Essex County Waterloo Regional Hastings and Prince Edward Counties Leeds, Grenville and Lanark District Brant County	Durham Regional Halton Regional Hamilton-Wentworth Regional Toronto Public Health (5 coalitions) Middlesex-London Peterborough County York Regional Kingston, Frontenac and Lennox & Addington Ottawa-Carleton Regional Peel Regional

From: Ontario Heart Health Program Evaluation: Organizational and Programming
Indicators – Qualitative Study (2000)

Appendix B

Email Requesting Permission to Contact Heart Health Coordinator

School of Nursing,
University of Ottawa
451 Smyth Road,
Ottawa, ON K1H 8M5

Date:

Name:
Health Unit
Address

Dear: Heart Health Coordinator/Chronic Disease Manager

Re: **Exploring the Role and Turnover of Heart Health Coordinators in
Ontario Heart Health Coalitions: A Qualitative Study**

The Ontario Heart Health Project: Preliminary Evaluation (2000) found that significant turnover of Heart Health Coordinators was causing problems with heart health coalition function. Heart Health Coordinators are not remaining long enough for coalitions to successfully plan and implement heart health promotion strategies. This qualitative research study employs focused ethnography to explore the role of the Heart Health Coordinator, reasons for and the impact of Heart Health Coordinator turnover in the Ontario Heart Health Project and strategies to overcome it. While the Ontario Heart Health Project Evaluation informs this research study, it is not a part of it. Findings are expected to provide information that will reduce the problem of turnover and/or reduce its negative impact.

I would like to include your perspective on this important issue. I will be interviewing Heart Health Coordinators (past and present), the Chronic Disease Manager and two heart health coalition members from eight different heart health coalitions at a time that is convenient to them. All interviews will take place in English.

I am inviting you to participate in a thirty minute taped semi-structured interview conducted over the telephone at a time convenient to you. I will be asking some background information such as length of time in the heart health coalition and experience working with coalitions. I will also be requesting you to draw a picture of the communication and working relationship of the Heart Health Coordinator, the health unit, the heart health coalition and the Ministry of Long Term Care.

I will be telephoning participants so that the Health Unit incurs no cost. Each interview will last approximately 30 minutes. All interviews will be taped and notes will be taken at the same time.

Confidentiality will be ensured. All data will have information removed that could identify individuals, health units or coalitions. Individual code numbers will be assigned to data,

and condensed into aggregate form. No identifying information will be used in the thesis or in research articles. All tapes and transcripts will be stored in a locked location at the University of Ottawa.

I would like permission to call you and tell you more about this important research. If you are interested, please email me at nmacvicar1@cogeco.ca and provide me with a phone number and a time to contact you.

Please call me or my thesis supervisor if you have any concerns or questions about this research.

Thank you for your time.

Sincerely,

Nancy MacVicar

Nancy MacVicar, B.N., B.Ed., MScN student at University of Ottawa
Email: nmacvicar1@cogeco.ca
Phone: (613) 394-6930

Thesis Supervisor
Dr. Nancy Edwards, Ph. D.
Email: nedwards@uottawa.ca
Phone: (613) 562-5800 ext. 8395

Appendix C

Recruiting Speech Requesting Participation in the Study

Date and Time of Recruiting Interview _____

Code Number assigned to Health Unit _____

Introduction: My name is Nancy MacVicar. I am a Masters of Science in Nursing Student at the University of Ottawa. I would like to talk to you about my research. It will take about fifteen minutes of your time (including screening). Is this a good time to speak with you?

Yes - proceed.

No - then ask if it is possible to call them at another time at their convenience.

Purpose of Phone Call: I am calling you because I am exploring the role of Heart Health Coordinators and the issue of Heart Health Coordinator turnover. I'm doing this research study as part of my master's degree at the University of Ottawa. I'm interested in comparing the experience of heart health coalitions that have consistent Heart Health Coordinators and those that have experienced turnover. Heart Health Coordinators have indicated that turnover is an important issue that may affect the coalition. (Ontario Heart Health Project: Preliminary Evaluation 2002)

Request for Participation: I would like to include the perspective of your health unit and Heart Health Coalition in my research by interviewing all Heart Health Coordinators (past and present), the Chronic Disease Manager and two Heart Health Coalition members. The questions will be about:

- Background information
- the role of the Heart Health Coordinator
- reasons for Heart Health Coordinator turnover
- the consequences of Heart Health Coordinator turnover
- solutions to Heart Health Coordinator turnover

I will also ask you to draw a diagram describing the communication patterns and working relationships of the Heart Health Coordinator, the health unit, and the Ministry of Health and Long Term Care. I will be asking you some questions about the diagram.

I will be telephoning participants so the Health Unit incurs no cost. Each interview will be in English, last approximately 30 minutes and can be conducted during the week, evenings or weekends. All interviews will be taped and notes will be taken at the same time. No one will know who participates and who does not. No one will know what others have said. You would have the right to withdraw from the study at any time. No sanctions will occur for not participating.

Confidentiality: Confidentiality will be ensured. All data will have identifying information removed, be assigned a code number, and be condensed into aggregate form. No identifying

information will be used in the thesis or in research articles. All tapes and transcripts will be stored in a locked location at the University of Ottawa.

This is important research because findings are expected to provide information that will reduce the problem of turnover and/or reduce its negative impact. I am wondering if you would be interested in receiving some more information on this research and possibly participating.

Yes _____ No _____

No – conclude discussion and thank person for speaking to researcher

Yes - continue phone discussion.

Before proceeding further, I need to verify if your health unit is eligible for the research study. The eligibility criteria is based on the whether your health unit has experienced Heart Health Coordinator turnover and if so, how many times. (Use Appendix 4 to do the screening.)

Heart Health Coalition Eligibility: Yes _____ No _____

If the Health Unit is Not Eligible:

Would you like an executive summary of the research findings?

Yes _____ No _____

If yes, do you have an e-mail address where I can send the executive summary of the research findings?

E-mail address: _____

Is there anyone else at the Health Unit that should be notified by telephone or in writing that the Health Unit is not eligible to participate in this research study?

Obtain contact information: _____

Thank you for your time. I will send you an executive copy of the findings.

Recruiting Speech to Heart Health Coordinator and Chronic Disease Managers (cont'd)

Eligible: Your Health Unit is eligible to participate in this research study

Eligible/Heart Health Coordinator (Chronic Disease Manager if no Heart Health Coordinator)

Recruitment of Active Coalition Members:

As part of this study, I am interviewing two active Heart Health Coalition members. Active is defined as attending meetings and participating in heart health activities. Would you be willing to contact two members of your Heart Health Coalition and obtain verbal permission for me to contact them and invite them to be interviewed?

For Heart Health Coalitions Experiencing Heart Health Coordinator turnover:

As part of this study, I am interviewing Heart Health Coordinators who left the job after less than one year for reasons other than maternity leave, medical reasons, relocation or retirement. Would you be willing to contact all former Heart Health Coordinators that fit this description and obtain verbal permission for me to contact them?

In order to get this information, I can call you back or send you a form that you can fax back to me. Which would you prefer?

Call back _____ Fax _____

Information Package:

Now that I have told you a bit about the study, I am wondering if you have any questions?

Are you interested in receiving an information package giving you some more information about the study? It will include: 1) a letter inviting you to participate, 2) a short summary of the study, 3) a request to draw a diagram of the Heart Health Coordinator relationships with the health unit, the Heart Health Coalition and the Ministry of Health and Long Term Care, 4) Consent forms and 5) an interview guide that includes the questions you would be asked. Receipt of this package does not mean that you are committed to participate in the research study. It provides you with enough information to make an informed choice about participating.

Yes _____ No _____

No: Conclude interview, but remind candidate to contact the coalition members and (if required all previous Heart Health Coordinators).

Yes: I will be sending you an information package that includes a participant information letter, consent forms, a list of interview questions including the ones on background information and the request for the diagram.

I will be calling you a week after I send you the information package for the research study. When would be a good time to check back? _____

Thank you for your assistance with my research. Good-bye.

Appendix D
Health Unit Screening Tool

<u>Code Number for Health Unit</u>		<u>Chronic Disease Manager</u>	
<u>Present Heart Health Coordinator</u>		Name: _____	
Name: _____		Phone: _____	
Phone: _____		Email: _____	
Email: _____			
Length of time in Heart Health Coordinator Position: _____			
Heart Health Coalition		Eligible for research study:	
Name: _____		Yes ☐ No ☐	
Non-Northern Rural ☐		If yes, category _____	
Non-Northern Urban ☐		If no, reason: _____	
Northern ☐			
Date established: _____			
Pre-existed OHHP (1998) Yes ☐ No ☐			
Number of Heart Health Coordinators since OHHP began: _____			
Heart Health Coordinator turnover:			
Yes ☐ No ☐			
TO BE COMPLETED AFTER VERBAL PERMISSION TO CONTACT RECEIVED			
Previous Heart Health Coordinators			
Name		Contact Information	
Active Heart Health Coalition Members			
Name		Contact Information	

Appendix E

Sample Request for Background Information

Health Unit Code Number	Health Unit Non-Northern Rural _____ Non-Northern Urban _____ Northern _____	HHC Turnover Yes _____ No _____
Name of Coalition		
Length of Time Heart Health Coalition Has Existed		Coalition Predates OHHP Yes _____ No _____
Name of heart health coordinator _____ Presently in Position Yes _____ No _____ Contact Information: Phone # _____ Email: _____ Length of time as a heart health coordinator _____ Profession _____ Length of Time Working With the Health Department _____ Previous Experience Working With Coalitions _____ _____ _____		

Appendix F

Participant Information Letter

I am a Masters of Science in Nursing student at the University of Ottawa. My research study examines the role of the Heart Health Coordinator in the Ontario Heart Health Project and the issue of turnover. This is important research because turnover has been identified as having an effect on the function and success of Heart Health Coalitions (Ontario Heart Health Program: Preliminary Evaluation Report, 2002).

I am inviting you to participate in a thirty minute taped semi-structured interview conducted over the telephone at a time convenient to you. I will also be asking some background information such as length of time in the Heart Health Coalition, time working with the health unit and experience working with coalitions. I am planning to interview:

- 4 Heart Health Coordinators who have remained in the position for at least one year
- 4 (or more) Heart Health Coordinators who left the job after less than one year for reasons other than maternity leave, medical leave, relocation or retirement
- 8 Chronic Disease Managers
- 16 Heart Health Coalition members

All participants will be telephoned and therefore will not incur any long distance costs. This study will be conducted only in English.

The interview will be tape-recorded and a transcript will be made. You may request to have the transcript returned to you prior to analysis to ensure the information is accurate. Notes will also be taken during the interview. I will remove individual identifying information including personal, health unit and coalition information from the transcripts. I will be using quotes in my thesis and research articles, but they will not contain names or identifiable information. All information will be kept confidential. You may request that your comments not be used in analyses. All data will be kept in locked area of the University of Ottawa. The thesis student, the thesis supervisor and the thesis committee will have access to the data.

You will also be asked to draw a diagram of how the Heart Health Coordinator, the heart health coalition, the health unit and the Ministry of Long Term Care communicate and work together. Semi-structured questions will be asked about this diagram at the same time as the other part of the interview.

Your participation is voluntary. If you choose to participate, you can withdraw at any stage of the interview. You may refuse to answer any questions. You are encouraged to say only what you feel comfortable saying. You may request that the tape-recorder be turned off at any point in the interview or portions of the tape or the entire tape be erased. If you choose

to withdraw from the study after the interview is completed, you may have the tape returned to you or have it destroyed. All transcripts will be returned to you or destroyed.

I will be contacting you to see if you are interested in participating in the study, to answer any questions and to arrange a time for an interview if required. No one in the Public Health Unit or heart health coalition will be aware of who participated or who did not. No one in the Public Health Unit will be aware of what you say. There will be no sanctions for refusing to participate or withdrawing from the research study.

This consent form must be signed and returned to the researcher by mail in the stamped, addressed envelope or faxed to (613) 394-6930 prior to the interview.

Thank you for considering this request. Your input will provide a better understanding of the role of the Heart Health Coordinator and the issue of turnover. If you have any concerns or questions about this research study, please contact the researcher or the thesis supervisor.

Sincerely,

Nancy MacVicar

Nancy MacVicar B.N., B. Ed., MScN thesis student
Phone: (613) 394-6930
Email: nmacvicar1@cogeco.ca

Thesis Supervisor:

Dr. Nancy Edwards, Ph.D., School of Nursing
Department of Epidemiology and Community Medicine
University of Ottawa

Phone: (613) 562-5800 ext. 8395
Email: nedwards@uottawa.ca

Appendix G

Research Summary

Exploring the Role and Turnover of Heart Health Coordinators in Ontario Heart Health Coalitions: A Qualitative Study

Cardiovascular disease is the foremost cause of death each year in Canada (Heart and Stroke Foundation of Canada, 2000, p. 68). The Ontario Heart Health Project has completed the first phase of a 15 year government initiative to reduce cardiovascular disease in Ontario. A main thrust of the Ontario Heart Health Program is the development of local heart health coalitions led by a heart health coordinator from the health unit. Coalitions are alliances among diverse community organizations that agree to work on solving a problem. The literature has identified effective leadership as key to the success of coalitions. The Ontario Heart Health Program Preliminary Evaluation (2002) found that Heart Health Coordinator turnover was causing problems with how coalitions function. In some health units, Heart Health Coordinators were not remaining long enough for coalitions to successfully plan and implement heart health promotion strategies. No research has been found that has examined this issue. This qualitative study employs a focused ethnographic approach to explore the role of the Heart Health Coordinator, reasons for and impact of Heart Health Coordinator turnover in the Ontario Heart Health Program and strategies to overcome turnover. It explores Heart Health Coordinator turnover in urban, rural and northern settings and in coalitions with and without Heart Health Coordinator turnover. Three sources of data will be used: (1) semi-structured interviews with key informants (Heart Health Coordinators in the position, Heart Health Coordinators who have left the position after less than one year, Health Unit Chronic Disease Managers, heart health coalition members), (2) secondary data analysis of qualitative data from two previous studies by the Community Health Research Unit (2000 and 2003) and (3) a review of relevant documents from the Ministry of Health and Long Term Care. Data will be analyzed using qualitative analysis software.¹

Heart and Stroke Foundation of Canada (1999). *The Changing Face of Heart Disease and Stroke in Canada 2000*. Ottawa: Author

¹ The purpose of this summary was for the recruitment of participants. A decision was made later in the research process not to utilize qualitative software

Appendix H

Heart Health Coordinator Consent Form (In a Health Unit without Heart Health Coordinator Turnover)

Title of study: Exploring the Role and Turnover of Heart Health Coordinators
in Ontario Heart Health Coalitions: A Qualitative Study

Researcher: Nancy MacVicar
Tel: (613) 394-6930
Email: nmacvicar1@cogeco.ca

Supervisor: Dr. Nancy Edwards, Professor,
School of Nursing and Department of Epidemiology and Community
Medicine, University of Ottawa
CHSRF/CIHR Nursing Chair,
Director, Community Health Research Unit,
451 Smyth Road,
Ottawa, ON K1H 8M5
Tel: (613) 562-5800 ext. 8395
Email: nedwards@uottawa.ca

In signing this document, I give my consent to participate in a qualitative research project conducted by Nancy MacVicar, MScN student, School of Nursing at the University of Ottawa. The project is being conducted under the supervision of Dr. Nancy Edwards. The purpose of the research is to explore the role of Heart Health Coordinators in the Ontario Heart Health Project and the reasons for turnover among coordinators. I understand that while the Ontario Heart Health Project Evaluation informs this research study, it is not a part of it.

This consent form is to be signed and returned to the researcher by mail in the stamped, addressed envelope or faxed to (613) 394-6930 prior to the interview.

I am aware that this study will be conducted only in English.

I understand that I will be asked to give my opinion on the role of the Heart Health Coordinator, factors that contribute to Heart Health Coordinator turnover, the effect of turnover on Heart Health Coalition functioning. I will also be asked background information such as the length of time working as a Heart Health Coordinator, my profession, and length of time I have worked with the Health Unit and my previous experience working with coalitions. The method of participation will be through an approximately thirty minute taped semi-structured interview conducted by telephone at a time convenient to me. I will also be asked to spend ten minutes drawing a diagram of how the Heart Health Coordinator, the Heart Health Coalition, the health unit and the Ministry of Long Term Care communicate and work together. This diagram will be mailed or faxed to the researcher prior to the

interview. Semi-structured questions will be asked about this diagram at the same time as the other part of the interview.

I understand that there is a low level of social and economic risk and psychological discomfort from discussing negative work related experiences. I realize that this research may remind me of challenging or frustrating aspects of the job. I also realize that my supervisor and Heart Health Coalition members may also participate in this study and I may be concerned about the effect of their comments on my job performance appraisal. I also may be concerned that the reputation and working relationship in the Heart Health Coalition may be compromised by negative information from participants. These risks will be minimized because my supervisor and the coalition members will not know whether or not I participate and will not be given any information about what I say. I have the right to refuse to participate at any time, to censor what I say, request to have the tape-recorder turned off, to review the interview transcript and remove any information at that time. No sanctions will occur should I choose at any time to withdraw from the study. I will be given all audiotapes and transcripts from my interview should I withdraw. I will also be given the number of Human Resources at my agency for confidential assistance if desired.

I have received assurance from the researchers that the information I will share will remain strictly confidential. I understand that the contents will be used only to explore the role and turnover among Heart Health Coordinators and that my confidentiality will be protected. Anonymity will be protected in the following manner. All identifying information will be removed from the data. I understand that I do not have to agree to be quoted and I cannot be asked why I do not wish to be quoted. I can request that all or part of the tape be erased during the interview. I will not be identified in any publications.

I understand that the audiotapes will be transcribed and that identifying information will be removed from the transcripts. I may request to have the transcript returned to me prior to data analysis to ensure the information is accurate. The transcripts will be kept in a locked cabinet at the University of Ottawa. A list of names and code numbers will be generated and kept in a separate locked cabinet at the University of Ottawa. Code numbers will identify all transcripts and only the thesis student, thesis supervisor and thesis committee will have access to the raw data. The audiotapes will be destroyed after one year and the transcripts will be destroyed after five years.

Heart Health Coalitions that have not had a consistent Heart Health Coordinator have had trouble developing and implementing heart health activities (Ontario Heart Health Program: Preliminary Evaluation Report, 2002). Findings from this study will enable researchers and participants in the Ontario Heart Health Project to better understand how to reduce turnover among Heart Health Coalition Coordinators.

I understand that I will receive an executive summary of this study

If I have any questions or concerns about the study, I may contact:

Nancy MacVicar, MScN student (613) 394-6930 Email: nmacvicar1@cogeco.ca
Dr. Nancy Edwards, (613) 562-5800 ext. 8395 Email: nedwards@uottawa.ca

If I have any questions about my rights as a research participant, they may be addressed to the Protocol Officer for Ethics in Research,
Tabaret Hall,
550 Cumberland Street,
Room 159,
Ottawa, ON,
K1N 6N5
(613) 562-5841
or ethics @uottawa.ca.

Please Initial Applicable Sections:

I agree to participate: Yes _____ No _____

I have kept a copy of this consent form: _____

I agree to have my interview taped: Yes _____ No _____

I agree to be quoted: Yes _____ No _____

Contact information to forward an executive summary of the report:
Email or Mail:

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

Appendix I

Interview Guide for Heart Health Coordinator in Coalition *without* Turnover
(estimated time for interview – 30 minutes)

Part I

Preamble: Thank you for agreeing to participate in this study exploring the role of the heart health coordinator and the issue of turnover. I am interested in getting your perspective on the issue. The first questions address the role of the heart health coordinator while the others deal with turnover. The final questions are about the relationship of the heart health coordinator to the health unit, the heart health coalition and the Ministry of Health and Long Term Care.

Questions	Probes
1. How would you describe the role of the heart health coordinator? What are the critical skills or assets that a heart health coordinator must possess in order to be successful?	What are the rewards of the job? What things do you find tough or difficult about the job? How would you envision the ideal heart health coordinator? Is the heart health coordinator role different or similar to positions you have held in the past?
2. If you had to give advice to a new heart health coordinator what would it be?	When you first took the position of heart health coordinator, did you feel prepared to assume the role? Why or why not? What could have helped you assume the role as a new heart health coordinator? What sources of support did you have when you took this position?
3. In terms of the coordinator role, what are the responsibilities of the heart health coordinator to the health unit? In terms of the coordinator role, what are the health unit responsibilities to the heart health coordinator?	What demands does the health unit make? What supports does the health unit offer?
4. What do you think contributes to heart health coordinator turnover province-wide?	What common problems are faced by heart health coordinators province-wide?
5. Why do you think that your particular coalition has not experienced heart health coordinator turnover?	What do you think facilitated your heart health coordinator remaining in place?
6. What changes would assist the heart health coordinator to perform his/her role more effectively? What is the most important thing that could be done to reduce heart health coordinator turnover?	What could the coalition do to reduce the problem of heart health coordinator turnover? What could the health unit do to reduce the problem of heart health coordinator turnover? What could the Ministry of Health and Long Term Care do to reduce the problem of heart health coordinator turnover?

Appendix J

Interview Guide for Heart Health Coordinator in Coalition *with* Turnover (estimated time for interview – 30 minutes)

Part 1

Preamble: Thank you for agreeing to participate in this study exploring the role of the heart health coordinator and the issue of turnover. I am interested in getting your perspective on the issue. The first questions address the role of the heart health coordinator while the others deal with turnover. The final questions are about the relationship of the heart health coordinator to the health unit, the heart health coalition and the Ministry of Health and Long Term Care.

Questions	Probes
1. How would you describe the role of the heart health coordinator? What are the critical skills or assets that a heart health coordinator must possess in order to be successful?	What are the rewards of the job? What things do you find tough or difficult about the job? How would you envision the ideal heart health coordinator? Is the heart health coordinator role different or similar to positions you have held in the past?
2. If you had to give advice to a new heart health coordinator, what would it be?	When you first took the position of heart health coordinator, did you feel prepared to assume the role? Why or why not? What could have helped you assume the role as a new heart health coordinator? What sources of support did you have when you took on this position?
3. In terms of the coordinator role, what are the responsibilities of the heart health coordinator to the health unit? In terms of the coordinator role, what are the health unit responsibilities to the heart health coordinator?	What demands does the health unit make? What supports does the health unit offer?
4. What do you think contributes to heart health coordinator turnover province-wide?	What common problems are faced by heart health coordinators province-wide?
5. Why do you think that your particular coalition has experienced heart health coordinator turnover?	What do you think are the root causes of heart health coordinator turnover in your heart health coalition?
6. How are heart health coordinator responsibilities handled when there is no heart health coordinator in place?	Who takes over the heart health coordinator role during the time that you lack a heart health coordinator? How does your coalition function when there is no heart health coordinator in place?

Interview Guide for Heart Health Coordinator in Coalition *with* Turnover
(Cont'd)

Questions	Probe
7. What has been the effect of heart health coordinator turnover on your coalition?	Has heart health coordinator turnover affected the composition of your coalition? Has turnover affected the function of your coalition? What do you think would happen to a coalition that consistently experienced heart health coordinator turnover?
8. What changes would assist the heart health coordinator to perform his/her role more effectively? What is the most important thing that could be done to reduce heart health coordinator turnover?	What could the coalition do to reduce the problem of heart health coordinator turnover? What could the health unit do to reduce the problem of heart health coordinator turnover? What could the Ministry of Health and Long Term Care do to reduce the problem of heart health coordinator turnover?

Appendix K

Interview Guide for Chronic Disease Manager in Coalition *without* Turnover
(estimated time for interview – 30 minutes)

Part 1

Preamble: Thank you for agreeing to participate in this study exploring the role of the heart health coordinator and the issue of turnover. I am interested in getting your perspective on the issue. The first questions address the role of the heart health coordinator while the others deal with turnover. The final questions are about the relationship of the heart health coordinator to the health unit, the heart health coalition and the Ministry of Health and Long Term Care.

Questions	Probe
1. How would you describe the role of the heart health coordinator? What are the critical skills or assets that a heart health coordinator must possess in order to be successful?	1. If you were choosing a new heart health coordinator what qualities you would want in that person?
2. How does the heart health coordinator role fit within your organization? In terms of the coordinator role, what are the responsibilities of the health unit to the heart health coordinator? In terms of the coordinator role, what are the responsibilities of the heart health coordinator to the health unit?	2. Describe an optimal relationship between the heart health coordinator and the health unit. Does this describe your particular heart health coordinator/health unit relationship? Is your heart health coordinator a full time staff member? Do they have duties beyond being a heart health coordinator?
3. What do you think contributes to heart health coordinator turnover province-wide?	3. What common problems are faced by heart health coordinators province-wide?
4. Why do you think that your particular coalition has not experienced heart health coordinator turnover?	4. What has facilitated your heart health coordinator remaining in place?
5. What changes would assist the heart health coordinator to perform his/her role more effectively? What is the most important thing that could be done to reduce heart health coordinator turnover?	5. What could the coalition do to reduce the problem of heart health coordinator turnover? What could the health unit do to reduce the problem of heart health coordinator turnover? What could the Ministry of Health and Long Term Care do to reduce the problem of heart health coordinator turnover?

Appendix L

Interview Guide for Chronic Disease Manager in Coalition *with* Turnover
(estimated time for interview – 30 minutes)

Part 1

Preamble: Thank you for agreeing to participate in this study exploring the role of the Heart Health Coordinator and the issue of turnover. I am interested in getting your perspective on the issue. The first questions address the role of the heart health coordinator while the others deal with turnover. The final questions are about the relationship of the heart health coordinator to the health unit, the heart health coalition and the Ministry of Health and Long Term Care.

Questions	Probe
1. How would you describe the role of the heart health coordinator? What are the critical skills or assets that a heart health coordinator must possess in order to be successful?	1. If you were choosing a new heart health coordinator for the position, what would be the qualities you would want in that person?
2. How does the heart health coordinator role fit within your organization? In terms of the coordinator role, what are the responsibilities of the heart health coordinator to the health unit? In terms of the coordinator role, what are the responsibilities of the health unit to the heart health coordinator?	2. Describe an optimal relationship between the heart health coordinator and the health unit. Does this describe your particular heart health coordinator/health unit relationship? Is your heart health coordinator a full time staff member? Do they have duties other than being a heart health coordinator?
3. What do you think contributes to heart health coordinator turnover province-wide?	3. What common problems are faced by heart health coordinator province-wide?
4. Why do you think your particular coalition has experienced heart health coordinator turnover?	4. What do you think are the root causes of heart health coordinator turnover in your coalition?
5. How are heart health coordinator responsibilities handled when there is no heart health coordinator in place? How do you orient a new heart health coordinator to the position? If you had to give advice to a new heart health coordinator, what would it be?	5. Who takes over the heart health coordinator role during the time you lack a heart health coordinator? What role does the health unit play when there is no heart health coordinator? What is it like for the coalition when there is no heart health coordinator? What supports do you offer a new heart health coordinator?

Interview Guide for Chronic Disease Manager in Coalition *with* Turnover
(Cont'd)

Questions	Probe
6. What has been the effect of heart health coordinator turnover on your coalition?	6. Has heart health coordinator turnover affected the composition of your coalition? What happens to the coalition function when there is heart health coordinator turnover? What do you think would happen to a heart health coalition that consistently experienced heart health coordinator turnover?
7. What would assist the heart health coordinator to perform his/her role more effectively? What is the most important thing that could be done to reduce heart health coordinator turnover?	7. What could the coalition do to reduce the problem of heart health coordinator turnover? What could the health unit do to reduce the problem of heart health coordinator turnover? What could the Ministry of Health and Long Term Care do to reduce the problem of heart health coordinator turnover?

Appendix M

Interview Guide for Coalition Member in Coalition *without* Turnover (estimated time for interview – 30 minutes)

Part 1

Preamble: Thank you for agreeing to participate in this study exploring the role of the heart health coordinator and the issue of turnover. I am interested in getting your perspective on the issue. The first questions address the role of the heart health coordinator while the others deal with turnover. The final questions are about the relationship of the heart health coordinator to the health unit, the heart health coalition and the Ministry of Health and Long Term Care.

Questions	Probe
1. How would you describe the role of the heart health coordinator? What are the critical skills or assets that a heart health coordinator must possess to help the coalition plan and implement heart health promotion activities?	1. How would you envision an ideal heart health coordinator?
2. What role does the heart health coordinator play with regard to the heart health coalition?	2. What is the most important thing that the heart health coordinator brings to the coalition?
3. What do you think contributes to heart health coordinator turnover province-wide?	3. What common problems are faced by heart health coordinator province-wide?
4. Why do you think that your particular coalition has not experienced heart health coordinator turnover?	4. What has facilitated your heart health coordinator remaining in place?
5. What would assist the heart health coordinator to perform his/her role more effectively? What is the most important thing that could be done to reduce heart health coordinator turnover?	5. Is there a role for the coalition in helping to reduce heart health coordinator turnover?

Appendix N

Interview Guide for Coalition Member in Coalition *with* Turnover

(estimated time for interview – 30 minutes)

Part 1

Preamble: Thank you for agreeing to participate in this study exploring the role of the heart health coordinator and the issue of turnover. I am interested in getting your perspective on the issue. The first questions address the role of the heart health coordinator while the others deal with turnover. The final questions are about the relationship of the heart health coordinator to the health unit, the heart health coalition and the Ministry of Health and Long Term Care.

Questions	Probe
1. How would you describe the role of the heart health coordinator? What are the critical skills or assets that a heart health coordinator must possess in order to be successful?	1. How would you envision the ideal heart health coordinator?
2. What role does the heart health coordinator play with regard to the heart health coalition?	2. What is the most important thing that the heart health coordinator brings to the coalition?
3. What do you think contributes to heart health coordinator turnover province-wide?	3. What common problems are faced by the heart health coordinator province-wide?
4. Why do you think that your particular coalition has experienced heart health coordinator turnover?	4. What do you think are the root causes of heart health coordinator turnover in your coalition?
5. How are heart health coordinator responsibilities handled when there is no heart health coordinator in place?	5. Does the coalition continue to meet when there is no heart health coordinator? Who takes over the heart health coordinator role during the time that you lack a heart health coordinator? How do you help manage the coalition through the transition period from one heart health coordinator to the next?
6. How do you orient a new heart health coordinator to the position? If you had to give advice to a new heart health coordinator, what would it be?	6. What is it like for the coalition when a new Heart Health Coordinator starts in the position? How long does it generally take for a heart health coordinator to get comfortable in the role? What supports are available to a new heart health coordinator?
7. What has been the effect of heart health coordinator turnover on your coalition?	7. Has heart health coordinator turnover affected the composition of your coalition? Has heart health coordinator turnover affected the function of your coalition? What do you think would happen to a coalition that consistently experienced heart health coordinator turnover?

Interview Guide for Coalition Member in Coalition *with* Turnover
(cont'd)

Questions	Probe
8. What would assist the heart health coordinator to perform his/her role more effectively? What is the most important thing that could be done to reduce heart health coordinator turnover?	8. Is there a role for the coalition in helping to reduce heart health coordinator turnover?

Appendix O

Diagram of Heart Health Coordinator Relationships and Questions

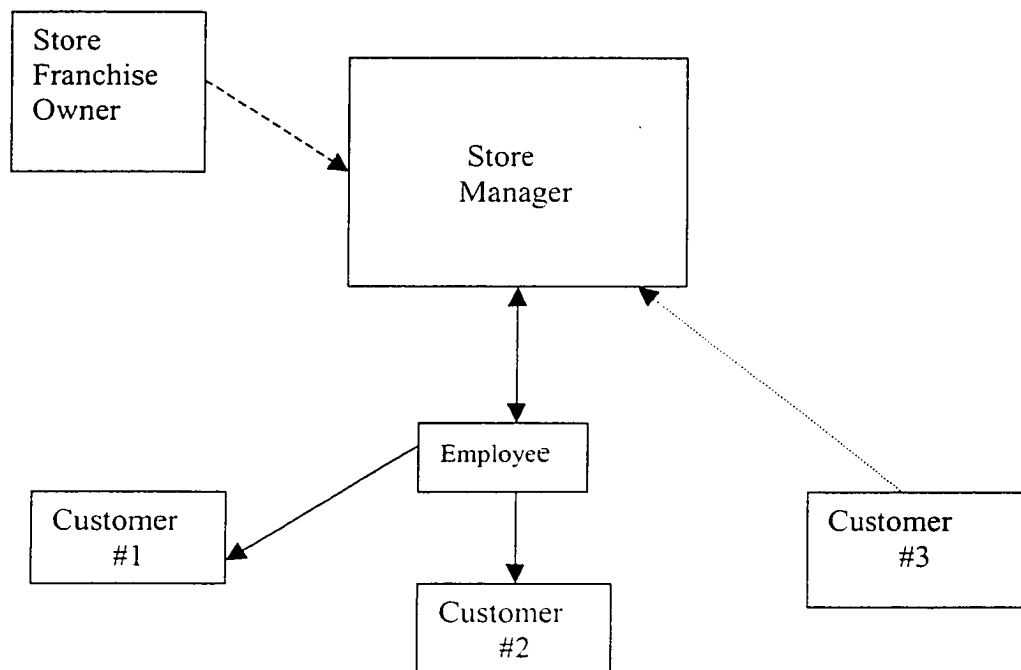
As a (heart health coordinator or chronic disease manager or heart health coalition member) you possess a unique understanding of how the heart health coordinator, the heart health coalition, the health unit and the Ministry of Health and Long Term Care communicate and work together. Take a few minutes and sketch for me your perception of how these individuals and groups communicate and work together.

- Use **squares** to represent each **organization** or **individual**. Place the central individual or organization in the centre. Let the size of the shape vary with importance or power. Let the physical distance between characters reflect the perceived psychological distance between characters. Label the squares with the role of the individual or organization.
- Use **lines or arrows** to show organizations and individuals **communicating and working together**. Solid lines with an arrow at the end represent a person who feels close to another. A broken line or arrow represents a conflict with another person or organization. The direction of the arrow indicates the direction of communication.

The configuration indicates the patterns of relationships. I have included a sample to demonstrate how the drawing could be constructed.

I would ask that you fax this to me at (613) 394-6930 prior to our telephone interview. I will be asking you some questions about this drawing.

SAMPLE (Diagram of communication and working together in a corner store)



Questions for Part 2

A request will be made to the heart health coordinator (past or present), chronic disease manager or heart health coalition member to draw a diagram ahead of the interview showing how the heart health coordinator, the health unit, the heart health coalition and the Ministry of Health and Long Term Care all relate to each other. The diagram will be faxed to me along with the consent and the demographic information. Should the participant not wish to complete the diagram, they will be asked the same questions omitting number 4.

During the interview, the following questions will be asked about the diagram:

You were asked to draw a picture of how you viewed the relationships between the heart health coordinator, the coalition, the health unit and the Ministry of Health and Long Term Care. I would like to ask you a few questions about the picture. (Both the participant and the interviewer have a copy of the picture).

Describe to me how the heart health coordinator and 1) the coalition, 2) the health unit and 3) the Ministry of Health and Long Term Care communicate and work together?

1. Which individual or organization is the largest square? Describe why?
2. Which individual or organization is placed in the center? Describe why?
3. Which individuals/organizations are placed closest to each other? Describe why?
4. Which individuals/organizations are placed farthest from each other? Describe why?
5. Which individuals/organizations communicate well with each other? Describe why?
6. Which individuals/organizations communicate poorly with each other? Describe why?
7. Are there any individuals/organizations that do not communicate at all? Describe why?
8. **(To be completed only if the participant drew the picture).** Now that we have talked about the picture, is there anything that you want to add or change the diagram?

Appendix P
Copy of Ethics Certificate



Université d'Ottawa • University of Ottawa

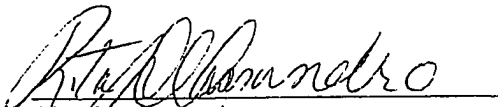
Cabinet du vice-recteur
à la recherche

Office of the Vice-Rector,
Research

HEALTH SCIENCES AND SCIENCE RESEARCH ETHICS BOARD

CERTIFICATE OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Health Sciences and Science Research Ethics Board has examined the application for ethical approval for the research project entitled **Exploring the Role and Turnover of Heart Health Coordinators in Ontario Heart Health Coalitions: A Qualitative Study (file H 05-04-13)** submitted by Nancy F. MacVicar who is supervised by Dr. Nancy Edwards, both of the School of Nursing. The Board found that this research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave it a Category 1a (approval). This certification is valid for one year from the date indicated below.


Rita D. Alessandro
Protocol Officer for Ethics in Research
For Dr. Hugh French, Chair of the
Health Sciences and Science REB

July 5, 2004
Date

Appendix Q
Copy of Ethics Certificate Renewal



Université d'Ottawa University of Ottawa
Service de subventions de recherche et d'éthologie Research Grants and Ethics Services

HEALTH SCIENCES AND SCIENCE RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICS APPROVAL

This is to certify that the University of Ottawa Health Sciences and Science Research Ethics Board (REB) examined the application for extension of ethics approval for the research project **Exploring the Role and Turnover of Heart Health Coordinators in Ontario Heart Health Coalitions: A Qualitative Study (file H 05-04-17)** submitted by Nancy Frances MacVicar and supervised by Nancy Edwards of the School of Nursing, Faculty of Health Sciences. This project received initial ethics approval on July 5, 2004 by the REB as meeting appropriate ethical standards set out in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards. The University of Ottawa REB members accordingly gave it a one-year extension of ethics approval. This ethics renewal certification is retroactive to July 5, 2005 and valid until July 5, 2006.


Rita D'Alessandro

Protocol Officer for Ethics in Research
For Dr. Daniel Lagarec, Chair of the
Health Sciences and Science REB

July 22, 2005
Date

Appendix R
Sample Categorization of Interview Data
(Provincial and Local Heart Health Challenges)

Provincial Challenges
Late announcement of Phase II funding - Decreased coalition membership and activity - Coordinators worried about job security
Problems because funding is for heart health but risk factors address other disease e.g. cancer - Strict Ministry of Health and Long Term Care guidelines for use of funds - Problems attracting members in organizations that address risk factors but are not heart health
Heart health coordinator is caught in the middle between the employer (health unit), the Ministry and the heart health coalition - Powerless – pulled in many directions - Vulnerable - receive flack for problems caused by others (Ministry/Health Unit) - Lack of direct communication with people making funding decisions
Structural and funding challenges Structural changes occurring at the same time as the Ontario Heart Health Program included municipal amalgamations, downloading of public health funding costs to municipalities, decreased funding for public health, significant public health crises, education, welfare reform, and health system renewal.
Local Challenges
More complex and different than the other health unit frontline jobs - Coordination role - staff prefer to implement initiatives not just coordinate - Heart health coordinator position requires multiple talents and expertise that are unrealistic for one person (eg understanding the needs of marginalized groups, conflict resolution etc) - Hard to recruit suitable candidates with experience in health promotion - Learning curve is high - New program – bigger than other health programs
Job demands are too high - Time pressure, - A lot of paperwork; heavy reporting requirements - lack of administrative support, - Other health unit responsibilities - Often take on responsibilities that coalition members should be doing
Lack of recognition of the challenges and difficulty of heart health coordinator job by health unit
Problems Maintaining Coalition - Scarce Community Resources (People/Money/Time) - Often face multiple community issues that are not heart health - Lack of community leadership
Inadequate financial recompense - For demands and expertise required for heart health coordinator position - Lack of consistency in pay among health units - Lack of recognition of the challenges and difficulty of the heart health coordinator position
Lack of direction when a new heart health coordinator - Took two years to learn job - Did not know how coordinator fit into coalition
Coalitions with frequent heart health coordinator turnover - Heart health coordinator out of communication loop - Spent time developing coalition and building relationship not formulating and implementing initiatives - New coordinator might not be welcomed if there had been conflicts
Ministry of Health and Long Term Care did not understand needs of rural communities Difficulties recruiting and retaining coalition members

Appendix S

Sample Matrix
(Local Challenges of the Job)

n=15

	Non-Northern Rural - HHC turnover		Non-Northern Rural no HHC turnover		Non-Northern Urban HHC turnover		Northern HHC turnover		
	HHC	CDM	HHC	Coalition Members	HHC	Coalition Members	HHC	CDM	Coalition Members
	1	1	2	2	2	2	2	1	2
Atypical public health job		X	X		2X	2X	2X	X	X
Lack of knowledge/ experience with steep learning curve	X	X	X		2X	2X	2X	X	X
Overwork leading to burnout									
• Too big a job for 1 person						X	2X	X	
• Responsibilities other than HHC		X	X	2X	2X	X	2X	X	X
• Lack of administrative support			X		X		X	X	
• Time pressures			X		X				
• Large amount of paperwork	X	X	2X	2X	X		2X	X	
Lack of support									
• Didn't feel that concerns were being heard by Ministry, HU	X		2X	2X	X	X	2X	X	
• Lack of managerial support	X		X		X	X	X	X	
• Lack of recognition by HU of complexity and responsibility of this job (money, position)		X	X		X		X		
• HU rules and regulations			2X	2X	2X	2X	X		X
Multiple Loyalties – to HU, Coalition and Ministry			X	X	2X	2X	X		X
Community Coalition									
• Small coalition – do most of the work	X		X	X			X		
• Problems recruiting and maintaining membership		X		X		X	2X	X	X
• Limited participation by coalition membership	X	X	X	X		X	2X	X	X
• Dealing with community agendas above and beyond Heart Health					X	2X			
HU that has experienced HHC turnover	X	X			2X	X	2X	X	

Appendix T

Ontario Heart Health Program Selective Document Review

Document	Purpose/Research Methods	Findings
Towards Benchmarking Heart Health Coalitions: Developing a Systematic Process for Documenting and Enriching Community/Health Unit Partnerships, (2001)	This benchmarking study used mixed methods to systematically identify best practices from eight varied heart health coalitions in the Ontario Heart Health Program	A Collaborative Partnership • Strong collective identity that recognized the varied needs of different partners that is supported (and not directed) by the health unit. Some coalitions in the Ontario Heart Health Program saw this as predominately a health unit program, designed to meet the mandate of the health unit, which left other community partners feeling marginalized. Other health units were not inclined to participate because the coalition was viewed as separate from the health unit and not belonging to it. The health unit must be seen as one partner of the coalition and as supportive, not dictatorial. • Executive committee decision making is reflective of input from task groups and diverse community sectors. In some communities, the health unit was making the final decision on coalition recommendations for heart health initiatives. It is uncertain whether this occurred because of the health unit having fiscal responsibility or because there was no demarcation between health unit and coalition responsibilities. While the health unit has financial accountability, it must not over rule community decision making. • Conflict resolution strategies must be established to resolve conflict in an open and fair manner. Jointly establishing these strategies with coalition members is a useful process. It is important to anticipate areas of potential conflict and discuss these areas prior to problems arising. • Management of funds must encourage joint decision making and a collective identity. In the Ontario Heart Health Program there was some concern about organizations that joined to access funds rather than improve heart health. The coalition as a whole should be responsible for developing and implementing initiatives rather having individual agencies within the coalition implement projects. • A balance between recruitment and retention of coalition membership that is based on a coalition which is perceived to benefit all partners and that works in a collaborative manner. Some communities

Selected Ontario Heart Health Program Document Review

Document	Purpose/Research Methods	Findings
Towards Benchmarking Heart Health Coalitions: Developing a Systematic Process for Documenting and Enriching Community/Health Unit Partnerships, (2001)		dealt with coordinator and coalition member turnover – this can be very difficult particularly as the coalition is becoming established. For some communities few new members were becoming involved in the coalition and this led to burnout among individuals and organizations. Organizations, themselves, must be committed to involvement in the coalition, not just the individual representing the organization. Coalition Planning • Priority setting/ Broadly based planning/ Timing and content that built on existing initiatives and partner resources and interests, involving all partners without favouritism, and permitted all partners to participate. For the Ontario Heart Health Program, communities were expected to develop a 4-year plan. It was difficult developing a plan that employed comprehensive programming that was intensive enough to make community change and cover (for some health units in particular) a broad geographic area. A lack of expertise in planning and the perception by some community partners that the health unit was driving the planning process without community input frustrated some members and limited community buy in to the project. Sufficient time must be given to develop relationships among the partners prior to beginning long term planning. Communities require resources and expertise to support the planning process. Interpersonal Relationships • Interpersonal relationships are positive when personality conflicts do not interfere with coalition functioning, there is active participation by members in meetings and activities, and partners collaborate in other activities above and beyond heart health. Stability of the coordinator and a core group of coalition members is essential in the early stages of coalition development. Successes, decision making that involves all partners and conflict resolution build a strong interpersonal relationships. Flexibility • Flexibility to adjust to change in planning and programming and as coordinators and coalition members come and go.

Selected Ontario Heart Health Program Document Review

Document	Purpose/Research Methods	Findings
Towards Benchmarking Heart Health Coalitions: Developing a Systematic Process for Documenting and Enriching Community/Health Unit Partnerships, (2001)		Champions - Champions are found within and outside the health unit and are decision makers and opinion leaders. Coalitions that became dependent on the support of one person cannot cope when this person leaves or burns out. Communication - Coalitions communicates in a variety of ways that including formal minutes, newsletters, etc. In the Ontario Heart Health Program, initially most communication occurred through the heart health coordinator, but as coalitions matured more informal communication occurred among partners. As coalitions increased in size, a more formal means of communication became essential. Health Unit Role - Health units must be supportive of the coalition and the coordinator must be perceived to be working for the whole coalition, not just the health unit. The health unit must support community-based decision making by the coalition and be seen as just one coalition partner. Health unit programming must be integrated with coalition activity. - This was a problem area in the Ontario Heart Health Program as many heart health coordinators found themselves torn by conflicting demands of the health unit, the Ministry of Health and Long Term Care and the coalition. The role and responsibilities of heart health coordinators differed from those of other health unit employees. Health unit procedures and decision making policies were not congruent with the Ontario Heart Health Program. Differences between health unit and community views of how the Ontario Heart Health Program should be implemented were sometimes problematic. Coalition Output - Data was collected from Annual Activity Reports and an In-Kind Contribution Report required by the Ministry of Health and Long Term Care. Information was not available for data being collected from the Ontario Heart Health Program Phase I Evaluation for this document.

Selected Ontario Heart Health Program Document Review

Document	Purpose/Research Methods	Findings
Towards Benchmarking Heart Health Coalitions: Developing a Systematic Process for Documenting and Enriching Community/Health Unit Partnerships, (2001)		Process • Amount and characteristics of coalition based activity based on priority health units and community agencies gave to heart health. This was identified by the amount of in-kind contributions – there was some difficulty with this method of tabulation because some health units stopping collecting in-kind contribution statistics once the minimum requirement was met. The in-kind contributions were noted to be increasing over time indicating a higher commitment to heart health. • Success indicators for the coalition and success indicators that demonstrate community change are different. Change over time is an important indicator and since coalitions were at the early stages of development, community level change indicators were not supplied. Coalition Sustainability • Unable to assess empirically - this aspect was identified as a concern to heart health coalitions
Continuation Plan for 2003 and Beyond, (2002)	The purpose of this document was to plan a cohesive and systemic approach that integrated the Ontario Heart Health Program within a more comprehensive chronic disease prevention strategy. Document was compiled from the results of a number of studies.	Background: • Throughout Ontario, chronic disease prevention strategies were developing independently for cancer, stroke, diabetes, asthma with separate funding, infrastructure and accountability for each Health Promotion Resource Centres (e.g. Heart Health Resource Centre) were developing partnerships to facilitate coordination of activities • Province had begun to develop nutrition and physical activity strategies similar to the tobacco control strategy • Chronic disease prevention is mandated for Ontario health units in the Mandatory Health Programs and Services Guidelines • The Ontario Heart Health Program had developed local community coalitions to address cardiovascular disease prevention

Selected Ontario Heart Health Program Document Review

Document	Purpose/Research Methods	Findings
Continuation Plan for 2003 and Beyond, (2002)		Findings - Heart health was a high priority within most health units in 2000 (72%) -- and because of the mandate and expertise of the health unit most community partners supported having the health unit as the lead agency - The percentage of health units rating heart health activity as very well coordinated increased from 45% in 1997 to 75% in 2000 2,500 local partners were participating in heart health across the province -- recruiting and retaining coalition partners was a continuing issue in coalition functioning - The Heart Health Resource Centre consulted at 98 sites, provided 29 training events for the Ontario Heart Health Program, responded to over 1000 questions and coordinated 8 Ontario Heart Health Network meetings and two Ontario Heart Health Network conferences - The Ontario Heart Health Network facilitated networking among coordinators, coalition members, the funding source, support systems and researchers - As of October 1999: -727 activities had occurred -\$10 million of in-kind contributions were obtained for 1999/2000 (more than the 2:1 matched funding) -over 1,100 groups were members of heart health partnerships - As of October 2001 -957.5% of health units had shared resources with other community Agencies -90% of health units had increased the priority of multiple-risk factor Programming -communities contributed over \$11 million in-kind contributions (for 2000/2001) - 3.91 local dollars for each provincial dollar on average -2,500 community partners for entire province

Selected Ontario Heart Health Program Document Review

Document	Purpose/Research Methods	Findings
Continuation Plan for 2003 and Beyond, (2002)		Recommendations 1. Steering Committee formation: Formation of a chronic disease prevention steering committee representative of both local and provincial perspectives to provide advice on chronic disease prevention issues and assist with identifying program priorities 2. Ontario Health Promotion Resource System should support the chronic disease prevention strategy with training and consultation and assist with rationalizing other technical support agencies to avoid duplication of effort. This system would also assist groups with similar approaches to build relationships. 3. Ontario Health Promotion Resource System should facilitate centralized program development by coordinating development of a chronic disease prevention program (for cardiovascular disease, stroke, diabetes, and cancer prevention) at provincial and local levels with community coalitions) that uses a multi-factoral, multi-sectoral approach. This centralized provincial program development would facilitate the development of standardized messages across the province – but must not compromise the needs of varied settings (non-northern rural, non-northern urban and northern Ontario health units). 4. Develop a common provincial program identifier for provincial programs – local groups would continue to have their own logo used for local programming. 5. Reporting requirements: Working group to identify reporting and evaluation requirements and to develop a centralized activity form and report that could be accessed online that is linked to the Public Health Mandatory Program and Service Guidelines. Research should explore whether to continue Heart Health Benchmarking and data that relates to specific needs within communities. 6. Chronic Disease Health Promotion Strategy for Ontario: The strategy needs to address cardiovascular disease, diabetes, stroke and cancer prevention by integrating tobacco use prevention, physical activity and healthy nutrition strategies. At the local level it would be

Selected Ontario Heart Health Program Document Review

Document	Purpose/Research Methods	Findings
Continuation Plan for 2003 and Beyond, (2002)		important to continue community-based coalitions (already established for the Ontario Heart Health Program) with the health unit continuing in the role of lead agency. Human resource requirements regarding coordinators should be reviewed in light of "the high turnover of coordinators, inappropriate match of people to the coordinator position, inequities of full-time employee allocation in local health units and special staffing issues across the province" (p. 25). Coordinators also appreciated opportunities to review their activity plans at regional networks meetings. Peer mentoring could provide additional support for coalitions. 7. Community coalitions should continue because they support sharing of resources and avoids duplication of effort. Funding for the Ontario Heart Health Program should be continued because it would be difficult to recreate it at a later date. Twelve sites already have expanded beyond heart health and eight sites are considering expansion. 8. Health unit role Health units are mandated to implement chronic disease prevention strategies by the Mandatory Health Programs and Services Guidelines. Health units should be stewards of the Chronic Disease Prevention Program because their mandate is congruent with the program, and they have resources that can be contributed to the program, can handle fiscal responsibilities, can act as a secretariat and ensure that best practices are followed. However, the health unit must share decision making and leadership with coalition membership. 9. Heart health coordinator role The provision of a full time equivalent heart health coordinator in each health unit was unrealistic. While larger health units had adequate staffing to designate a full time coordinator, smaller health units found this difficult. It was sometimes perceived as depleting staff from other programming. However, coordinators with time dedicated to the project is essential for successful coalition functioning. There is a need for ongoing research to understand the roles and supports necessary for the coordinator and the coalition.

Selected Ontario Heart Health Program Document Review

Document	Purpose/Research Methods	Findings
Continuation Plan for 2003 and Beyond, (2002)		10. Facilitate peer mentoring through Regional Networks to facilitate peer mentoring through regional networks facilitated by the Heart Health Resource Centre and integrated into the planning process. Coordinators. 11. Joint planning process with coalition members incorporating a two year planning cycle. 12. Evaluation process for local prevention programs – conduct a formative evaluation of local coalitions to improve their programs – designed to promote coalition development and accountability. 13. Clarify roles and responsibilities of the health unit, the Ministry of Health and Long Term Care and the coalition. 14. Long term stable funding for community-based coalitions participating in health promotion: Application guidelines for the Ontario Heart Health Program stated, that “additional funding will not be available for local projects beyond the duration of the local Heart Health Program” (p. 5). This statement reduced the momentum of the coalition particularly as Phase I of the Ontario Heart Health Program drew towards the close. Partners could not be recruited and many left. In evaluation of the Heart Health Action Program (demonstration projects implemented prior to Phase I of the Ontario Heart Health Program) commented that “relatively little attention has been devoted to if, when and how coalitions terminate and the effects of termination of the participating organizations and communities. The instability...when the sites were nearing the end of the demonstration period and the eternal funding situation was highly ambiguous raises questions about the necessary supports (external and/or within communities) to ensure heart health initiatives continue” (p. 24). 15. Continue to require same level of in-kind contributions jointly from the health unit and community partners. It is important to develop easier methods to track in-kind contributions and clarify what is included and the value of contributions.

Selected Ontario Heart Health Program Document Review

Document	Purpose/Research Methods	Findings
Continuation Plan for 2003 and Beyond, (2002)		16. Develop a consultation process to explore funding mechanisms for the heart health coordinator position. A problem-solving process should examine alternative funding methods for the coordinator position. 17. Make small funding grants available to local communities for innovative projects – this enhanced funding would support special projects
Ontario Heart Health Program – Phase I Final Evaluation Report: Informing Future Directions for Healthy Living and Chronic Disease Prevention in Ontario (2004)	The purpose of this document was to evaluate the success of Phase I of the Ontario Heart Health Program, recommend whether or not Phase II should be funded and if funding was recommended, make suggestions for improvements for Phase II. Mixed method research over multiple years and consultation with expert advisory committee	Characteristics of the Ontario Heart Health Program • 37 local areas participated – in all but one jurisdiction, health units were the lead agency - accountability for heart health funds lay with the Board of Health from each health unit (except in one area) • During Phase I provincial funding was 3.4 million annually for five years – ranged from \$52,000 to \$566,000 per health unit - to be used exclusively for program costs and not staffing • Community coalitions were mandatory (involving broad-based organizational and citizen representation) • Funding for Phase I ran from January 1998 until March 31, 2003. Phase II funding was not promised until year 5. • Each health unit was responsible for funding a 1 full time equivalent staff person to support the Ontario Heart Health Program at local level. • In-kind local contributions from community partners and the health unit were required (\$2 local for \$1 provincial) • Local programming was to implement a population health approach that focused on tobacco use prevention, and physical activity and healthy diet promotion that built on existing initiatives (best practices) • Provincial programs such as Eat Smart were to be implemented locally • Reporting requirements – 4 year activity plan, annual activity plans, sustainability plan, interim and annual reports on financial, in-kind contributions and activities implemented

Selected Ontario Heart Health Program Document Review

Document	Purpose/Research Methods	Findings
Ontario Heart Health Program – Phase I Final Evaluation Report: Informing Future Directions for Healthy Living and Chronic Disease Prevention in Ontario (2004)		Rationale/Context for Ontario Heart Health Program • Addresses a serious health problem Health status risk behaviours can be reduced at the population health level • Applies current evidence-based prevention strategies • While it addresses heart health, many other chronic diseases share the same risk factors • Other provincial and local initiatives supported the Ontario Heart Health Program approaches to cardiovascular disease prevention • Public health system faced many challenges during Phase I of the Ontario Heart Health Program (restructuring, downloading of services to municipalities, budget restrictions, Walkerton water crisis, West Nile virus, and Sudden Acquired Respiratory Syndrome - SARS) Goals/Objectives of Ontario Heart Health Program • Provincial goals were to reduce smoking, improve physical activity levels and improve unhealthy eating • To increase the implementation of comprehensive population-based heart health programs • Increase knowledge among the population of cardiovascular disease risk factors, ways to reduce the risk and available services Provincial Issues and Challenges that Occurred Simultaneously during Phase I of the Ontario Heart Health Program • Structural and funding challenges occurred at the same time as the Ontario Heart Health Program including municipal amalgamations, downloading of public health funding costs to municipalities, no funding increases for public health, provincial tax cuts, significant public health crises, education reform, welfare reform, and health system renewal, and public health mandatory program review and monitoring requirements Provincial Supports for Ontario Heart Health Program • During the first 4 years, the Ontario Heart Health Program was under the Community and Health Promotion Branch of the Ministry of Health and Long Term Care. In year 5 it shifted to the Health Promotion and Wellness, Public Health Branch, but maintained the support of a

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Ontario Heart Health Program – Phase I Final Evaluation Report: Informing Future Directions for Healthy Living and Chronic Disease Prevention in Ontario (2004)		Provincial Supports for Ontario Heart Health Program provincial manager and two part-time coordinators. A committee of Heart Health Provincial Partners gave advice for the first 3 years. - Heart Health Resource Centre received \$400,000 per year to provide technical assistance and training. - During the first 4 years, the Ontario Heart Health Program was under the Community and Health Promotion Branch of the Ministry of Health and Long Term Care. In year 5 it shifted to the Health Promotion and Wellness, Public Health Branch, but maintained the support of a provincial manager and two part time coordinators. A committee of Heart Health Provincial Partners gave advice for the first 3 years. - Heart Health Resource Centre received \$400,000 per year to provide technical assistance and training Ontario Heart Health Program Evaluation Findings: Successes - Developed local infrastructure and capacity for cardiovascular disease prevention - Recognition by community that public health system should be lead agency - Increased community involvement in chronic disease prevention including heart health - In-kind community and health unit resources were more than requirements (\$4 local: \$1 provincial) - Improved environmental conditions supporting positive changes in reducing smoking, improving physical activity and healthy diet - Programming addressed multiple risk factors

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Ontario Heart Health Program – Phase I Final Evaluation Report: Informing Future Directions for Healthy Living and Chronic Disease Prevention in Ontario (2004)		Require Improvement • Health units only reached moderate level of support for heart health promotion • Community agency involvement only reached a low level • Province-wide implementation only reached a low level • Need to emphasize environmental support and policy initiatives rather than awareness and education Ontario Heart Health Program Evaluation Findings (cont'd): Require Improvement • Need to overcome barriers to implementation of Ontario Heart Health Program that included (funding uncertainty, recruitment and retention of coalition members, health unit/Ministry of Health and Long Term Care reporting requirements, high turnover of heart health coordinators, lack of direction and coordination at the provincial level, and the lack of integration of the Ontario Heart Health Program with Chronic Disease Prevention strategies. Ontario Heart Health Program Evaluation Findings Recommendations: • “Ensure sustainable and sufficient funding” (p. v) • “Strengthen public health leadership” (p. v) • “Strengthen local-provincial partnerships” (p. v) • “Strengthen provincial policy development to integrate the Ontario Heart Health Program with related healthy living/chronic disease prevention initiatives” (p.vi) • “Strengthen the provincial enabling system” (p. vi) – the Heart Health Resource Centre • Strengthen and coordinate surveillance, evaluation and research for the Ontario Heart Health Program” (p. vi)