

Ep.6-Strategies-on-the-Streets.mp3

[music]

Natalie Meade [preview]:

When we sort of realized we made it is when clients starting referring their peers to our team. The very first time it ever happened, we had gone into our local jail and were visiting a client. And she said, near the end of our meeting with her, “Well, hey. My cellmate actually just got diagnosed with HIV as well. Do you think you guys could help *her*?” The outreach worker and I just sort of looked at each other and said, “Well, absolutely.” So that was really sort of a big milestone for us when other clients really started reaching out and wanting to refer their peers to us because they had such great relationships with us, and were having such successful encounters, and really meeting their healthcare needs.

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Susan Blue:

Hi, I’m Susan Blue.

Maureen Cava:

And I’m Maureen Cava.

Susan Blue:

This is *Stories From The Field: Public Health Nursing in Ontario*. In today’s episode, we’re meeting three expert public health nurses from different parts of Ontario. All of them provide nursing services to marginalized populations—the most vulnerable of the vulnerable.

Maureen Cava:

Today’s episode shines the light on a very important aspect of the public health nursing role: working with highly vulnerable individuals who are living in compromising situations on the streets of their communities.

Susan Blue:

We’ll learn about one-to-one work with unhoused and underhoused high-risk clients, and also a community approach to addressing substance use.

Maureen Cava:

Alcohol, drugs, and communicable disease infections are the main issues that both Natalie and Becky encounter on a day-to-day basis. Chris completes the episode, discussing a harm-reduction approach to substance use.

Natalie Meade [preview]:

My name is Natalie Meade. And I am a public health nurse with the Middlesex-London Health Unit on the outreach team.

Maureen Cava:

Natalie has worked in the community outreach program for four years. She assists clients, who are living on the street, with accessing medical services, and links them to other resources such as food and financial support. Natalie's previous experience in mental health is a definite asset to her work

Becky Bridgman [preview]:

My name is Becky Bridgman. And I've been a public health nurse, Thunder Bay District Health Unit, for about 14 years now. And my current role is, ah, street nurse in our street outreach program. And I've been doing this, on and off, for about 12 years.

Maureen Cava:

Becky had eight years of sexual health experience before joining the street nursing program. She's a compassionate and energetic public health nurse. And it's apparent she really cares about her clients.

Chris Arnott [preview]:

My name is Chris Arnott. And I am a public health nurse at Durham Region Health Department. And right now I have been re-deployed—as many of us have been—to our COVID response. But prior to that, a year ago I was working in our opioid response program.

Susan Blue:

Chris has been a public health nurse since 1989. Her career has included work with childbearing-age families, mental health, and harm reduction. While Chris does not work one-on-one with clients, her work at a broader community level is equally important. She'll share some insights about population-health promotion.

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Maureen Cava:

But first, we'd like to acknowledge and thank both the Lawrence S. Bloomberg Faculty of Nursing and the University of Toronto. Funding from the Verna Huffman Splane Endowment Fund enabled us to produce the podcast series. A public health nurse who lived to be 100, Verna's legacy donation supports education that promotes public health nursing.

We started with Natalie, who shares her experiences as an outreach public health nurse. She tells us how the team was started and their important work with vulnerable individuals.

Natalie Meade:

So our team was founded in 2017. The Middlesex-London area noticed an increase in HIV infections, invasive Group A Strep infections, and some other health concerns related to the population of people who inject drugs. So as a whole, the Health Unit and

some other stakeholders in the community, related to health care, came together, and recognized these issues, and created our team to help folks get connected into care.

So our team consists of a manager, two public health nurses, and two outreach workers. And recently, we had the addition of a peer navigator to our team, who has just started, and she's just a couple weeks in. So that's very exciting for us.

Maureen Cava:

Can you just give us a snippet of what a typical day looks like for you—if there *is* such a thing as a typical day?

Natalie Meade:

So definitely no day is ever the same. And no day starts or goes as planned, shall we say. We usually sort of have a team check-in to plan our day: who is going to check in with what client; have any crises popped up over the weekend or overnight. Then we sort of go from there.

So we really help to facilitate folks getting connected and retained in HIV care. That's our main purpose. However, because we are serving the most vulnerable of the vulnerable, a lot of times they don't have other contacts, or connections, or supports. So we often bridge the gap. We may be helping people get connected with ODSP and that application process. We may be helping people get connected with a social worker to fill out some housing forms. We may be looking into their pharmacy and medication changes. Or have they been missing medication doses, is there a reason? How can we help navigate and mitigate those issues and concerns?

Maureen Cava:

You talked about, and you used the words, “the most vulnerable of the vulnerable.” What do you mean by that? Who are the people that you see in your community?

Natalie Meade:

The folks that we support are often the folks that don't have any other supports. So they may not be supported by any mental health programs. They're often homeless; or “deprived of shelter” is another way of phrasing that. And folks that don't have a shelter really can't plan. And their priorities are much different than the rest of the population. So if you don't know where you're going to sleep at night, where your next meal is coming from, if you're safe, you really can't prioritize your health care. Even though absolutely it is something you're interested in and you want to want to participate in, there's just so many other pieces to the puzzle for priorities of where that may fall.

There are certainly folks who may be connected with other outreach teams through the city, or through other programs, and through other agencies, however, most of the folks that we end up supporting are just folks that haven't been connected or are falling through the cracks for other reasons.

Maureen Cava:

How do you begin to develop trust with these individuals that you're working with?

Natalie Meade:

So we were very lucky. When our team first started, one of the outreach workers, he was involved with another agency, and he had been there for about ten years, working as mobile outreach for the needle syringe program. He then transitioned to our team. And so he was already really embedded in that community, and had some trust within that community, and had some relationships developed with some of the folks who were referred to our team. So I really do give that a lot of credit for where we had such huge successes.

Through my career, I had worked in sexual health promotion. And my portfolio had really encompassed a lot of harm-reduction work and doing some outreach work. And so I, also, was a little embedded into that population. And that really got us started.

And then it's really just connecting with folks where they are. It's getting out of the office and onto the streets—meeting folks physically where they are but emotionally and mentally where they are as well. And it's no-strings-attached. It's offering whatever their need is in that moment.

So ultimately, our end goal, of course, is to have them retained in care. However, perhaps when we're meeting them in the moment, that's not what their need is. Perhaps they need clean gear. Perhaps they need to get connected to a shelter. Or they have some other imminent need. And it's really just showing them that we *are* here to support them. Like I said, there's no strings attached. There's nothing that *they* need to do to reciprocate on their end. And it's just continuing to show up every day, every time that we say we're going to, and following through with that.

[music]

Maureen Cava:

Natalie's team includes a peer navigator. Peer navigators are individuals who have lived experiences similar to the clients they're helping. They develop trusting relationships and offer support to their clients in navigating the medical system, and working on their personal needs.

We asked Natalie to expand on what this role is, and how her team found their current peer navigator.

Natalie Meade:

The peer navigator role, at this stage it's a research role. So this is somebody who is considered a youth. They will be looking to engage with other youths who could be street-involved, definitely at risk of HIV. And so they'll be going out to help supporting folks to get tested, helping them sort of stabilize, again in their healthcare needs, and just going out to do some education as well.

So a very brand new role. She's doing all the onboarding and the training phases. But she was actually a client of ours. She was facing a lot of challenges. We met her in the hospital. And she had been diagnosed with HIV, Hepatitis C, as well as infective endocarditis.

So she was facing, ah, nine weeks in hospital on antibiotics, and going through withdrawal—and we have a wonderful addiction, ah, management physician in the hospital in our area, who she was connected with to help stabilize her—and was discharged, and then of course has all these followup appointments that she should be needing to attend, and of course was feeling very overwhelmed and very stressed.

When we explained our role—and we could not only help transport her to these appointments but we would accompany her, we would hear all the information, be able to relay the information, and again just help keep her on track—slowly, she was just able to sort of let go from our team, I guess is a good way to describe it. She ended up going back to school.

And she has remained stably housed, was hired on. And we are so excited to have her join our team. And that's something that she often commented, from the beginning her engagement with our team, was just how much she appreciated the help and she really wanted to sort of be on the other side of that and wanted to give back in that way. And she did it! She made it. And—and here she is now a colleague.

Maureen Cava:

That's a great story. And I'm sure that there will be other clients that you see, and other individuals, that actually will know her if she has been in your area. So you think that that connection will be easier then for your team, knowing that they have someone that *is* one of their peers?

Natalie Meade:

Definitely. I do think that that will be sort of a bonus to help us with our mission. And I know that one thing—which I'm so proud of her for recognizing—she has reached out to ask about boundaries and how do we navigate that in our work life and can we share some tips. And I just thought that that was so amazing that she had that insight to be aware and to reach out and sort of initiate that conversation.

Maureen Cava:

With a position that's rooted in engaging with the community and helping individuals in crisis, it is important to maintain boundaries.

Natalie Meade:

So definitely our boundaries of our work shift. So, you know what? At 4:30 the day is done; we really do try to shut it off. One of our outreach workers, she is very good about saying, "Boundaries. Boundaries." and not taking their crises on as our own, and just making sure that we keep ourselves separate.

It's definitely sharing a little bit of our personal pieces. Because I think that that is important—that, yes, we do need these boundaries but at the same time we still need to be a human, and we still need to convey that humanity to our clients. We don't, of course, over-share but certainly if somebody's in a situation that we can relate to, or if they do ask you a question—of course it's not too personal or too private but—just being relatable. And again, I think that that's something that really came through with the peer navigator, that she mentioned, was that she always felt she was treated equal. She was never less-than; she was always equal-to. Which I think is so important.

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Maureen Cava:

It's necessary to engage with vulnerable populations without judgment. And Natalie shared with us how she tries to keep personal biases out of her work.

Natalie Meade:

Nobody generally starts out on this path. Something has happened along the way. You know, I have been very privileged in the life that I have led. And especially when you see, and you start working with, some of our clients, realizing the struggles that they go through every day that we may never face and we may never know, I think that that's just so important for perspective. We aren't better than anybody; we are just human, and we are just on our own path. And we don't know how people came to be. And we don't know the reasons or the experiences that other folks have had. Again, I always say, I shouldn't have to tell somebody to treat a human like a human.

[music]

Maureen Cava:

Natalie wanted to share one more story with us—one that exemplifies the importance of treating a human like a human, and taking the time to meet clients where they're at. In her story, Natalie mentions MRSA—a bacteria which generally doesn't cause harm but is very contagious and is resistant to many antibiotics.

Natalie Meade:

So I was at an appointment—it was his HIV appointment—with this client. And he had a spot on his back, a little bit of an infection. The doctor came in, did the standard HIV questions, opened it up to him for any other concerns. And I was able to prompt him to show the physician this sore. And she commented, "Oh, yep. That looks like it's infected. You're going to need some antibiotics. You've got MRSA. I'll go get that script for you."

And he said, "No, no, no. I just need some polysporin. I just need some ointment."

And she said, "No. You have MRSA. Your skin is colonized with MRSA. You need an antibiotic." And she walked out of the room.

And he shook his head and said, “You know, doctors over-prescribe antibiotics. I don’t need that. I just need an ointment.”

So this was an amazing opportunity to explain to him what MRSA is, and how MRSA came to be. That folks don’t take their antibiotics properly: they don’t take them at the proper time; they may not finish them completely. And what happens is a bacteria then gets smart, so to say, and can then mutate and become resistant to different antibiotics.

And so I was able to have this discussion with him. And I was able to explain to him that his skin is colonized with MRSA, which just means that he’s sort of always got it, and that he always needs to be mindful of this, and that that’s why she was going to prescribe this antibiotic, as well as a body wash, for him.

And he looked at me just completely dumbfounded. He never knew that he had MRSA, had no idea why antibiotics were prescribed, and why it was so important to take them as prescribed and complete them. And he just said, “Oh! Well, thank you so much for explaining that. I’ll make sure I finish them.”

I just thought, you know, what a perfect example of how healthcare providers often have our own agenda and we want to push this agenda on folks and don’t take the time to understand where folks are coming from—to give them the time to explain.

As if that wasn’t great enough, we checked in with him later on—you know, a week or so later. And he was taking his antibiotics. And a couple weeks after that, he said that was the first time in his entire life—and this gentleman is approaching 60—he had finished all of his antibiotics. That was the first time ever.

And while we were there, he had a peer who had an infection and he was asking about going to have it assessed, and asked about getting antibiotics from the pharmacy. The client was then able to turn and relay all this knowledge, and explain why antibiotics work, and explain why it’s so important to finish them. So we just thought two-birds-with-one-stone. Not only were we able to help impact him but then he was able to share that knowledge with a peer, which, again, is so important with this population—that peers carry so much more weight, often, than professionals do. And so when you’re able to educate folks in this population, and share that information, and get buy-in, you can just disseminate that message so much more quickly and to such a broader audience.

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Maureen Cava:

We’ll start by speaking to Becky about her role as a street nurse in a northern Ontario public health unit. She describes some of the challenges she faces as she works with people who have no fixed addresses and who are dealing with many other complex issues. Becky speaks about how she and her clients work *together* to overcome systemic barriers.

Becky Bridgman [preview]:

As a street nurse, we do one-on-one kind of interaction with people, all in the encompassing world of management of communicable infections. And specifically for our street nursing program, we're talking about STIs, BBIs, and then of course things like tuberculosis.

Maureen Cava:

Sexually transmitted and blood-borne infections could spread from person to person, and could cause serious concerns. Hepatitis B, C, and HIV are the three main blood-borne viruses.

Becky Bridgman:

The overarching mandate for our street outreach program is to manage these communicable infections within our vulnerable populations. My vulnerable population is adult people that either are underhoused, couch-surfing, or rough sleepers sleeping in the streets or tents or wherever they're sleeping, and then of course those with mental illnesses and substance use, which is usually all-encompassing for my clients.

Maureen Cava:

You mentioned that many of your clients that you see on the street are vulnerable. How do you develop a trust with them? How do you get them to want to speak to you?

Becky Bridgman:

It is difficult, especially when we're seeking out specific people if we're, you know, looking to do case investigation or contact investigation of an infection. It has taken years to engage a lot of the people that *do* connect with us. And so we're just ongoing engagement.

We do react to infection disease investigations. And that's where our program came, because we know that the health inequities that are amongst our vulnerable populations, we thought we'd break down the barriers and try to be that bridging system between absolutely no health care for some people—because they've been abused or had bad experiences within our system. It can years to engage people. But we just keep pressing at it.

So which means we make our stops. And people just approach us. We'll give them.... Do they need food? Do they need a toothbrush? You just want to say, "Hi." Very non-invasive—try to be, anyway. If we're searching for someone, sometimes we have to be a little bit more upfront in saying we're looking for someone. But we generally make scheduled stops around our city, so people can get to know us, so we can bring them harm-reduction equipment, or hats and mitts and scarves, depending on the weather.

We definitely have a presence in our community but still have a lot of work to do. Because my clients, or the people that I try to engage, are very difficult to get into the healthcare system. They have other things that they prioritize, as well, right? So if I have to tell someone they have HIV, that's not the most pressing thing for that day. Shelter,

food, or their substance-of-choice that they need so they don't into withdrawals, all that kind of stuff is usually their priority. So we're trying to work through that kind of system, because we know that our priorities don't match our clients'. And that doesn't mean our clients don't care, it just means that they have other pressures that, unfortunately, could be more important than something like HIV, at that time.

We have success stories here, of course. They're not the success stories that people would think were a success. Like, you know, we're getting people on treatment but I can't get them off the streets. You know, that kind of stuff. But I think it's more systemic issues outside of my control—like the systemic issues with the medical system, with the housing system.

We've acquired people housing, and then you wonder, "Why don't they live there?" But they're given so many rules about you can't have people over. But the people they're with on the streets are their family. These are the people they trusted. And so if you or I were to rent an apartment, nobody would say anything about who we let into our apartment.

So I find that there's all these different pockets, or gaps, that here in our street outreach program we're trying to fill those gaps. Because with those gaps, we can't actually get our job done efficiently and effectively.

Maureen Cava:

We asked Becky to walk us through one of her days as a street nurse.

Becky Bridgman:

So let's say we're just doing, ah, outreach stops. Some stops are static. We go there and stay for an hour or two, because there's a soup kitchen going on or something. And then some days we do drive-arounds to our areas that we know there's people congregating and see if anybody needs anything.

So at our stops that we stop at for an hour or so, we kind of park there. We can address a lot of things. We usually have a computer. We can look people up, we can draw blood, do all that kind of stuff.

We also have the SUV, which we use for like home visits—going specific places to do specific tasks—or if you're going to drive around and hand out water. If it's super-hot, often we'll go out and hand out water, and juice, and snacks—just because we know people aren't hydrating.

One particular time we went to Thunder Centre. There was like six people congregated under a tree. And we just stop in and say, "Hi," and we talk to them. And we have laughs all the time, especially if we know them.

When people are engaged, they're more than happy to test for Hep C, HIV. It could be an innocent stop and you've got ten different things to do with ten different people. And

so definitely it's unpredictable. So I would describe my job as fly-by-the-seat-of-your-pants and you've definitely got to make decisions as you're going.

Maureen Cava:

Becky shared how she navigates boundaries while working with her clients.

Becky Bridgman:

Boundaries are super-important. So I try to ensure that I don't give too much of myself and that people know the professional boundary. But you definitely have to give a little bit of yourself for them to trust you, for my clients to trust you. Because we're asking them very personal questions, to tell us lots of personal things in their lives. And I don't think it's fair that we don't offer a little bit on our end.

Maureen Cava:

Becky offered advice to nursing students about engaging with vulnerable populations while being aware of their own biases.

Becky Bridgman:

Just ask people their stories. Talk to them like they're people, because they *are*. If you share a little bit of yourself, they'll share a little bit of their self. It's a give-and-take. So I think if students actually just took the time to get to know their clients. Whether they're clients on the street, or they're clients in the hospital, or you're going to someone's home, it's really important to understand their story. Because lots of their story tells you why they're at where they're at, at that moment. And then you'll definitely have a better understanding of who that person is.

That shows interest, of course, in them as a person outside of whatever disease or medical issue they're looking at. Because, like, if I just followed people up for, say, HIV, I want to just tell them about HIV, tell them they need treatment, and then walked away, I'm really not doing a good job at ensuring that they know how to manage their HIV in where they're at right now.

That's the one bit of information I would give to, ah, new nurses or new people working in the caring field—is that to understand you're working with people, that you couldn't imagine what they went through.

Maureen Cava:

Becky also offered a suggestion for the type of nursing practice that every nurse should try.

Becky Bridgman:

Home care. Everybody tends to go to the hospital. And I find home care allows a new nurse to really learn how to critically think and solve problems in the moment. And you *do* see people where they're at when they're at home. And so it really gives you a background on how to connect with people.

And when you go to people's homes, usually you're still seeing them where they are most comfortable. And I think it's a nice caveat too, if you want to work with people that are homeless, or underhoused, or with substance use. That's what I would tell them.

Maureen Cava:

For students looking to relocate, Becky discussed some of the benefits of living and working in a smaller community like Thunder Bay.

Becky Bridgman:

Thunder Bay being smaller, you can get to know people better. Right? You can get to know people easier, different organizations, that kind of stuff—your connections. You tend to see the same people out—whether it's clients or outreach workers from other organizations. It's nice to have a smaller community, definitely.

We have, like I was saying, the geographical area is bigger. So sometimes I can't find my clients because we have a lot of bushes and stuff, that geographically (laughing) can be an issue.

But definitely people do stay here. Thunder Bay has a lot to offer. It is beautiful. If you enjoy the outdoors and you can handle the extreme cold at times, you would do great up here.

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Susan Blue:

We'll complete today's episode in conversation with Chris. In contrast to Natalie and Becky's one-on-one work with highly vulnerable clients, Chris' work in the area of harm reduction and opioid use is at a broader, community-based level.

Tell us what brought you to choose public health nursing as a career.

Chris Arnott:

I went to university for nursing. And I had a placement, actually, student placement in Thunder Bay as a public health nurse. And in working in the community, working with people and working within their homes, I really got a broad sense—a fuller sense, I think—as to what people's different health influencers are. And it really allowed for that wholistic, comprehensive understanding of those factors that influence an individual's health. Thirty years later, here I am (laughs).

Susan Blue:

What are the benefits of a harm-reduction as opposed to an abstinence-based approach in your work?

Chris Arnott:

A harm-reduction approach, I think, is much more realistic. It's much more compassionate. It keeps your engagement with the individual. You're meeting the

individual where they are at, and maintaining that contact, maintaining that relationship, enhancing that relationship with the potential of working towards engagement in recovery program.

The abstinence programs with opioids, those really set up an individual for failure. They're really, quite frankly, they're frightening. You know, an individual can get into an abstinence program and their tolerance to opioids immediately decreases. And for whatever reason—I mean, life is full of stresses—they initiate use again, at a level that they thought was manageable for them, and they end up overdosing because they have not used and so their tolerance level has gone down.

You know, having a harm-reduction approach is evidence-based approach to opioid addiction.

Susan Blue:

Harm reduction provides non-judgmental strategies to minimize potential harms for people who are dealing with addictions. We asked Chris to tell us about the principles that guide her work in harm reduction.

Chris Arnott:

My personal principle is meeting an individual where they are at, client-centred practice. If you can't meet an individual where they are at, that's harmful. It's disingenuous. And that's critical to developing a therapeutic patient-nurse relationship. Because really what you're trying to do is offer an individual support and create that therapeutic relationship, so that they're open to receiving any support that you're able to provide.

Susan Blue:

There's a real stigma that's associated with people that use drugs. The reality, though, is that we know as time goes on that the opioid crisis really goes across the board—people of all ages and stages, and lifestyles, and socio-economic levels, etc. And yet there is still a stigma. So I'm wondering if you can actually talk a little bit, to our nursing listeners, around, ah, how you, in your work, are addressing that stigma.

Chris Arnott:

This issue of stigma, it's a significant barrier to individuals seeking the help that they need, for fear of the stigma they're going to encounter when they try to reach out to, ah, service providers, healthcare providers. Establishing—or trying to establish safe injection sites, or consumption and treatment services sites, you need to do community consultation to ensure that the community is accepting of these kinds of services. And there's stigma that exists with that. And so by not not having those services available, that's detrimental to the individuals who need them. So, I mean, stigma is far-reaching, and it really acts as a barrier for individuals getting the help they need.

And so what we ended up doing here in Durham, as part of our opioid response, we undertook a project that involved creating four videos addressing different aspects of stigma. The participants in the videos were various individuals from the community.

They were champions; they were people in leadership positions; service providers; healthcare providers. We had people with lived experience: individuals who they themselves had substance use disorders; individuals with family members who suffered from substance use disorders. And so the intent of those videos, and the supporting information, was really to relay the message that no one is immune to developing an opioid addiction, in addition to increasing the awareness and the understanding of stigma. But it was also intended to increase compassion—compassion around that issue—and that really anyone who has a substance use disorder is deserving of health care, just as any other health condition that a person may have.

Susan Blue:

Chris provided some insights on the public health nursing role and the type of nurse who would be interested in this kind of work.

Chris Arnott:

It's a specialization area, as any other area in nursing is. It's very different, in that you don't have day-to-day client-patient interaction. It's a lot of research. You're looking at the evidence and becoming informed on different topic areas. It's very political; you need to have an understanding of what's happening politically on whatever your health issue is.

And again, it depends on what area in public health you're interested in. There is that patient contact, but there's other areas where you're involved in policy development where you're working at a broader perspective at a population-health perspective.

Susan Blue:

We also asked Chris to share with us how she evaluates success in her practice.

Chris Arnott:

Many of the outcomes of our effects, of our programs, you don't see those immediate outcomes, or even an outcome a week or a month down the road, like you would perhaps with other health issues or other kinds of client interactions. Our work can take years for shifts in health views and policies to change.

I think a big example of that would be tobacco legislation. We remember when you could smoke in hospitals. You could smoke in the restaurants. That was many years in the making, getting to the point of where we now have smoke-free sports fields. It took years to get to that point.

Susan Blue:

Based on the fact that you've been working in this field for three decades, are there any sort of final thoughts that you would leave for our listeners?

Chris Arnott:

This is a conversation that often comes up when we're mentoring students at the Health Department. And clearly, public health is not for everyone. Again, there are those

individuals who really like the clinical setting, the hospital setting. And it's not to say that in public health we don't have programs that don't involve that direct client engagement, but a lot of the public health programs are population-based, population level, and so we are looking at communities as the client. And so, while you may not get that energizing directly that you get from client interaction, the population level or the community level brings with it just a whole other array of strategies and experiences that you get.

I've spoken about the political experience. Understanding your community as a whole—the different layers, the different influencing factors—just understanding your community as your client. The other piece is the health of the community contributes to the health of the individual. And so, really, there's a real synergy between the two.

And so if that's an area that interests you then give public health a try.

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Susan Blue:

Thank you for listening to *Stories From The Field*, hosted by me, Susan Blue...

Maureen Cava:

... and me, Maureen Cava.

We are so grateful to the Ontario Public Health Nursing Leaders Association, and the Chief Nursing Officers, for their support in identifying public health nurses willing to share their stories.

Susan Blue:

This series is produced by Katie Jensen and Sabrina Brathwaite of Vocal Fry Studios.

Maureen Cava:

There are five other episodes in this series. And we'd love it if you could listen to them all. Thanks for listening.

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