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International Nurse-Family Partnership® (NFP)

Phase Four Annual Report

Phase Four - Continued Refinement and Expansion
This phase includes; building capacity and establishing sustainable systems for funding; embedding clinical leadership; selecting and developing new sites; recruiting and educating new NFP nurses and supervisors; and continuously improving program implementation, including refinement and use of the NFP information system. It is expected that countries will move to a higher level of self-sufficiency during this phase while continuing to meet licensing requirements through the annual review process, including completing this annual report. Any substantive change in the way NFP is implemented will continue to require approval of the PRC.

Purpose of annual report:
As part of the license agreement with the University of Colorado, each country is required to prepare and submit an annual report. Through the annual report, data is reported, analysed and reviewed, to guide discussion of the country's implementation successes and challenges, as well as emergent outcome variations. The annual report forms the basis for annual review of NFP implementation and fidelity in licensed partner countries and for discussing quality improvement plans. By using quantitative and qualitative data, the annual report creates an opportunity for each country's leadership team to reflect on progress and develop quality Improvement plans for the following year.

Completing the report:
The country license holder is requested to coordinate the completion of this report, with contributions from the national implementing body, and others, as required.

Please note: If you are unable to complete any items in the report template, please indicate whether this data is not collected in your country or is not able to be analysed at this time. Where terms used in the report template are generic, please specify how items are measured in your country. Where you have adapted your data collection schedule/timings or approach to accommodate local systems, please adapt the document as necessary to take account of this.

The report will be sent to the Partner NFP lead at least three weeks before the review. If there are any issues, please contact the Global Director or Coordinator.

PART ONE: PROGRAM OVERVIEW

Name of country: Ontario, Canada
Dates report covers (reporting period): Jan 1, 2023 to Dec 31, 2024
Report completed by: Lindsay Croswell, Ontario NFP Nursing Practice Lead (Clinical Lead)
Date submitted: March 11, 2024

Agency acronyms:
MLHU – Middlesex London Health Unit
HPHS – City of Hamilton, Public Health Services
TPH – City of Toronto, Public Health Division
RMON – Regional Municipality of Niagara, Public Health and Emergency Services
YRPH – Regional Municipality of York, Public Health Branch
HPEPH – Hastings Prince Edward Public Health
PPH – Peterborough Public Health
HKPR – Haliburton, Kawartha & Pine Ridge District Health Unit
KFL&A – Kingston, Frontenac, Lennox and Addington Public Health
SWPH – Southwestern Public Health

The size of our program:

Fulltime NFP Public Health Nurses (PHNs)	6 MLHU 4 TPH (+1 PHN on leave) 3 YRPH 6 HPHS (1 PHN is team lead, providing RS while carrying a small caseload) 6 RMON (1 PHN is team lead, providing RS and carrying a small caseload) 2 PPH & HKPR 2 HPEPH & 3 KFL&A **Total FTE PHNs (full-time) = 32 (+1 PHN on leave)**
Parttime NFP PHNs	0 MLHU 0 TPH 0 YRPH 0 HPHS (1 PHN is team lead, providing RS while carrying a small caseload) 0 RMON 2 PPH & HKPR 0 HPEPH & 1 KFL&A **Total FTE PHNs (full-time) = 1.5**
Fulltime NFP Supervisors ***all Program Managers have additional non-NFP assignments/staff reporting to them but are fulltime***	2 MLHU (Supervisor and Program Manager) 1 TPH (Program Manager) 1 YRPH (Program Manager) 1 RMON (Program Manager) 1 HPHS (Program Manager) 2 PPH & HKPR (Program Managers) 2 HPEPH & 1 KFL&A (2 Program Managers) **Total FTE Supervisors (full-time) = 11**
Parttime NFP Supervisors	0 MLHU 0 TPH 0 YRPH 0 RMON 0 HPHS

	0 PPH &HKPR 0 HPEPH & KFL&A (1 Supervisor) **Total FTE Supervisors (full-time) = 0**
Total FTE (PHNs and Supervisors)	**44.5 (+1 PHN on leave)**

*RS (Reflective Supervision)

Key Points:

- 9 implementing agencies
- 7 sites/teams (NFP supervisor-led groups of NFP PHNs), we have 4 agencies working in partnership as 2 sites/teams
- Ratio of NFP PHNs to supervisor ranges between 1-7 NFP PHNs to 1 supervisor (all sites have additional, non-NFP direct reports ranging from 2-15 per supervisor that completes Reflective Supervision with PHNs)
- No mediators or FPW positions
- No part time PHNs or Supervisors (there are 3 PHNs who work full-time, but are only assigned to NFP part-time)
- 4 of 7 sites/teams are delivering the program in a shared supervision model where the supervisor provides weekly 1:1 RS (2 sites have supervisors carrying part-time caseloads and a Program Manager (also having completed NFP Education) completes RS with the supervisor and oversees performance management requirements
- 4 new agencies partnering to create 2 new sites/teams were established over the reporting period, no sites decommissioned NFP over the reporting period, 1 new site/team will be established in 2024

Successes/challenges with delivery of NFP through our implementing agencies/sites:

Summary:

- Sites continue to report that strong senior leadership support greatly contributes to the success of the program
- Several sites experienced unexpected staffing changes (leadership changes, retirements, PHN leaves etc.) that impacted plans to complete program promotion, outreach and sometimes resulted in multiple client transfers to new PHNs; sites that report low staff turnover have highlighted the continuity this provides for clients

- HPHS returned to hosting client events that provide barrier-free opportunities to engage young families in community-based activities in a variety of locations within the community (e.g., recreation centres, libraries) that include bus tickets, incentives, food, and fun activities
- KFL&A prioritized potential NFP clients at their agency's intake resulting in quicker response times; data collection and reporting process has been a significant learning curve for supervisor but acknowledgment that it will increase understanding and improve quality of documentation and forms completion
- RMON reported challenges with some community partners not making referrals despite program awareness, planning continues for establishing a community advisory board; they report strong relationships with other partners like community health centres and some obstetricians making consistent referrals
- RMON also reported continued success with their unique model of shared supervision and how they have found increased success around client engagement when they are most flexible and accommodating for client needs
- TPH reported challenges related to increased staff transit time due to the large urban geographic spread of Toronto paired with the reality of clients moving frequently
- YRPH reported that lack of overall referrals continues to be a challenge and reflected on the impact of times when clients are most difficult to engage or may withdraw from service delivery: prior to enrollment, times of increased stress/crisis

Description of our national/ implementation / leadership team capacity and functions

License holder name: Dr Alexander Summers

Role and Organization: Medical Officer of Health, Middlesex-London Health Unit (MLHU), on behalf of all the implementing sites in Ontario

Description of our National implementing capacity and roles:

Canada now holds three licenses across three provinces. While there is no single national leadership and implementation team, the province of British Columbia (BC) and the team in the province of Ontario (ON) have participated in a Canadian Collaborative for NFP since 2017. This collaborative has worked hard to build shared leadership, advocacy, research and resource capacity across provinces while respecting the need to make program and education decisions regarding implementation at the provincial level. Nova Scotia launched implementation of NFP in the fall of 2023 and will be welcomed to participate in the collaborative moving forward. The Terms of Reference for the NFPCC were last updated in the fall of 2019 were included in 2020's annual report and are available upon request.

1. Clinical Leadership:

MLHU continues to employ a Community Health Nurse Specialist as the Ontario NFP Nursing Practice Lead to fulfil the responsibilities of an NFP Clinical Lead. Funding for this position continues to be shared among NFP implementing sites in Ontario. The current lead has not changed since our last annual report. She had previous experience in the role as the Provincial Clinical Lead during the CaNE pilot and has 6 years of NFP home visiting experience she brings to the role.

Ontario NFP Nursing Practice Lead responsibilities:

A. Education Lead (e.g., develop/revise curriculum; plan and deliver face-to-face/virtual education sessions)
B. Coordination/Liaison (e.g., liaise between work groups/committees; organize and chair/co-chair meetings; liaise between NFP sites, NFP international stakeholders, McMaster School of Nursing; coordinate, draft, and present annual report)
C. Nursing practice consultation (e.g., provide consultative support to sites regarding nursing practice, documentation, and program fidelity by phone and in person)
D. Implementation leadership (e.g., develop resources; provide resource consultation for sites; develop and lead CQI process for Ontario, lead Ontario NFP Data Collection Workgroup and associated tasks; initiate CQI activities to contribute to overall CQI processes (e.g., documentation scan, education evaluations, site report templates, etc.); give guidance on and participate in development of program material; create reference documents for practice consultation)
E. Marketing & communication (e.g., maintain/provide shared access to marketing templates for service providers and clients; consult on marketing materials; facilitate approval by NFP International and NSO; ensure timely communication of program updates to sites; manage education website; upload website content; provide website access for all new/ongoing NFP PHNs and supervisors)

2. Data analysis, reporting and evaluation:

Since 2019, our sites have been transitioning to the use of site-specific electronic client record systems (where NFP forms are completed electronically) to help produce the requested program data. Ontario's Ministry of Children, Community, and Social Services (MCCSS) provincial database (referred to as ISCIS) also continued to be utilized to collect data and provide monitoring reports related to program standards, expectations and CQI. The Ontario NFP Data collection workgroup continues to revise the shared data dictionary annually (based on reviewing the previous year's data collection, reporting and analysis process and again when the NFP Annual Report templates were updated with additional data requests) to guide the process of data reporting and analysis across multiple databases and documentation systems. All sites have been using the NFP forms revised by the group in 2019 for the entire reporting period. The instructions and guidance on forms is reviewed annually to reflect any feedback with the goal of continuing to improve the accuracy and consistency of data collection. One member of the data collection workgroup (who is a data analyst for the health unit in Niagara) has continued to provide additional support to the Nursing Practice Lead for data analysis and participates on the NFP International Research and Analytical Forum.

3. Service development/site support:

Site implementation is led by NFP directors and supervisors, in consultation with and guided by the Ontario NFP Nursing Practice Lead, who continues to develop implementation resource documents for Ontario that are accessible online and modelled after the NFP International guidance documents. In this expansion phase of NFP in Ontario, the MLHU Director (responsible for NFP) and NFP Nursing Practice Lead continue to engage with interested agencies considering NFP implementation and support those agencies to assess readiness and initiate implementation if and when they are ready.

4. Quality improvement:

See CQI program section for details on the planned CQI process

5. NFP educators:

The Ontario NFP Nursing Practice Lead is lead educator in Ontario. Since the CaNE pilot, she has facilitated all phases of the education model. In addition to curriculum development, Dr. Susan Jack initially facilitated all IPV education in Ontario. The Nursing Practice Lead began co-facilitating the IPV education in 2019 with the intention of developing a sustainability plan for IPV education. In 2023 Ontario continued co-facilitation of virtual education cohorts with BC, assessing the strengths and needs of this approach as a comprehensive education sustainability plan is being considered as part of post-RCT planning.

Since 2021, a select group of NFP Supervisors and PHNs from both provinces have been able to support education planning and delivery.

For more details on education in Ontario, see the NFP education section.

6. Other (please describe):

Jennifer Proulx is the current public health Director and the Chief Nursing Officer for the Middlesex-London Health Unit, the current Ontario NFP license holder. Jennifer was previously the NFP Program Manager since the beginning of the CaNE pilot. The director continues to provide leadership and guidance on NFP strategy and implementation in Ontario, co-chairs the NFPCC, chairs the Ontario PAC and Steering Committees, supervises the Ontario NFP Nursing Practice Lead and the NFP program manager at MLHU, and liaises with MCCSS regarding NFP work in Ontario. The administrative assistant to the Director provides administrative support for the Ontario PAC and Steering committees. The Directors responsible for NFP at each public health site are all members of the Steering Committee and many have been members of the Provincial Advisory Committee (PAC).

Dr. Susan Jack was the principle investigator for the CaNE pilot, and due to her NFP expertise, has continued to

provide significant guidance, leadership, and IPV education support to NFP program delivery in Ontario. In addition, she continues to contract staff and experts to design and maintain the technical components of the education platform. She continues to work on behalf of the McMaster School of Nursing, with the Ontario NFP Nursing Practice Lead, on curriculum refinement and further transformation of the curriculum into an e-learning format.

Sonya Strohm is a program manager in the School of Nursing at McMaster who works with Dr. Susan Jack. She has been a contributing member of Dr. Jack's research teams since the Hamilton pilot. In addition to research, her role supports the maintenance of the NFP Canada website (e.g., adding content updates and new users) and program content revisions as a member of the Canadian Clinical Workgroup.

Description of our local and national NFP funding arrangements:

The Ontario Ministry of Children, Community and Social Services (MCCSS) has approved allocation of funds earmarked for nurses, managers and administrative staff from the Healthy Babies Healthy Children (HBHC) Program to implement NFP in Ontario in most sites. In addition to funds received from MCCSS, some of the sites allocate cost-shared monies received from the Ministry of Health and local municipalities to fund nurses, managers, administrative staff, and program supplies for the full implementation of the NFP program. Four health units (MLHU, RMON, PPH & HKPR) use Ministry of Health funding only to implement and deliver NFP. One health unit (TPH) uses funding only from MCCSS to implement and deliver NFP. Four health units (YRPH, HPHS, HPEPH, and KFL&A) use a combination of funding from both the Ministry of Health and MCCSS to implement and deliver NFP. In these health units, it is typical for staffing costs to be covered through the MCCSS funding envelope, and for shared NFP program costs to be covered from Ministry of Health funding. However, it is important to note that across these three health units, the funding ratio (from MCCSS and the Ministry of Health) allocated to NFP implementation and delivery does vary. The Hamilton site has received an annual grant since 2019 from the Hamilton Community Foundation for operational needs. Some sites have leveraged in-kind contributions from community partnerships (e.g., participation on Community Advisory Committees).

Current policy/government support for NFP:

The collaborations and foundational infrastructure developed during the CaNE pilot remains in place at present and could be used in scaling-up the NFP program across the province. NFP complements the existing home visiting program, Healthy Babies Healthy Children (HBHC), which is funded by the Ministry of Children, Community and Social Services and offered by all public health units across Ontario. Home Visiting funding in general has been sustained in Ontario public health units since the 1990s. Ontario invests over $80 million annually in the HBHC home visiting program for families in the early years. The HBHC program is initiated through a screening tool which identifies parents and children at-risk, and services are delivered to eligible 'with risk' clients. The screen can be completed during the prenatal, postpartum, or early years' time periods. Early postpartum screening is completed universally across the province. HBHC is a voluntary home visiting program in which a PHN completes evidence-based assessments (e.g., NCAST), and provides education, nursing support, and service coordination, while a Family Home Visitor paraprofessional (FHV) in many sites (but not all) provides hands-on application of teaching and social connection. Families can receive visits starting during pregnancy until school entry, and involvement typically ranges from 1 month to 1 year. Involvement (content and duration) is directed by the family's goals and focuses on learning about healthy pregnancy and birth, connecting with their baby, how children grow and develop, being a parent, breastfeeding, healthy nutrition, creating a safe environment, self-care, and other community services for children and families. PHNs generally visit once every 3-5 weeks and FHVs visit every 2 weeks. In nurse-only

models of care, PHN's visit approximately every 3 weeks, with frequency of visits influenced by family need.

The addition of NFP to the suite of current home visiting programs in Ontario has strengthened services provided to families in Ontario by public health units. Given the success of the feasibility and acceptability pilot study completed in Hamilton, evaluation/research being conducted in BC, the educational framework established by the CaNE project, and the success of NFP in its ongoing implementation in five health units in Ontario since the conclusion of the CaNE project, NFP was well-positioned for expansion in Ontario beginning in 2023.

The introduction of NFP into this province has occurred at the grassroots level and has not been an initiative of the Provincial Government. However, the Ontario NFP license holder, McMaster-based NFP research team, as well as local NFP champions from participating health units, continue to increase awareness about NFP with key policy leaders in the Ministry of Health and the Ministry of Children, Community and Social Services. Over the last 8 years, interest and engagement from Ministry staff has progressively increased and there has been a focus on the successful integration of the home visiting programs (HBHC and NFP) within the initial 5 health units delivering the NFP program. In 2019 there was a funding commitment made by the MCCSS to enhance the online education modules for the NFP education curriculum developed during the CaNE project. In 2020, this commitment developed into a project with McMaster School of Nursing aimed at providing support to home visiting programs, specifically aimed at learning how programs pivoted to provide service during the pandemic and funding work to develop practice guidance where the needs are identified. This funding has continued through 2023.

At the end of 2022, our NFP Steering Committee began developing a briefing note aimed at advocating for the expansion of NFP in Ontario as a policy option to address current provincial needs and priorities. These priorities include supporting primary care capacity, easing the pressure on emergency rooms through reduction in paediatric emergency visits, increasing school readiness and improving childhood immunization rates impacted by the pandemic. Two committee members led the work on completing this policy brief document and it was made available in early 2023 on the PHN PREP website.

Organization responsible for NFP education:

For details on the education phases and curriculum, including a link to the applicable CaNE summary report, see NFP Education section.

NFP supervisor and nurse education is the responsibility of the license holder and is led by the Ontario NFP Nursing Practice Lead. Hiring of nurses and supervisors/managers is completed by the supervisors, program managers, and directors at each site. When a new staff is hired, the supervisor or manager informs the Nursing Practice Lead who arranges an introduction by phone/video, creates a user profile for the staff on the education website, and requests a user profile for them on the NFP Canada website (where they access the visit-to-visit guidelines). Once given access, staff begin working through the online self-study phase NFP Foundations (unit 1) at their own pace. The NFP Foundations (unit 2) is offered in-person and virtually. Since the CaNE pilot launched in 2016, one to two cohorts have been educated each year. In 2020, in response to the pandemic restrictions, ON completed its first virtual education cohort in collaboration with BC. Since then, ON has offered two annual virtual education cohorts in collaboration with BC, focused on meeting education needs related to staff turnover at exisiting sites. In-person education is prioritized for new sites implementing NFP and is offered based on need.

Description of any partner agencies and their role in support of the NFP program:

As outlined above, the MCCSS has provided their support for sites to continue implementing NFP as a targeted intervention under the broader umbrella of home visiting programs in Ontario. The Ministry of Health publishes the Onatio Public Health Standards which identify the minimum expectations for public health

programs and services to be delivered by Ontario's 34 boards of health/public health units. Nurse-Family Partnership contributes to meeting the requirements outlined under the Healthy Growth and Development Program Standard and the Healthy Babies Healthy Children Program Protocol.

McMaster University and more specifically, the School of Nursing (for ongoing implementation support) has led the research and advocacy work for the NFP in Canada. Dr. Susan Jack (Professor in the School of Nursing) continues to work closely with our leadership and governance groups in Ontario in addition to being the program founder and lead for the Public Health Nursing Program, Research and Education Program (PHN PREP) at the School of Nursing. In partnership with MCCSS, PHN PREP develops, evaluates and mobilizes evidence-informed resources to support home visiting program teams (including NFP) in Ontario. Dr. Harriet MacMillan (Distinguished University Professor in the Departments of Psychiatry and Behavioural Neurosciences and Pediatrics) also was an active member of the NFP Collaborative in Canada.

Some sites have formed Community Advisory Boards with representation from local community partners to inform and support program implementation. Objectives of CABs include: to better understand client needs, identify existing resources and service gaps, and identify and implement actions to ensure a solid continuum of support and opportunity for NFP families; to facilitate community awareness of, and ongoing support for, the NFP program as an integral component in a spectrum of community supports; to generate and sustain referrals into the NFP Program; to facilitate NFP clients' access to needed services; to support assessment of and response to NFP program implementation challenges; and to provide consultative support to the NFP program regarding quality improvement.

Other relevant/important information regarding our NFP program: none at this time

PART TWO: PROGRAM IMPLEMENTATION

Clients

392 unique NFP clients participated in the program over the last year (clients with at least 1 visit during the reporting period)

There were 275 current NFP clients at the time of the report (active as of Dec 31, 2023)

Total number of current clients per phase:

- Pregnancy 107/275 (39%, 2022 was 25%, 2021 was 20%)
- Infancy 115/275 (42%, 2022 was 41%, 2021 was 34%)
- Toddler 53/275 (14%, 2022 was 27%, 2021 was 46%)

Nursing Workforce

- Average nurse caseload for existing sites: 14.4 (London 11, Hamilton 13, York 14, Niagara 17.8, Toronto 16)
- Average nurse caseload for all sites (including those that launched during reporting period): 10.9 (HPE 9, KFL&A 4, PPH/HKPR 2)
- Changes to the Supervisors/Managers included the Hamilton site Program Manager retiring and a new structure emerging for the division of NFP leadership responsibilities that includes a Senior Manager and Program Manager with NFP under their portfolios.

	Nurses	**Total across sites**
# of staff at start of reporting year:	MLHU 6 YRPH 4 RMON 6 HPHS 6 TPH 4 (+1 on leave) HPEPH & KFL&A 6 PPH & HKPR 4	36
# of staff who left during reporting period	MLHU 3 YRPH 0 RMON 1 HPHS 0 TPH 1 HPEPH & KFLA 1 PPH & HKPR 0	6
% annual turnover	MLHU 50% YRPH 0% RMON 17% HPHS 0%	8%

	TPH 20% HPEPH & KFLA 17% PPH & HKPR 0%	
# of replacement staff hired during reporting period	MLHU 3 YRPH n/a RMON 1 HPHS n/a TPH 1 HPEPH & KFL&A 0 PPH & HKPR n/a	5
# of staff at end of reporting period:	MLHU 6 YRPH 4 RMON 6 HPHS 7 TPH 4 (+1 on leave) HPEPH & KFL&A 5 PPH & HKPR 4	36
# of vacant positions	MLHU 0 YRPH 0 RMON 0 HPHS 0 TPH 0 HPEPH & KFL&A 1 PPH & HKRP 0	1

Reflections (including successes/challenges with recruitment) on NFP nurse/supervisor turnover/retention during reporting year:

- Unexpected leaves of absence, parental leaves of absence, and attrition due to organizational budget constraints and restructuring in a unionized environment was noted as challenges by 2 sites
- The time needed for hiring and then orientation, education and availability of peer mentors has presented challenges for sites in 2023
- Additional COVID funding received by agencies ended in 2023 presenting some challenges in terms of positions changing throughout the agency resulting in an increased number of applicants to NFP vacancies (more time spent interviewing but challenging to find appropriate candidates for NFP in this wider applicant pool)
- Despite challenges, most sites reported no issues with recruitment and low turnover (relative to the size of the teams)
- Leaders have discussed challenges and shared resources during community of practice meetings to support one another to maintain staffing stability and improve the recruitment process (e.g., posting templates, interview questions, qualification requirements)

Any plans to address workforce issues:

- Continue to address challenges around recruitment as they arise with community of practice

- Review our mentorship guidelines (developed in 2023) to ensure they are meeting the needs of new staff orientation

NFP education

Briefly describe your NFP education curricula:

CaNE Report linked here: Nurse-Family Partnership Education Curriculum for Use in Canada - summarizing the curriculum development and components as piloted in Ontario

Overview:

PHNs and supervisors' competencies:

1. Application of theories and principles integral to implementation of the NFP Model
2. Use of evidence from NFP randomized controlled trials and data systems to guide and improve practice
3. Delivery of individualized client care across the six program domains
4. Establishment of therapeutic relationships with clients
5. Utilization of reflective processes to improve practice

NFP Curriculum:

The curriculum consists of: 1) a three-phase approach to PHN education; and 2) NFP supervisor education. Both supervisors and nurses are required to complete the NFP PHN education. The three phases of the Canadian NFP PHN education are:

1. ***NFP Foundations***: Completion of short chapters (still in process of transforming into E-Learning modules), augmented by independent reflection and suggested team-based discussions, accessed through the NFP Ontario web-based learning management system. This educational phase (20-25 hrs) is focused on increasing knowledge of: NFP history, evidence, core model elements, theories, and visit-to-visit guidelines; client-centered principles, reflection, parenting, attachment, communication, recruitment and retention, intimate partner violence (IPV), and nursing assessment forms. Learners are introduced to a Canadian NFP program model, a nursing theory (Critical Caring Theory), and principles of trauma-and-violence informed care.
2. ***NFP Fundamentals***: Engagement in a five-day face-to-face or 6 half day virtual, interactive learning environment, expertly facilitated by an NFP Educator. The focus is on the development of the specialized nursing skills required to deliver NFP. Learners have an opportunity to discuss, practice, and apply their knowledge of the NFP program through group reflection, role playing, and completion of NFP tools, resources, and assessment forms. The integration of new program innovations is highlighted, including use of the NFP program's Strengths and Risk (STAR) framework.
3. ***NFP Consolidation and Integration***: Consolidation and application in practice of knowledge and skills acquired in the first two phases of education. This consists of phased professional development completed at the local public health unit and coordinated by the NFP Supervisor. While on-going professional development is expected for as long as nurses and supervisors are delivering the NFP program, the consolidation and integration phase of learning is considered complete after 1 year of practice. Learning strategies include job shadowing with experienced NFP PHNs, completion of NFP team meeting education modules, guest speakers to provide additional content on priority topics, site visits to community partner agencies, and technical support/mentorship from the NFP Nursing Practice Lead. Additional on-going education opportunities have been included since 2020 as part of the monthly NFP Live in Ontario calls (formerly Live with Lindsay).

The Supervisor Education curriculum consists of completion of the above three phases as well as specialized training following each phase to support the development of NFP supervisor competencies. Additional supervisor education consists of:

- NFP Foundations (three additional e-learning modules on NFP supervision, reflective supervision, and client recruitment and referrals, taking approximately 10 hours to complete); and
- NFP Fundamentals (additional four day in-person training focused on skill acquisition in leadership, reflective supervision, and coaching, addressing compassion fatigue and job stress, implementation and supervision of IPV pathway, continuous quality improvement, and facilitation of ongoing NFP training)

Changes/improvements to NFP education since the last report:

After several versions of our NFP Fundamentals education participant workbook, and several methods of access/providing it to participants we have implemented an updated strategy beginning in 2023. We now provide a PDF fillable version of our workbooks for participants, accessible on our education website/learning platform. Participants can choose to print a hard copy (through their health unit) or use it electronically for their education. Although this is a small change from automatically printing a hard copy or providing both a PDF or Word version to participants, this change ensures that only 1 copy needs posting and participants using an electronic version are all on a consistent page number.

An Ontario Education Syllabus was developed in late 2022 and became an integral part of orientation for new staff in 2023. It includes guidelines for mentorship of new sites that will be reviewed and revised in 2024. The Nursing Practice Lead revised it as needed throughout the year and ensured that all new staff were sent it by email and then (as it indicates) booked a Teams meeting to review the role of the Lead as well as the education program. So far, the ability to revise and keep it an evergreen document has been invaluable to communicating the most current guidance around staff orientation and education.

This was the first year we created an annual schedule of education dates (BC and ON), intentionally creating 6 months between the two cohorts of shared virtual NFP Fundamentals education and appropriate time between the supervisor only education, IPV Fundamentals virtual education, ongoing IPV education and ON Annual Team Education Day. This helps to create better work planning for prepping and facilitating education as well as communication and planning for teams that are hiring. The current syllabus is available upon request.

Facilitator Guidance Documents were developed for each NFP Fundamentals session with educator notes, options for virtual or in-person delivery and an updated deck of slides. These primary slide decks and facilitator guides were provided to the Nova Scotia Education Lead during their orientation with the ON Nursing practice Lead. We are also hopeful they will increase support and consistency for new educators as our teams expand and/or evolve in our individual provinces.

Successes/challenges with delivery of NFP education and CPD:

In 2023 we were able to return to in-person education with the onboarding of our two new teams/4 sites. We continue to recommend that new sites complete in-person education instead of completing it virtually based on the positive feedback received and assessment of educators. Any sites in Ontario with new staff were welcome to attend the in-person cohort if feasible (instead of waiting for a virtual cohort), and 2 sites did in fact send 2 new PHNs each.

Quote from in-person education feedback survey (Feb 2023):
"This training has been extremely useful and has increased my confidence level in understanding my curriculum and the role of being an NFP nurse. I love that there was many opportunities for open

discussion as that is where I find I get the most rich education hearing advice and experiences from other more seasoned home visiting nurses. [The Educator] has been incredible at delivering the content in a fun and interesting way!"

We hosted the first cross-provincial ongoing IPV education day in the Fall of 2023. This was an opportunity for all NFP PHNs and Supervisors in ON, BC and NS to join a call to discuss case scenarios using the IPV Clinical Pathway. While the event was considered a success, there was valuable learning completed for hosting future calls of the same size and scale. Feeback received has been helpful for future planning. Moving forward, the agenda will accommodate additional time in small groups and increased facilitation needs during the debrief portion.

During our June in-person NFP Fundamentals cohort we welcomed the new Nova Scotia (NS) education lead to participate and observe. She gained a foundational understanding on the NFP education model used in ON and we were able to support her in planning for the implementation of NFP education in NS. Next steps include planning for collaborative education work and supporting the first cohort of education in NS in Jan 2024.

Reflective Supervision

Successes/challenges with NFP nurse reflective supervision:

- HPHS reports successfully implementing another variation of a shared model of supervision where a PHN, called a Home Visiting Specialist, carries a half caseload and provides 1:1 reflective practice facilitation weekly with the individual team members; program data submitted by the site showed a significant decrease in the average number of sessions per PHN for 2023 (from an average of 33 sessions annually over the previous 4 years to 12 sessions in 2023). As such, we will explore this during their annual data review meeting
- While one site reports they continue to prioritize the regular frequency of RS (missing only when staff are off on leave or ill) because it continues to be viewed as such a positive support, another site reports that PHNs feel the required frequency is too much but have strategized shorter sessions when there is less to address
- Although the average number of accompanied home visits across sites has increased since last reporting period, it is still below the expected benchmark and sites (especially new sites) have acknowledged this, committing to making it an area of focus for 2024
- Newer sites reflected on the challenges of RS (including capacity when visits are frequent and schedules are full and the pull towards clinical supervision when client complexity is high) and the value added to practice for both the PHN and supervisor (experienced support, structured/dedicated time for RS, intentional planning for next visits); they also commented on the use of virtual meetings when needed to help alleviate some of the pressures of capacity and scheduling
- A challenge reported by our new and partnering agencies/shared sites is when PHNs are not working exclusively in NFP it presents challenges in terms of time to meet weekly for reflective supervision and flexibility to accommodate client schedules, but a success reported is the use of cross management supports being helpful for covering reflective supervision when needed

NFP Information System

High level description of our NFP information system, including how data are entered:

Data in British Columbia, Ontario and now Nova Scotia continue to be collected and analyzed separately. In Ontario there continues to be an absence of a dedicated NFP Information System shared across sites. The sites are mandated to utilize a provincial data system (called ISCIS) as part of the provincially mandated home visiting service program. Some reports are pulled from this provincial database for NFP indicators per site and may include the number of completed visits, referrals, travel time and visit time, however, the NFP data collection forms cannot currently be integrated into this system. In addition, sites utilize different systems to support nursing documentation, as well as health unit specific assessments and forms.

Guided by the Ontario NFP Data Dictionary definitions, sites utilized the reporting capabilities of their specific documentation systems and ISCIS to pull data to complete the site data report developed by the Nursing Practice Lead.

Once again for this reporting period, updated site data report templates were created for sites to complete and then the Nursing Practice Lead compiled all individual reports into one collective report for Ontario (attached). The report included fidelity indicators, outcome indicators and site-specific reflections using the data collected by the forms to contribute to the content of this overall report.

Commentary on data completeness and/ or accuracy:

Five incoming transfers were reported across sites but only four clients were reported having been discharged due to the reason “transferred to another NFP site” during 2023. Unfortunately, there is still no way of integrating client specific data when this happens so we don’t know where the missing data is. However, this is the first year that we can we have both sets of data instead of only reporting on the discharge reasons. Average caseloads are challenging to interpret with staff “leaves” and new sites beginning implementation at various points throughout the reporting period. Finally, the data collected in the Health Habits form on the quantity of cannabis consumed by clients, may still be inaccurate as stated in the 2022 annual report. At present, the question only accounts for consumption by smoking joints or pipes and not in the form of edibles or drinks. It is challenging for clients to convert the amount consumed in this case. Revisions to the language used in this data collection question have been made and will be implemented beginning Jan 1, 2025. Some sites have limited ability to pull new data from NFP forms when there are additions to reporting requirements. For example, MLHU was not able to report on Depression or Anxiety scores for 2023.

Description of reports that are generated, how often, and for whom:

Since 2019, NFP site data reports have been generated annually using the template developed by the data collection workgroup and sent by the Nursing Practice Lead. Individual site reports are combined and cleaned by the Nursing Practice Lead to create a single report for Ontario to inform the annual report. The goal of quarterly reporting (first identified in 2020) continues to be evaluated but reporting on all indicators has remained impossible due to capacity. However, new this reporting period, Supervisors/Managers were able to provide monthly data related to team caseloads, number of referrals and enrollments. The Nursing Practice Lead facilitates an annual report data presentation and discussion for each individual site and then creates an overview of the most relevant data and information for sending to the Steering Committee and Provincial Advisory

Committee.

Supervisors/Managers can review monitoring reports produced by the provincial database ISCIS. These reports include program data like visits completed and the format, caseload information, and referral information.

Our reflections on our information system - what we need to do to improve its functionality, usefulness and quality:

See CQI Section (CGQ goals) for next year

Any other relevant information: none at this time

PART TWO: PROGRAM IMPLEMENTATION - NFP CORE MODEL ELEMENTS (CMEs)

Please complete the table below to identify how the CMEs are being monitored/assured, benchmarks for your country, progress against benchmarks, and actions planned or undertaken to address any challenges. Where there is a need to add more content than space allows, please add appendices as necessary. Please also explain any missing data or analyses as necessary.

NB: Where any temporary variances to the CMEs have been agreed, please indicate these in the text box below as well as completing Appendix 2 of this document

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Commentary: Challenges + suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% voluntary participation Monitored /assured by: (e.g., by signed informed consent)	100% voluntary participation	
2. Client is a first-time mother	100% first time mothers enrolled	100% first time parenting experience	
3. Client meets socioeconomic disadvantage criteria at intake	The eligibility criteria for inclusion in the program in our country are: • First parenting experience • Meets age requirement (has varied across sites from 21 years and under to 24 years and under) • Experiencing socioeconomic disadvantage • < 29 weeks gestation This includes the socio-economic criteria of: screens 'at-risk' on general prenatal intake referral screen (completed for both NFP and Healthy Babies Healthy Children programs)	100% clients enrolled who meet the country's socioeconomic disadvantage criteria	

	which includes screening questions related to education, age, supports and income. Application of these criteria are assured and monitored by: prenatal screening at referral completed by PHN and confirmed by client at first contact.		

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Commentary: Challenges + suggested actions to address these
4. Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy.	a) 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy. b) 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. c) 60% of pregnant women are enrolled by 16 weeks' gestation or earlier	90% of NFP clients receive their first home visit no later than the 28th week of pregnancy 80% of eligible referrals who are intended to be recruited to NFP are enrolled in the program 27% of pregnant women are enrolled by 16 weeks' gestation or earlier	7/8 sites reported less than 100% compliance, 1 of which reported over 93% compliance. 6/8 reported less than 90% compliance but only 1 site reported less than 84% compliance (the average for 2022). Therefore, compliance increased by 6% over last reporting period to reach 90%. It is acknowledged however that we did not meet the goal of all sites reporting >98% compliance, as outlined by our approved variance. The enrolment rate for 2023 was 80% making it an improvement of 5% over our last reporting period and meeting our goal for this reporting period. There was a 1% improvement in the number of clients enrolled by 16 weeks' gestation. It is acknowledged that this is still well below the international benchmark of 60%. We plan to support willing teams in the establishment of CABs as one strategy to increase early referral and subsequent enrollment.

5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	100% of clients are assigned an identified NFP nurse.	100% clients are assigned an identified NFP nurse	It is acknowledged that despite clients always being assigned to a single PHN while they are enrolled, the number of transfers between PHNs has been higher than expected during the last three reporting periods due to short, temporary redeployments and staff turnover in some sites.
6. Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible.	Current National benchmark is not established. For Ontario we have indicated in our data dictionary that the benchmark is >50% of visits or "the majority."	80% in-person visits take place in the home % breakdown of where in-person visits are being conducted other than in the client's home: • Doctor/Clinic/Hospital: 2% • School: 1% • Public Health Office 0% • Child Welfare Office 0% • "other" location: 10% • Family/Friend home: 5% 14% of visits where second parent of child is present (NEW) 8% of visits where other family members participated (NEW)	

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Commentary: Challenges + suggested actions to address these
7. Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse.	Current National benchmarks are not established	100% of clients being visited on standard visit schedule (sites do not offer an alternate schedule as a permanent option; a standard schedule is the default for all clients and then is assessed and adjusted as the need arises, but it is always dynamic and being reassessed, therefore there is never a permanent alternate schedule offered). Average number of visits per client during the reporting period is 10.7 Length of visits by phase (average and range): • Pregnancy phase: average 55 min, range 46 – 60 min • Infancy phase: average 55 min, range 48 – 61 min • Toddler phase: average 55 min, range 47 – 61 min Client attrition by phase and reasons during the reporting period: 13% attrition in Pregnancy phase 28% attrition in Infancy phase 37% attrition in Toddler phase	Currently unable to accurately report on the total average number visits for clients and by stage (program dose). The average number of visits per client for the reporting period does not provide an accurate program dose reflection. There is planning underway to develop options for reporting on dose data in 2025. This is the third time reporting on client attrition by phase however, once again, it is only reflective of the total discharges for the reporting period and not reflective of true client attrition (overall/lifetime) in order to

		See Appendix 1 for more visit data including: graduation, attrition reasons	consider true program outcomes/impacts. Like with reporting on dose, there is a plan to develop options for reporting on overall attrition data in 2025.
8. NFP nurses and supervisors are registered nurses or	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by: Standardized hiring requirements for PHNs in Ontario	100% NFP nurses are registered nurses with a minimum of a baccalaureate /bachelor's degree	

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Commentary: Challenges + suggested actions to address these
registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.			
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	100% of NFP nurses and supervisors complete the required NFP educational curricula There is no national benchmark established for the % of NFP team meetings, case conferences and team education sessions that are completed. Ontario benchmarks for team meetings and case conferences are to complete both twice per month (approximately 25 annually).	100% of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities <u>Ontario Averages per team:</u> Team Meetings = 25 Case Conferences = 19 Team Education Sessions = 11	
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.	Please complete the section at the end of this table*.	Please complete the section at the end of this table*.	Please complete the section at the end of this table.

11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	100% of 4-monthly Accompanied Home Visits (AHVs) completed (against expected 3 per PHN annually).	1.3 - average number of AHV completed per PHN (0-3 range across sites, includes new sites)	It is acknowledged that while the average across sites did not meet the benchmark, the average improved since last reporting period and is the highest since pre-pandemic program implementation. 2/5 existing sites met the average benchmark of 3 and without our new sites the average for existing sites was 1.9. We expect this average to continue improving during 2024.
Core Model Element	**National/Country Benchmarks and how these are being monitored**	**Progress against Benchmarks**	**Commentary: Challenges + suggested actions to address these**
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	100% of NFP teams have an assigned NFP Supervisor 100% of reflective supervision sessions conducted against expected 30 per PHN annually (calculated by considering average across sites over 3 years and the expected number of working weeks based on vacation entitlement and paid provincial holidays).	100% of NFP teams have an assigned NFP Supervisor An average of 24.2 Reflective Supervision (RS) 1:1 sessions per PHN was reported for the reporting period in our existing sites whereas an average of 16 RS sessions was reported by new sites implementing for approximately 5 months. The range of average RS 1:1 session reported by sites was 11-35. Somewhere between an average of 47%-120% of the expected reflective supervision sessions were conducted. The range reported by sites (based on the average per PHN reported): Existing sites: • HPHS 40% (83% in 2022) • MLHU 117% (120% in 2022)	It is acknowledged that the Hamilton site significantly dropped in the reported average of RS 1:1 sessions. Although there were leadership changes, these do not fully explain this change. The Nursing Practice Lead will review this data during the site's

		• RMON 111% (100% in 2022) • YRPH 63% (67% in 2022) • TPH 70% (47% in 2022) New sites (using the expected average over the course of 6 months = 15): • HPEPH 160.6% • KFL&A 73% • PPH & HKPR 80%	annual site data review and explore local strategies to improve the average during 2024.
13. NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.	No benchmark. Monitored/assured by: The Ontario Data Collection Workgroup; all sites participating and following in the agreed data reporting process using a shared data dictionary; the Nursing Practice Lead compiling all site data reports, cleaning data and engaging sites as needed; providing final data report as part of the annual review	progress: The 2023 site data reporting process built on the method of data sharing (using SharePoint) revised over the last 2 reporting periods that continued to increase consistency in reporting	Planning work continued in 2023 with established goal of developing a process within each site for reporting on additional indicators for 2024. Seeking opportunities to collaborate on the data collection, reporting and analysis process continues to be included in post-RCT scenario planning between BC, Ontario and now NS.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Commentary: Challenges + suggested actions to address these
14. High quality NFP implementation is developed and sustained through national and local organized support	Current National Benchmarks are not established. Each board/group reported on has established their own meeting frequency and attendance expectations outlined by individual terms of reference.	There were no Community Advisory Board (CAB) Meetings held in 2023. (0% of the expected 1-2 meetings per year). There were no Provincial Advisory Board (PAC) meetings held in 2023. The NFP Collaborative in Canada (NFPCC) did not meet in 2023. The scheduling of meetings was postponed as the BC RCT results were not published until July of 2023.	There are 3 sites currently in the process of establishing CABs. Our PAC membership and objectives are currently being re-evaluated by the license holder. Provincially, our Public Health Standards are being reviewed and the outcomes could impact the implementation of NFP in Ontario. Ensuring the accuracy of membership and purpose moving forward is a priority. Despite not formally meeting, the NFPCC implementation leads from BC and ON worked collaboratively on shared education initiatives (e.g., NFP Canada Website) and are moving forward with the development of a formalized agreement between the provinces. This agreement will now include representation from the province of Nova Scotia (who launched the program in late 2023).

Domain coverage*

Please complete with your National /Country benchmarks and average (for proportion of time spent within each domain during visits)

Legend:	Meeting benchmark	Above benchmark	Below benchmark

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35-40	43 No change from last reporting period (43)	14-20	25 Slight increase from last reporting period (24)	10-15	20 Slight improvement from last reporting period (21)
Maternal Role (My Child and Me)	23-25	23 Improved from last reporting period (20)	45-50	44 Improved from last reporting period (40)	45-50	42 Improved from last reporting period (35)
Environmental Health (My Home)	5-7	10 Slight increase from last reporting period (9)	7-10	10 Slight increase from last reporting period (9)	7-10	13 Increase from last reporting period (11)
My Family & Friends (Family & Friends)	10-15	17 Slight increase from last reporting period (15)	10-15	15 Slight increase from last reporting period (14)	10-15	16 Slight increase from last reporting period (15)
Life Course Development (My Life)	10-15	11 Improved from last reporting period (9)	10-15	11 Improved from last reporting period (9)	18-20	16 Improved from last reporting period (14)

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):
There are currently no Canadian benchmarks, so the benchmarks noted are the international benchmarks. The phase/domain combinations that were outside the benchmark ranges will be the priority focus of our Annual Data Review meetings with teams. There were six phase/domain combinations that improved from what was reported in 2022, two moving further toward the benchmark and four moving within the benchmark. Most changes in reported time spent per domain in each phase were only slight and we are considering them less than significant. The reported time spent in the Maternal Role domain increased across all stages, a positive change that will be reviewed and celebrated. We plan to review this data during our site review meetings, help teams prioritize and focus on strategies to continue improving.

Reflections from the sites:

- Time spent in personal health still seems high but likely due to the high % of clients with significant and complex mental health concerns impacted by IPV, inadequate housing, lack of primary care, obstetricians not seeing clients until later in pregnancy, focus on postpartum screening and assessment
- Life course development is challenging to discuss due to limited interest from clients and available employment/education options, i.e., a client may want to work but cannot find suitable daycare, or they want to return to school but struggles with finances, suggestions would be to start discussing these topics early in the NFP program and support the client to think about their life course goals and what they would need to achieve these
- Additional time spent in Environmental health because clients have limited housing options, and many are living in insecure and unsafe housing
- Additional time spent in Personal health during toddler stage could be impacted by discussions on birth control, family planning, and in some cases second pregnancies occur and become a topic of focus for clients
- Less time being spent in Life course development during toddler phase could be the result of clients often feeling stuck, usually due to their poor mental health, other clients are in school, their goals are met and there is a sense of stability, so for those clients, this domain does not generate a lot of discussion.

PART THREE: PROGRAM IMPACTS

Countries report on data indicative of program outcomes to demonstrate continuing achievement of the three NFP program goals:

1. Improve pregnancy outcomes 2. Improve child health and development 3. Improve parents' economic self-sufficiency

Please complete the tables below and add any additional text or diagrams in Appendix 1. Where terms used in the report template are generic, please specify how items are measured as necessary. Please explain any missing data or analyses.

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)**	**Current Period (n/%)**
Age (range and mean)	Ontario (4 sites): mean of 21 years; range of 12-26 years HPHS: 20 years; range 15-24 RMON: 20; range 16-26 years YRPH: 23, range 20-28 years	Ontario (7 teams/9 sites, 1 partnered site is reporting separately): mean of 18 years; range of 13 to 32 years HPHS: years; range 15-28 RMON: 21; range 15-28 years

	MLHU: not able to report TPH: 19 years, range 12-25	YRPH: 22, range 18-26 years MLHU: 20 years; range 13-26 TPH: 21 years, range 15-32 HPEPH: 18 years; range 15- 24 KFL&A: 20 years; range 16-24 PPH/HKPR: 20 years; 18-23
Race/ethnicity distribution (Clients can select multiple answers, proportion indicates the % of total forms where an answer was selected, for e.g., on 26/197 (13%) intake forms completed in 2023, Indigenous/First Nations/Metis/Inuit was selected)	Indigenous/First Nations/Metis/Inuit 9% Arab/West Asian 3% Black 20% Filipino 1% Latin-American 6% South Asian 2% South East Asian 4% White 51% Other 5%	Indigenous/First Nations/Metis/Inuit 26/197, 13% Arab/West Asian 6/197, 3% Black 35/197, 18% Filipino 5/197, 3% Korean 1/197, 1% Latin-American 14/197, 7% South Asian 4/197, 2% South East Asian 3/197, 2% White 116/197, 59% Other 7/197, 4%
Income (personal annual income of less than $25,000 CAD*) * based on 2021 LICO cut-off table, $22,801 (or less) for 1 person (Statistics Canada. Table 11-10-0241-01 Low income cut-offs (LICOs) before and after tax by community size and family size, in current dollars https://doi.org/10.25318/1110024101-eng	50% of clients at enrolment (at least 6 indicated 'no income' and some clients unwilling to answer income question) It is acknowledged that this data appears to indicate a discrepancy between 100% of clients meeting the socioeconomic disadvantage criteria. However, clients are eligible at referral if they screen 'at-risk' on intake screen which includes screening questions related to education, age, supports and income but their personal income amount is not explicitly asked. This data may also be problematic due to the number of clients not willing to answer and the number of clients that are unsure about their actual income and provide an	75/197, 38% of clients at enrolment It is acknowledged that this data appears to indicate a discrepancy between 100% of clients meeting the socioeconomic disadvantage criteria. However, clients are eligible at referral if they screen 'at-risk' on intake screen which includes screening questions related to education, age, supports and income but their personal income amount is not explicitly asked. This data may also be problematic due to the number of clients not willing to answer and the number of clients that are unsure about their actual income and provide an estimate

	estimate	
Inadequate Housing (housing security used as indicator instead, defined as the # of clients who select one of the following answers on client intake form: apartment/house, foster home or residential home)	85% securely housed	157/197, 80% securely housed
Educational Achievement	38% secondary school enrolment 46% secondary school completion 13% post-secondary school enrolment	59/197, 30% secondary school enrolment 111/197, 56% secondary school completion 19/197, 10% post-secondary school enrolment
Employment status (fulltime and part-time answers both included)	32% workforce participation	63/197, 32% workforce participation
Food Insecurity (please define)	Not collected as a single question, only ask about receiving financial assistance at intake (36% reported receiving income assistance)	Not collected as a single question, only ask about receiving financial assistance at intake (73/197, 37% reported receiving income assistance)
Child Protection Involvement (ever as a child or currently)	Not currently collected as a single question at intake	
Home visits where father/partner is present	339 visits or 9% of all reported visits for 2022	633 visits or 18% of all reported in-person visits for 2023 It is acknowledged that this data may be slightly inaccurate as it may not include all interactions with the current partner and/or father of the child due to a lack of definition in the reporting process. Clarity will be added to the definition of this indicator for the next reporting period.
Home visits where other family members are present:	233 visits or 6% of all reported visits for 2022	913 visits or 26% of all reported in-person visits for 2023
Frequency of contact with biological father of the child	Collecting but not currently reporting, plans to review for 2024	
Obesity (BMI of 30 or more)	Do not collect BMI data	
Severe Obesity (BMI of 40 or more)		

Underweight (BMI of 18.5 or less)		
Heart Disease	5% or 6/123	or 9/180, 5% *one site was unable to report on health history concerns
Hypertension	0% or 0/123	2/180, 1%
Diabetes – T1	0% or 0/123	2/180, 1%
Diabetes – T2	0% or 0/123	0/180, 0%
Kidney disease	1% or 1/123	0/180, 0%
Epilepsy	2% or 3/123	6/180, 3%
Sickle cell Disease	0% or 0/123	0/180, 0%
Chronic Gastrointestinal disease	2% or 2/123	2/180, 1%

Asthma/other chronic pulmonary disease	20% or 24/123	28/180, 16%
Chronic Urinary Tract Infections	7% or 9/123	6/180, 3%
Chronic Vaginal Infections (e.g., yeast infections)	6% or 7/123	3/10, 2%
Sexually Transmitted Infections	13% or 16/123	17/180, 9%
Substance Use Disorder	Not currently collecting at intake as a single question	
Mental Illness	60% or 74/123	29/180, 16%
Other (please define)		

Please comment below on the vulnerability of your client population, including analysis of STAR (or equivalent) data and reviewing trends over time. Please include comments on:

Many sites have reported an increase in client acuity, complexity, and vulnerability. Some sites report seeing younger clients and the challenges that they are experiencing in delivering the program to them (e.g., harder to engage especially initially and more averse to attending in-person groups/supports). Sites report increasing food insecurity seen due to inflation of food prices and a reliance on family housing to have basic needs met. Also, a reported lack of access to primary care has resulted in decreased prenatal care for some.

Mental illness and mental health supports continues to be a significant issue reported by may sites. They report insufficient Perinatal Mental Health Psychiatric care (i.e., only one Psychiatrist who specializes in PMH for our community) and limited mental health services in the community and/or long wait lists for services. Complex mental health needs are high in both the newcomer population and those born in Canada. Clients have multiple mental health diagnoses and are increasingly also managing the mental health of their partners or family members. PHNs from one site report that clients self-medicating with

cannabis is common, as clients prefer this to prescribed mental health medications. Clients also use cannabis to help accomplish sleep and substantial dietary intake during pregnancy. Clients do not smoke traditional joints or pipes but do consume through vaping device.

Despite the data showing a decrease in the number of clients that disclosed IPV in 2023, all existing sites reported that exposure to IPV continues to be a significant issue. They report clients staying in controlling and violent relationships.

Several sites reported that housing remains challenging, unstable and chaotic/crowded for clients. Housing costs are a significant concern, and the capacity of shelters and availability to subsidized housing is often not enough. Reporting on the stability and security of client housing remains problematic. We attempted to improve the accuracy of data by increasing the guidance on the data collection forms however, the data indicating the number of clients that are "securely housed" still appears to be an overestimate. Feedback is that the language used in the answers for clients to provide is misleading (e.g., Apartment/House is often chosen based on the building description, regardless of how secure and stable their housing is i.e., permanency). With the plan to implement newly revised forms for Jan 1, 2025, we have proposed new language for this question that better aligns with he intended objective of this indicator.

Some sites are reporting an increasing number of clients who are new to Canada. The influx of refugees that RMON started experiencing a few years ago began to impact the NFP program in 2023, with an increase in the number of newcomers participating in the program. With this emerging diversity of clients there is an increased need for settlement and translation services. York has also reported both an increase in language diversity in the regions and an increase in refugees in 2023 living shelters.

Site-specific observations on client vulnerability:

HPHS:

- Starting to see the impact of the pandemic with toddlers falling very short on ASQ/ASQ SE screens, difficult to determine if this is due to COVID impacts or if the child is on the spectrum for ASD or other developmental issues; working closely with our Child and Adolescent Program advocating for fast tracking of some families to receive 1:1 intervention as there are long waits for developmental pediatric referrals

MLHU:

- Transportation barrier (poor public transit system): clients report experiencing discrimination when seeking employment if employer is aware of client dependent of public transit due to unreliability

Niagara:

- Clients have a common, newly emerging fear of birth control, specifically IUDs and implants

Toronto:

- Huge drop off in breastfeeding - get formula everywhere they go - Jessies, food banks, other community agencies.

York:

- More educated clients on entry noted (attended/attending university/college on entry)

Alterable Maternal Behavior/ program impacts for clients (please complete for all the time periods where the data is collected)					
Notes: MLHU not able to report on Anxiety or Depression scores, new sites (HPEPH & KFL&A, PPH & HKPR) do not have clients past postpartum as of the end of the reporting period	**Intake**	**36 Weeks of Pregnancy**	**Postpartum**	**12 months (Does not include new sites)**	**18 months (Does not include new sites)**
Anxiety, (n, % scoring indicates mild anxiety and severe anxiety on GAD-7) **(4/5 sites able to report)**	38% or 38/101 mild anxiety 33% or 33/101 severe anxiety	32% or 18/56 mild anxiety 18% or 10/56 severe anxiety	29% or 30/104 mild anxiety 31% or 32/104 severe anxiety	31% or 8/30 mild anxiety 10% or 10/30 severe anxiety	24% or 7/29 mild anxiety 41% or 12/29 severe anxiety
Depression, (n, % scoring indicating moderate and severe range on PHQ-9) **(4/5 sites able to report)**	42% or 36/85 moderate range 13% or 11/85 severe range	29% or 14/48 moderate range 2% or 1/48 severe range	31% or 25/81 moderate range 10% or 8/81 severe range	28% or 8/29 moderate range 21% or 6/29 severe range	23% or 6/26 moderate range 23% or 6/26 severe range
Cigarette Smoking, includes e-cigarettes (any smoking during last 7 days) (n, %)	45% or 82/183 (50% in 2022)	18% or 18/99 (17% in 2022)		45% or 22/49 (36% in 2022)	
Alcohol, (n, % during pregnancy, units/last 14 days)	32% or 58/183 (38% in 2022)	1% or 1/99 (0% in 2022)		45% or 22/49 (36% in 2022)	
Cannabis, (n, % used in pregnancy, days used last 14 days)	42% or 76/183 (47% in 2022)	15% or 15/99 (21% in 2022)		35% or 17/49 (27% in 2022)	
Cocaine, (n, % used in pregnancy, days used last 14 days)	2% or 4/183 (1% in 2022)	0% or 0/83 (0% in 2022)		16% or 8/49 (0% in 2022)	

Other street drugs, (n, % used in pregnancy, days used last 14 days)	1% or 1/183 (6% in 2022)	0% or 0/83 (0% in 2022)		2% or 1/49 (0% in 2022)	
Excessive Weight Gain from baseline BMI during pregnancy (n, %)	Not collecting				
Mastery, (n, mean)	Collecting but not currently part of data report, planning for inclusion				
IPV disclosure, n, %): defined as clients who disclose current (or within the last 12 months) exposure to IPV and IPV data form was completed by PHN during reporting period	35% or 54/153 (59% in 2022, 55% in 2021)				
	6 Months	**12 Months**	**18 months**	**24 Months**	
Reliable Birth Control use, (n, %)	40/72, 56%	28/50, 56%	17/37, 46%	21/40. 53%	
Subsequent pregnancies, (n, %)	8/72, 11%	8/50, 16%	11/37, 30%	16/40, 40%	
Breast Feeding, (n, %) (HPE not able to report) • Intention 156/178, 88% (87% in 2022) (defined as clients reporting yes to any of the following; yes, definitely, possible or not certain) • Initiation 120/144, 83% (86% in 2022) (defined as receiving ANY breastmilk)	13/75, 17% (6% in 2022) - Exclusivity at 6 months 30/75, 40% (20% in 2022) - receiving ANY breastmilk at 6 months	13/52, 25% (25% in 2022) - receiving ANY breastmilk at 12 months	8/38, 21% -receiving ANY breastmilk at 18 months	7/39, 18% -receiving ANY breastmilk at 24 months	
Involvement in Education, (n, %): secondary school enrolment	15/72, 21%	10/50, 20%	9/37, 24%	3/40, 8%	
Involvement in Education, (n, %): secondary school completion	45/72, 63%	32/50, 64%	28/37, 76%	35/40, 88%	
Involvement in Education, (n, %): post-secondary school enrolment	8/72, 11%	10/50, 20%	6/37, 16%	8/40, 20%	
Employed, (n, %): fulltime or part-time workforce participation	5/72, 7%	7/50, 14%	8/37, 22%	14/40, 35%	
Securely Housed, (n, %) (housing security used as indicator instead of Housing	67/72, 93%	45/50, 90%	36/37, 97%	38/40, 95%	

Needs, defined as the # of clients who select one of the following answers on client intake/update form: apartment/house, foster home or residential home)					
DANCE (or equivalent), (mean - 2, 9, 15, 22 months).	NCAST is used in ON, currently completing but not reporting, plan to report initial data in 2024				
Father's involvement in care of child, (n, %) (other responses included that made up the minority of answers: they do most/all of the care, 3-6 times a week, 1-3 times a month, less than once a month)	At 6 months old 31/72, 43% report "Everyday" while 20/72, 28% report they have not spent time caring for or interacting with the baby"	At 12 months old 21/50, 42% report "Everyday" while 18/50, 36% report they have not spent time caring for or interacting with the baby"	At 18 months old 17/36, 47% report "Everyday" while 8/36, 22% report they have not spent time caring for or interacting with the baby"	At 24 months old 12/39, 31% report "Everyday" while 11/39, 28% report they have not spent time caring for or interacting with the baby"	
Other (please define)					

Please comment below on the program impacts for clients, as indicated by the data provided (include comparisons where possible e.g., to previous years, to rates achieved in RCT, to equivalent populations etc.)**:**

Overall reflections for combined data/rates across sites:

- Breastfeeding rates at 6 months (both exclusivity and any) appear to have increased significantly compared to 2022, intention to breastfeed increased slightly whereas initiation decreased slightly over 2022 data, rates at 12 months remained unchanged, it is the first year we are reporting on breastfeeding at 12 and 18 months
- This is the first-year reporting on Anxiety and Depression scores
- Cannabis rates appear to have decreased at intake and 36 weeks gestation but increased at 12 months when compared to 2022 data
- Smoking rate reported at intake decreased by 5%, increased at 36 weeks by 1% and increased at 12 months by 9%
- Cocaine use at 12 months old increased significantly this year (16%) over any other year since 2019 and is almost all attributed to a single site

- IPV disclosure rate reportedly decreased from 59% to 35% in 2023 (this seems to be in contrast with the anecdotal reflections reported by sites but also includes new sites implementing for less than 6 months and may impact disclosure rates)
- Multiple sites have reported pregnancy rates for 21 and under, first times parents have steadily declined in the last few years
- Housing security is reported to be 90% or greater (after intake) across sites, see housing comment in above section on client vulnerability

In which areas is the program having greatest impact on maternal behaviors and which are the areas of challenge?

Our greatest challenge around data analysis has been to be not having enough data to comment on what areas of the program are having the greatest impact on maternal behaviours. Now that the Canadian RCT results and findings are available for comparison (as of July 2023), in addition to four years of consistent Ontario data for many outcome indicators we can begin to analyse the impact of the program on the indicators selected. Another challenge in analysing impact is that current reports include each outcome indicator as a defined proportion of the number of completed forms for each time point within the reporting period. It does not report on changes in behaviour across the involvement of client's time with the program. Currently, there is not capacity for this within the information system(s) and process to support this. As the purpose of the RCT was to measure program impact, and in view of limited data capabilities and resources currently at the local/provincial level, efforts will continue to be prioritized on collecting and analysing implementation data as we move forward looking to expand our ability to begin measuring program impact.

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks' gestation)	Not currently collecting this level of detailed breakdown regarding births and no plans to start collecting	
Very preterm (28-32 weeks' gestation)		
Moderate to late preterm (32-37 weeks' gestation)[1]		
Preterm Births (<37 weeks GA)	12/141	9%
Low birthweight (<2500 g)	18/141	13%
Large for Gestational Age (LGA) (>4000 g)	10/141	7%
Other (please define)		

Please comment below on your birth data:

- The reported preterm birth rate decreased to 9% for 2023 (2022 was 12% and 2021 was 11%)
- 2 sites provided local birth rate data for comparison: PPH 7.2%, HKRP 6.2%, RMON 8%
- This is the first year we are reporting detailed birthweight data, 13% of babies were considered low birthweight and 7% were considered large for gestational age
- RMON provided local birth weight data indicating that the average birth weight of Niagara resident babies born in 2023 was 3292 grams.

Child Health/Development				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	63/75, 84% (77% in 2022)	45/52, 87% (83% in 2022)	30/38, 79% (76% in 2022)	36/39, 92% (87% in 2022)
Hospitalization for Injuries in ingestions	3/75, 4% (8% in 2022)	1/52, 2% (2% in 2022)	3/38, 8% (5% in 2022)	3/39, 8% (8% in 2022)
ASQ scores requiring monitoring (grey zone)	Collecting this information in the client record but not currently part of data report, and not defined in data dictionary			
ASQ scores requiring further assessment/referral				

[1] https://www.who.int/news-room/fact-sheets/detail/preterm-birth

ASQ-SE scores requiring monitoring (grey zone)	Collecting this information in the client record but not currently part of data report, and not defined in data dictionary			
ASQ-SE scores requiring further assessment/referral				
Child Protection (currently involved)	10/75, 13%	10/52, 19%	10/38, 26%	7/39, 18%
Other (please define)				

Please comment below on your child health/development data:

- The reported rate of up-to-date immunizations increased across all timepoints
- Hospitalizations for injuries and ingestions increased at 18 months, remained unchanged at 12 and 24 months and decreased at 6 months
- This is the first year we are reporting on child protection involvement

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts None for the reporting period.
Client experiences
Please insert here any materials you would like to present regarding client experiences of the program. This can include collated client feedback, a case study or by clients providing video evidence etc. Niagara: see slides inserted  Niagara - 2023 NFP Annual Report - Clie

Quotes from clients during reporting period, about…

Meeting their goals:

- “My Public Health Nurse has helped me reach so many goals and helped me find incredible resources in the community, she's been there with me through so much, such an amazing person. Love this program.”
- “The NFP program has helped me get back into school, helped me get into different programs, helped me and through me-my friend with daycare stuff. Ny nurse helped me leave the house and many more things. I brag that my nurse is the best”

The trusting and therapeutic relationship with their PHN:

- “I just wanted to start this with how truly amazing she [NFP PHN] is! Going into this program I really didn't know what to expect I was even a little hesitant.” But I couldn't be happier I did!
- “She has helped me with so much more than she even knows!”
- “She is truly an amazing human!”
- “My last appointment with her, I was so upset about a doctor’s appointment I just had, I felt so unheard and after leaving my meeting with her I felt so much different in such a good way.”
- “I feel great, happy to know I have someone else who visits with me other than my husband. I only wish there was a more medical aspect like being able to use a doppler with clients. The info I receive is really important info and I have a support person who is there for me when I have questions and don't have to wait for my Dr. appointment.”

The difference the program has made in their lives:

- “Having a nurse for our family has eased our anxiety and has given us support in our parenting decisions. It's nice to have a professional answer our questions or give us the tools to get the questioned answered. We are grateful to have access to such resources and are very thankful to our nurse for all the work and care she has shown our family.”
- “She gives me the assures that I'm doing the right things and actually helps me so much mentally as well.”
- “NFP has given me a space to address and share concerns, achievements, and the new growth in my baby and now toddlers' life They been there consistently before birth and after. Great support and involvement.”
- "Some of my friends who are now having babies are like looking to me for advice. Lol. Especially those back home, I really think they need a first-time mom program in Guyana like when you did those visits with me. You have no idea how much more pleasant that have made my pregnancy. It also helped T (partner) pull himself up when I wasn't getting a break. lol. You played a very significant part in my story (heart shape emoji)"

Spotlight Summary Quote:

"I can go on and on about the program… I think the biggest part of it that helped me was that it gave me a resource (you) and support system outside of my family. My relationship with [the baby's] dad was toxic and I couldn't rely on him very much for support or guidance and was doing it mostly on my own (lucky for me with the help of my family). You gave me insight into why it was so important for me to keep pushing and a reality check on a lot of things - you made me realize the privilege I had thanks to family support and being in school. I think the biggest thing you helped me with though was breastfeeding. It was something I was really nervous about, and you always answered every question I had. You always reinforced how important it was and the benefits of it for me. I'm so glad I kept it going because it ended up being such a special experience for me. The program was the perfect balance between someone to support me but also give me professional advice. You were someone I always trusted, and you always made sure I knew that, and it was really special to me."

Sentinel / Significant events that deserve review:

Event	Number	What was the learning?
Child death	Hamilton 1 Niagara 1	Hamilton: Related to birth complication.
Maternal death	0	

Any other relevant information or other events to report:

Currently, there is no formal process for reporting significant events to the Nursing Practice Lead or for sharing learning with other sites. All policy and procedure related to significant events (like a client death) are followed by individual sites as instructed by their agencies. Moving forward, there is interest in exploring how sites report these events and share learning with our NFP community in ON. The Nursing Practice Lead will discuss these reported events with sites during their respective annual data review meetings to gain better understanding of the context and reflections shared by the site related to these events.

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

Briefly describe your system for monitoring implementation quality:

This reporting period was the fourth year we implemented the following CQI process (with small modifications):

- Following the annual review meeting, share final annual report and data report with all sites for review and reflection within context of each site and across sites
- Provincial Nursing Practice Lead books annual report data review meeting in April/May to discuss report and reflections and develop a plan collaboratively with sites for changes and enhancements to program implementation and data collection/analysis
- Consideration given to which actions/changes need to be implemented and monitored across all sites, and which would be implemented and monitored at specific sites
- Provide summary of annual report and data report to Data Collection Workgroup and review changes and enhancements discussed with sites for consultation on implementing required data collection and reporting potential
- Provincial lead supports sites to finalize plans using consultation of Data Collection Workgroup, with involvement of Directors and ONCOP as needed
- Action plans shared with sites, ONCOP and Steering Committee (this includes Directors)
- Sites begin implementing action plan
- Sites complete annual data report and submit to Provincial Lead by February to compile for next annual report
- Nursing Practice Lead combines submitted data, creates program data reports and populates current International Report Template (according to implementation stage)
- Report reviewed by license holder Director with recommendations for future areas of focus discussed and action planning confirmed by license holder Director, Steering Committee members and ON Nursing Practice Lead(s)
- Complete annual review meeting with assigned peer country (presently England)

Goals and Objectives for any CQI initiatives undertaken during the 2023 reporting period:
Nursing practice issues to address during ONCOP and Annual Data Review meetings:

- Review intake/referral numbers and process for each site, as well as adherence to eligibility criteria and benchmarks
- Discuss accompanied home visit expectations now that in-person visiting has returned
- Increase amount of client feedback received to include with annual report process
- Plan for additional timepoints for completing health habits and client intake update forms
- Include specific population health data requests from each site for 2023 on site report template (e.g., # of births to individuals under 25 years)
- Review strategies to improve forms completion rate
- Review integration of Family Planning Clinical pathway and PIPE Summaries

Data reporting issues for review with Data Collection Workgroup:

- Including a breakdown of housing answers from Client Intake/Intake Update form
- Including additional timepoints for reporting health habits and client intake update forms
- Integration of planned additional indicators (anxiety/depression, child protection, breastfeeding at 18- and 24-month, biological father/non-birthing parent involvement)

- Explore ability to report on outcomes by client (in addition to by reporting period)
- Review data related to forms completion in order to inform practice changes and improve forms completion rate

Outcomes of any CQI initiatives undertaken during the reporting period

Almost all goals and objectives stated above were accomplished during the reporting period. Although some additional population health data was included by sites in their 2023 data submission, they could not provide data related to childhood hospitalizations. When reviewing our forms completion rate, we noted that 199 clients were reported enrolling and there were 197 completed intake forms (rate of 99% for Client Intake Form in 2023).

Lessons learned from CQI initiatives and how these will be applied in future:

There are fidelity indicators that still require additional details in their definition for sites. This was evident through feedback from our newest sites. There are site reflections requested for the annual report that are required by the template but allow sites an important opportunity to reflect on data and plan for changes to practice.

Goals for CQI in next year (2024):
Nursing practice issues to address during ONCOP and Annual Data Review meetings:

- Review intake/referral process for each site to determine strengths and areas for improvement (e.g., improve consistency of how referral form is completed)
- Support sites with low RS 1:1 average to increase number of completed sessions
- Explore site support for proposing review of entire NFP CQI process to identify recommendations for strengthening current process and future possibilities
- Review of Family Planning Clinical Pathway and PIPE Summaries

Data reporting goals for Data Collection Workgroup:

- Integration of planned additional indicators (report on additional timepoints for health habits form, number of NCAST PCI scales completed, contact with biological father/non-birthing parent at intake
- Mastery Scores reporting plan
- ASQ scores requiring monitoring and referral reporting plan
- Program Dose and Attrition (by client, stage and weeks' gestation at first visit) reporting plan as guided by the newly developed international guidance document currently being completed
- Final draft of revised NFP forms for use beginning Jan 1, 2025

Program innovations tested and/or implemented this year (this includes both international and local innovations)

Program innovations tested[2]:

There were no formal program innovations tested across sites during this reporting period. There were also no decisions to formally implement any program innovations across sites.

Program innovations implemented:

A Family Planning Clinical Pathway and PIPE Summaries were developed in 2022 and rolled out to teams at the end of 2022. The Family Planning Clinical Pathway was developed with a masters nursing student, adapted from the US version (and addressed its gaps), to support the use of existing program resources, data collection and current Canadian resources. 22 PIPE topic summaries were

also developed with a second masters nursing student, to support the practice of nurses delivering the program and address some of the challenges experienced with the PIPE curriculum. Final versions of both resources are available to share upon request. We planned to review these new resources after implementing for 6 months, asking for feedback from our teams.

Findings and next steps:

We found that many nurses did not know where to access the resources and/or had forgotten about them when we sought feedback at the end of 2023. Feedback regarding access and more effective implementation was incorporated into a revised plan for reviewing these resources again during 2024.

Temporary Variances to CMEs

See Appendix 2 for previously approved variances (CME 12 and 4)

Additional Approved Model Elements (AAMEs)

None

Research and evaluation

Please tell us about any NFP related research and evaluation efforts currently being undertaken or planned in your country

Dr. Susan Jack is the principle investigator for the following studies.

1. RMON site – Shared Supervision in NFP (SHIP): A Case Study: This study discussed in previous annual reports has published a report in 2023 with results demonstrating the value of RS, the importance of relationship intelligence in those supporting RS and for the shared supervision model to be effective, the leaders must have an effective relationship.
2. RMON site - NFP Study: Qualitative study to explore NFP graduates' perceptions of mechanisms that influenced change/outcomes in their lives; their recommendations for how NFP graduates' can continue to engage/support/enhance NFP post-graduation; and (when relevant), role of the NFP PHN to support transition from the NICU to home. Over 50% of participants have been recruited and interviewed.
3. PPH & HKPR site - Integrated Model of NFP Implementation & Delivery: A qualitative descriptive study to describe the process of using an integrated model of NFP implementation and delivery to serve clients living in rural-urban and rural communities. A Public Health Resident (Queens University) is leading data collection of key program stakeholders. Ethics approval was received in February and plans to initiate recruitment have started.

[2] Please attach the materials used for the innovations .

PART FIVE: ACTION PLANS

LAST YEAR:	
Our agreed upon (with UCD) planned priorities and objectives for last year:	**Progress against those objectives:**
Working collaboratively with NFP International and BC to successfully transition to phase 4 of international NFP replication	Supported by the International team, formally entered phase 4 during the reporting period. Evidence of this transition is the approved expansion to additional sites in Ontario during 2023.
Goals for program indicators: • Improve enrolment rate by 5% (closer to 2021 rate of 89%) • Improve adherence to "first visit prior to the end of 28th week of pregnancy" eligibility criterion to get closer to international benchmark with all sites reporting > 98% compliance (as stated in the approved variance for CME4) • Increase # referrals by 50 (goal of 219 referrals in 2023)	The enrolment rate for 2023 was 80% making it an improvement of 5% and meeting our goal for the reporting period. Average compliance across sites for adherence to "first visit prior to the end of 28th week of pregnancy" increased by 6% over last reporting period to reach 90%. It is acknowledged however that we did not meet the goal of all sites reporting >98% compliance, as outlined by our approved variance. The # of referrals increased by 92, surpassing our goal of 50 for a total of 250 referrals in 2023.
Implementation Goals: • Successful website transition • Completion of 2022 outstanding list of V2VG revisions • Develop 4 additional implementation guidance document drafts • Review NFP client demographic data and local population data to determine who NFP is currently serving and identify gaps in service, then plan for how to address gaps by leveraging partnerships in the community and work already underway in each health unit • Carry over: support establishment of CABs and develop plan for Client Experience Survey and integrated process for client feedback	Completed a successful website transition in the Fall of 2023, working collaboratively with BC and McMaster School of Nursing. The transition occurred with no loss of access to program materials for NFP teams in all provinces. The goal of completing the outstanding list of V2VG revisions was not met due to capacity of Canadian Clinical working group. The goal of developing 4 additional implementation guidance documents was not met due to capacity of Nursing Practice Lead. Sites have begun to review local population health data to inform community outreach, additional data was included by some sites with their 2023 data submission. Facilitated sharing of resources for sites in the process of establishing CABs. Currently seeking feedback from sites on client feedback

	questions.
Education: • Development of educator guidance with BC and process for educator support and sustainability • Complete remastering of education materials (with McMaster School of Nursing support) • Return to in-person education and development of recommendations for methods of education delivery	Completed draft facilitator guidance documents for all NFP Fundamentals sessions in addition to a revised set of original PowerPoints. All educators in BC, ON and NS have access to these revised documents. Returned to in-person education delivery for new sites (completed 2 cohorts of NFP Fundamentals). Recommendation made for all new sites to participate in-person for initial cohort. Staff turnover following initial implementation can be addressed by the 2 virtual cohorts a year provided.
Data collection, analysis, and reporting: • Complete CME4 variance tracking and evaluation • Inclusion of additional indicators for 2023 reporting period	All teams were able to complete CME4 variance tracking, and 6/7 teams were able were able to include that data in their annual data submission. Additional indicators successfully added for 2023 reporting period: CME4 variance tracking, incoming transfers, referral sources, discharges reasons by stage, birthweight details, continuation of breastfeeding at 18 and 24 months, child protection involvement, biological father/non-birthing parent involvement and Depression and Anxiety scores.
Areas for further work identified by UDC in feedback: • Deeper analysis around significant adverse incidents including child death • Ensuring the leadership team is expanded. Currently relies on one individual. Potential significant risk as a single point of failure • Data capturing and consistency	Options explored regarding comparative population health data related to childhood hospitalization and death. Public Health Ontario (PHO) colleague and member of data collection workgroup confirmed PHO access to a Canadian database that includes health administrator data for 2018-2022. Request has been made for higher-level analysis (by postal code or region). Also considering review of data received from Hospital for Sick Children in Toronto for a Toronto sub analysis. Additional 0.5 FTE Nursing Practice Lead was approved by the Steering Committee to expand the leadership team and recruitment began at the end of the reporting period. Casual, in-kind administration support was provided to the Nursing Practice Lead by PPH and will continue into 2024. In addition to the annual refinement of Ontario CQI process with the data collection workgroup,

	Nursing Practice Lead also participated in the international Analytical & Research Leads Task & finish group, developing shared guidance on the analysis of implementation data. This work will inform data capturing and increase consistency moving forward. Ontario's Data Collection + Nursing Assessment Forms were also reviewed during 2023 and draft revisions created for teams to review again in 2024 and final drafts sent to sites for implementation in 2025.

Reflections on our progress:

- We celebrate meeting several of our goals and objectives for the reporting period
- We are recognizing that annual report action items require prioritization that aligns with emerging capacity and opportunities due to the current size and infrastructure of NFP in ON

NEXT YEAR:

Our planned objectives for next year and the measures planned for evaluating our success:

Goals for program indicators:

- Referral Goal of 95 additional referrals (for a total of 314 referrals)
- Maintain minimum enrolment rate of 80%
- Continue to improve adherence to "first visit prior to the end of 28th week of pregnancy" eligibility criterion to get closer to international benchmark with all sites reporting > 98% compliance (as stated in the approved variance for CME4)
- Review BC RCT data to inform CQI in Ontario

Implementation Goals:

- Review age eligibility criteria and potential program impact (capacity, referrals etc.)
- Develop formal agreement between provinces for collaborative work and elements of program accountability (e.g., education delivery, website maintenance)
- Develop orientation plan for additional Nursing Practice Lead (leadership team members) and successfully implement
- Review membership and objectives of Provincial Advisory Committee, communicate changes and draft new Terms of Reference as needed
- Review membership and objectives of NFP Canadian Collaborative with BC and NS leads, communicate changes and draft new Terms of Reference as needed
- Carry-over: outstanding V2VG revision work, additional ON implementation guidance documents, continue development for Client Experience Survey/feedback

Education Goals:

- Develop sustainability plan for educators (increasing the number of educators with facilitation experience)
- Carry-over: Complete remastering of education materials (with McMaster School of Nursing support)

Goals for Data Collection, Analysis, and Reporting:

- Continue CME4 variance tracking and evaluation
- Inclusion of additional indicators for 2024 reporting period
- Develop new proposal for review of CQI process and resources by informatics expert

Any plans/requests for program expansion? There are currently no additional sites (in addition to Southwestern Public Health) that have requested implementation for 2024. We will continue to respond to inquiries from additional health units and explore any requests as they are received for expansion in Ontario.

Please note: with permission, all completed annual reports are uploaded to the restricted pages of the international website so that every implementing country can mutually benefit in sharing their progress and achievements.

Please indicate your country's willingness to share this report in this way by checking one of the boxes below:

I agree to this report being uploaded onto the restricted pages of the international website	yes
I do not agree to this report being uploaded onto the international website	

PART SIX: RECORD OF MEETING FOR GLOBAL COLLABORATIVE GUIDANCE GROUP

Date of meeting:

Attendees from presenting country:

Attendees from reviewing country:

Reviewing country confirmation: We confirm that the presentation covered all the areas of content set out in the guidance document. Yes No If no, please indicate which areas were missing and how this was addressed in the meeting:

Key learning points arising from the meeting:

1.	
2.	
3.	

Appendix 1: Additional data analyses and /or graphic representations of the data

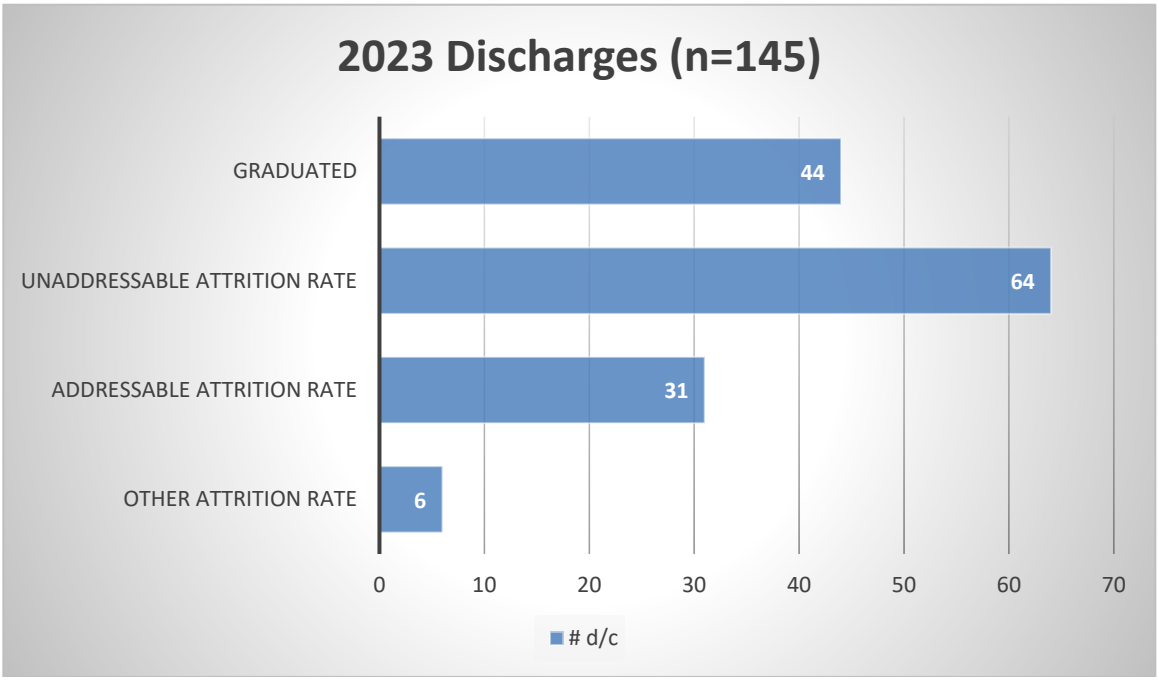
Total number of completed encounters

- Total # encounters = 4387
- Where program content was delivered = 4067
- For service coordination = 263
- "other" = 146

- Encounters reported by phase, total = 4387 (pregnancy 1401, infancy 2175, toddler 811)
- Encounters reported by format, total = 3980 (in-person 3554, telephone 290, video conference 136)
- Encounters completed after the child turned 24 months, total = 38

Attrition and Retention

- Total # discharged clients (for any reason other than graduating) total = 101 **discharge reasons missing on 4 clients*
- Discharged clients (for any reason other than graduating) reported by phase with reason, total = 97 (pregnancy 32, infancy 46, toddler 19)



Discharged due to graduation:

- 44 participants graduated in 2023

Discharged considered part of the "unaddressable" attrition rate:

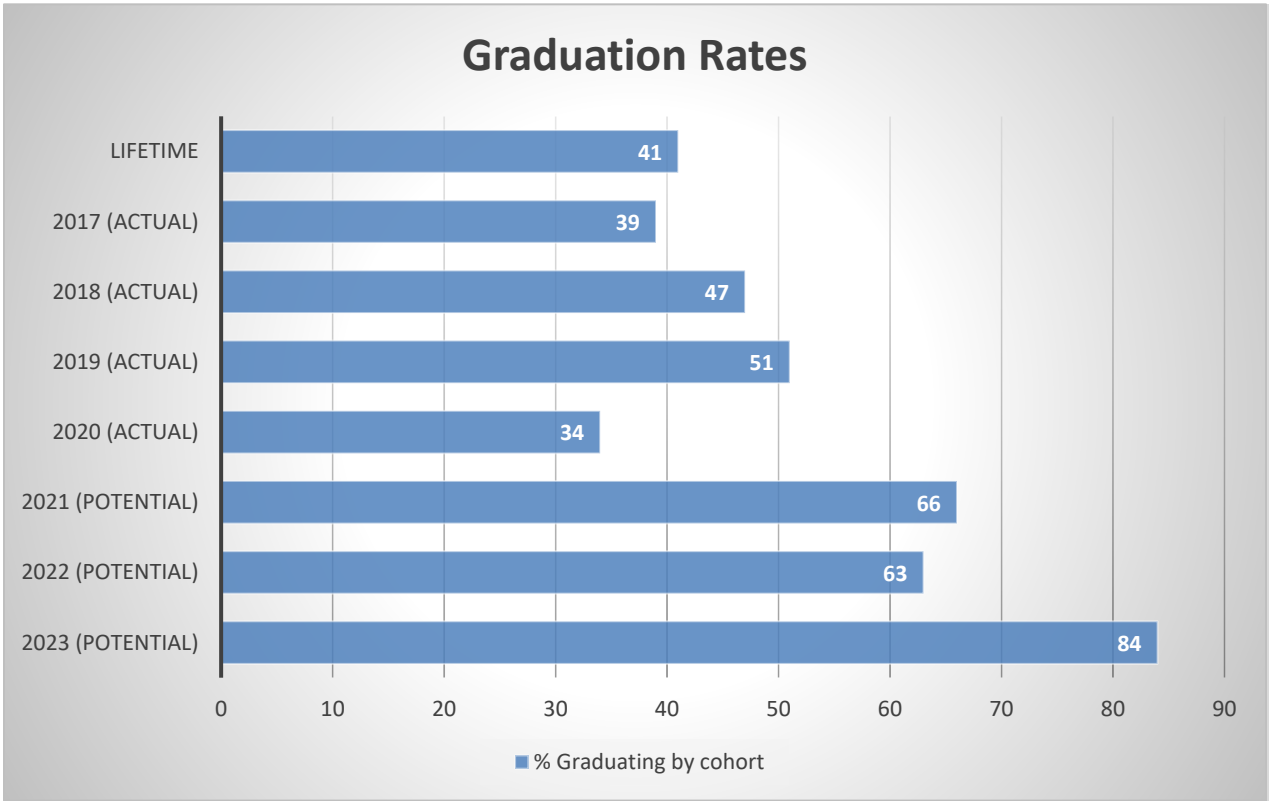
- 64 were discharged for reasons not initiated by client (lost to f/u, maternal death, pregnancy loss/child death, unsafe to visit, incarceration, moved out of an NFP service area)
  - 39/64 of those were lost to f/u

Discharged considered part of the "addressable" attrition rate:

- 31 were discharged for reasons initiated by the client

Discharges considered part of the "other" attrition rate:

- 4 transferred to another NFP site
- 2 did not continued with the program after having a child apprehended



[Back to program implementation data](#) **(CME 8, pg)**

Appendix 2: Evaluation of temporary CME variances

Please complete the table below for each variance agreed for your country.

CME #:
12 (minimum team size specifically)
Temporary Variance to CME agreed:
We are requesting to continue delivering the NFP program using a small portion of sites that have less than the stated minimum requirement of 4 fulltime Public Health Nurses (PHNs). This is the fifth consecutive variance request for the same reason and would currently apply to 2 sites: York Region and PPH & HKPR. Currently, both sites have the equivalent of three 1.0 FTE, full-time PHNs positions and have been able to accept all eligible NFP referrals without any capacity concerns. Both sites also have strategies in place for coverage needs when they emerge and ongoing connection to other sites as facilitated by the Nursing Practice Lead.
Brief description of approach taken to testing the variance:
Sites continue to regularly review the operational need for filling the fourth full-time PHN position. The sites have been able to easily manage the number of referrals coverage needs with the current team size and therefore there has not been a need for an additional nurse.
Methods for evaluating impact of variance:
This variance will continue to be evaluated using the data/information from the NFP Annual Report and we can review the need to complete an additional variance request annually.
Findings of evaluation to date:
The positive impact of continuing to vary the CME allows for continued delivery of the program at all sites. This variance has allowed for service delivery and the positive program impacts to continue without interruption since 2017 for a current total of 91 clients. The variance allowed for a more comprehensive and complete evaluation of the CaNE pilot project because of the additional number of participants. At present the variance also extends the small but close knit NFP community of PHNs and supervisors in Ontario and provides increased opportunities for collaboration across sites. The potentially negative impact in fidelity and implementation is that varying the CME continues for team size could result in potentially less robust case discussions, reduced opportunities for team education and limited availability of peer support (both informally and for case load coverage needs). We believe that by having multiple sites implementing under the same license and one Nursing Practice Lead providing support across sites, especially with the emerging use of virtual meetings, we have been able to continue to facilitate peer support, case discussion and shared education experiences to help address some of this risk.

CME #:
4 (late enrolment)
Temporary Variance to CME agreed:

For Ontario sites to permit late enrolment to the program (after the 28th week of pregnancy but before birth) on a case-by-case basis by up to no more than 2% of total enrolments annually. Each late entry enrolment decision would be made by sites in consultation with the Nursing Practice Lead. The process ensures that sites include the Nursing Practice Lead in local decisions that have, for the most part, historically been made by individual NFP supervisors/managers. The goal with this variance is to increase consistency in program decisions that impact program fidelity and develop a process to review data on program outcomes for clients enrolled later in pregnancy.

Brief description of approach taken to testing the variance:

Appropriate considerations for late enrolment have been defined and are applied as consistently as possible across the province. The process for requesting late enrolment by sites is outlined by a guidance document and done in collaboration with the Ontario NFP Community of Practice, on behalf of the license holder. The method of data collection and reporting was reviewed in collaboration with the Ontario Data Collection Workgroup. The late enrolment request process includes areas of discussion/questions (adapted from the US NSO) for the site with the Nursing Practice Lead about the referral such as: reason for request, current strategies to adhere to CME, positive/negative impact of late enrolment, age of client, weeks' gestation, current level of fidelity to CME (total number of requests), barriers to early enrolment, risk factors for client, alternate programs available to client, and COVID-19 pandemic related circumstances. The guidance document is available upon request.

Methods for evaluating impact of variance:

The anticipated time frame for this variance is approximately 27 months beginning Jan 1, 2023. A tracking process developed for all referrals in 2023 requires all sites to review and report data on attrition, dose, and outcomes. Ontario was approved to continue applying this variance for referrals received in 2024 through 2026 until such a time when all potential grads from the enrolment cohort year of 2023 are known. At that time, data can be reviewed and reported on (attrition, dose, and outcomes) for all those enrolled in 2023, comparing those who enrolled later than 28 weeks gestation with those enrolled earlier in pregnancy.

Findings of evaluation to date:

Initial 2023 cohort data:

Total Enrollments: 199
Total late enrollments: 21
The # of enrollments that had first visit/consent completed between 29-31 weeks gestation: 11
The # of enrollments that had first visit/consent completed between 32-34 weeks gestation: 9
The # of enrollments that had first visit/consent completed after 35 weeks gestation: 1
Total clients that left the program prior to graduation of 2023 enrollment: 33

A few sites were unable to submit data for all indicators at this time due to unexpected capacity changes with IT support but plan to submit as soon as possible in 2024.

There were a few inconsistencies reported in data for variance tracking when compared to the same indicators on site's annual report submission. This will be reviewed during site's annual data review meetings and at the Spring Data Collection workgroup meeting.

Appendix 3: Additional Approved Model Element (AAME)

AAME agreed:
Reflections and findings in relation to use of the AAME