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ADULT AND CHILD CENTER FOR OUTCOMES RESEARCH AND DELIVERY SCIENCE
UNIVERSITY OF COLORADO
CHILDREN'S HOSPITAL COLORADO

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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, analyzed, 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 analyzed 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: British Columbia - Canada
Dates report covers reporting period: Jan 1, 2024 - Dec 31, 2024
Report completed by: Penny Liao-Lussier & Leilani Jordan Date submitted: April 29, 2025

The size of our program:

	Number
Fulltime NFP Nurses	11
Part time NFP Nurses	17
Fulltime NFP Supervisors	3
Part time NFP Supervisors	2
Full time NFP Mediators/Family Partnership Workers (FPW) (if applicable)	0
Part time NFP Mediators/Family Partnership Workers (FPW) (if applicable	0
Total (as of December 31, 2024)	33

- We have 5 teams (supervisor-led groups of NFP Nurses) as of December 31, 2024
- Average Supervisor to NFP nurse ratio (include Mediator/FPW positions if you have them): 1:6
- **Current number of implementing agencies/sites delivering NFP:** 19 health unit sites covering approximately 60 communities/regions delivered through 3 regional health authorities (as of December 31, 2024)
- Number of new sites over reporting period 0
- Number of new teams over the reporting period 0
- Number of sites that have decommissioned NFP over the reporting period 1 health authority
- Successes/challenges with delivery of NFP through our implementing agencies/sites:

Regional health authorities identified several successes in implementing the NFP program over the previous year. Overall, these included having formidable team and client relationships, adhering to NFP benchmarks and program elements, and demonstrating flexibility. For example, one health authority described effectively maintaining supportive team relationships despite some nurses delivering NFP as the sole nurse on site within their local community through the use of virtual team meetings. Another site overcame challenges related to unfilled nursing positions and discovered in the process of handing over clients, that their nurses were highly skilled at quickly establishing therapeutic relationships with clients.

These strong relationships were also recognized by one region that described having high client retention and engagement, even with late enrollment clients who were noticeably young and experiencing many layers of adversity. Flexibility was described by some teams who indicated that while most of their nurses provided additional clinic-based immunization services they were able to meet NFP benchmarks of completed visits by seeing clients in the clinic setting, effectively managing their dual nursing role. Within this region, nurses also found success as they continue to offer flexible visit schedules and maintain engagement with the use of virtual care.

Some teams described their NFP supervisors' dual role as a value-add and opportunity. For example, by having two supervisors provide consistent support to the region's NFP team, they met their NFP obligations and were also able to extend and integrate their NFP expertise to other

nursing programs and services.

A few challenges were also identified, related to late referrals, travel requirements, unmet education needs, and unfilled positions. For example, one health authority reported receiving late gestational age enrollments due late referrals into the program. This was attributed to a lack of prenatal/antenatal primary care providers available in the region to "attach" to the client, impacting the submission of referrals into the NFP Program.

In terms of travel, some NFP supervisors found it difficult to satisfy the travel requirements necessary for the Accompanied Home Visit. This could have been attributable to inclement weather, vast geography of coverage for Accompanied Home Visits and/or a combination of the two amongst others.

One region had to pivot and adapt NFP program operations related to the organizational decision to sunset the NFP Program and its services. As a result, program staff paused accepting new referrals starting in May 2024, while continuing to deliver NFP to existing clients until their graduation. This created some challenges related to the retention of existing NFP nursing staff. As NFP nurses left their positions, these roles were not filled and client care was transferred to other NFP nurses which impacted workload, travel time, etc.

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

License holder name: Provincial Health Services Authority (PHSA) is the license holder for the Nurse-Family Partnership in BC as of 2023/2024. In late 2023, the Ministry of Health began working with PHSA (a publicly funded health service provider that provides province-wide specialized health services and programs) to support transitioning the BC NFP program license and program clinical operations oversight.

Role and Organization: The structure of NFP in BC is organized as follows:

- **Provincial Health Services Authority (PHSA)**: PHSA is responsible for the following: program oversight/support to program delivery agencies, program strategic direction, monitoring and reporting on fidelity, supporting governance and committees, assisting with the coordination of required training, and negotiating support and services related to the NFP Program on behalf of the province.
- **Regional Health Authorities (RHAs)**: The RHAs signed a Memorandum of Understanding in 2012 to implement the NFP program and agreeing to adhere to the Licensing Agreement. The NFP nurses, supervisors, managers, and other leaders are employed by their regional health authorities.
- **Community Partners**: Numerous collaborating committees struck in 2012, continue to exist, and support program implementation, adaptation, and quality improvement of NFP in the context of BC and Canada. Other collaborating committees were dissolved as per their deliverables.

Description of our National implementing capacity and roles:

1. **Clinical Leadership**: The BC Provincial NFP Clinical Lead attends various NFP International meetings to report on and represent the NFP program, develops an annual learning plan, supports, and leads quality improvement initiatives, and engages with numerous working groups to provide support to NFP supervisors, managers, nurses, and national collaborating committees. The NFP supervisors work for the regional health authorities and provide clinical nursing leadership, support, and guidance in their respective roles in NFP. In this regard, the NFP program is both centralized and de-centralized in BC with strong collaboration, knowledge exchange and regular communication.

   Currently, there are three NFP Clinical Leads in Canada to support the needs of the three NFP licensees (BC, Ontario, and Nova Scotia). Dr. Olds has supported the existence of multiple licenses in Canada due to the differences in context and expansive Canadian geography. However, there are many similarities and strong collaboration in Canada especially with the formation of a NFP Canada Governance Working Group in 2017. What was formerly the NFP Canada Governance Working Group is now known as the NFP Collaborative in Canada (NFPCC) who meet every month as able.

2. **Data analysis, reporting and evaluation**: Initially when NFP was launched in BC in 2012, a paper record system was used by the NFP nurses for documentation until 2013. A Family Module was then added and/or adapted to the electronic documentation system aligned with other public health programs. NFP nurses legally document client assessments and progress using the electronic data system available in their RHA for public health/family health programming and care planning. There are currently two systems in BC as of December 2023:

   - Panorama (Island Health Authority and Interior Health Authority): Provincial Panorama team has been building and refining data extract reports for NFP-Enhanced Public Health clients throughout 2024.
   - PARIS (Fraser Health Authority): Launched in June 2019, FHA PARIS has recently built and launched new Data Extract Reports for NFP clients throughout 2024.

   Note: The two electronic medical records documentation systems do not interface with each other (i.e., no information is shared between systems).

   These two electronic data systems support the development of data extract reports to be generated for analysis. The data that is available on the extract reports is analyzed by NFP supervisors and other health authority staff (such as data analysts) for the purpose of care planning, program planning, continuous quality improvement and annual reporting. It is standard practice for the NFP nurse to have at least two records for each family: a record for the mother and a separate record about the baby. The NFP nurse typically charts on both records following a visit (and as appropriate).

   Throughout 2024, nurse supervisors continued to provide monthly reports on client enrolment to the Ministry of Health through a secure, password protected SharePoint site.

3. **Service development/site support:** NFP is currently being offered to clients from approximately 60 communities/regions across BC (including approximately 13 First Nations communities/regions).

   PHSA continues to work closely with NFP delivery partners, including health authority nurse supervisors and managers. Throughout 2024, PHSA has supported local sites with organizing nurse education and updating data collection forms to improve usability.

4. **Quality improvement**: Within NFP, analysis of program performance occurs through reflection, collaboration, and analysis on multiple levels. Annual fidelity reporting also provides a tool for data analysis, feedback, and action planning. The NFP teams use data to implement a high-quality, effective program (see Part Two: Program Implementation and appendices for an overview of BC's continuous quality improvement processes).

Data analysis and transfer occurs in the following ways in BC:

• RHAs provide monthly client enrolment/attrition data to the Ministry of Health using a secure, password protected SharePoint site. This data is collated and reviewed regularly by PHSA.

• Annual report data received from the RHAs/supervisors who extract data reports on their local public health data systems.

5. **NFP Educators**: As a result of the pandemic, since 2020, BC has collaborated with Ontario to adapt to virtual delivery for nurse education. Throughout 2024, BC has continued to deepen its collaboration with ON by providing virtual delivery of NFP Fundamental and IPV Education. In addition, local NFP supervisors support new nurses with onsite training, including providing ad hoc education for nurses awaiting virtual sessions.

Other (please describe)

Description of our local and national NFP funding arrangements:

The regional health authorities implement NFP within their base operational budgets. PHSA does not providing any dedicated funding to health authority partners for operationalization of NFP services. PHSA provides ongoing funding for the Licensing Agreement and Support Services Agreements with the University of Colorado Denver. PHSA provides financial support for specialty education (including Partners In Parenting Education e-training).

Current policy/government support for NFP:

Provincial policy support for NFP currently rests in the following policy frameworks for BC either directly or indirectly:

- Healthy Families BC Policy Framework (2014)
- British Columbia's Population and Public Health Framework: Strengthening Public Health (Best Start in Life) (2024)
- A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia (Priority Area #1, Pillar #1) (2019)

The Community Health Nurses of Canada (CHNC) released revised Canadian Community Health Nursing Professional Practice Model and Standards of Practice in 2019 and these now include NFP as an example of a service delivery model in Community Health Nursing. 1

Organization responsible for NFP education:

- Since 2020, BC has collaborated with ON to provide virtual nurse education based on the Nurse-Family Partnership Education Curriculum for Use in Canada (CaNE project) developed by Ontario.
- PHSA provides funding for new nurses to complete the Partners in Parenting Education (PIPE) Comprehensive E-Training through How to Read Your Baby organization.
- DANCE education continues to be provided by the University of Colorado Denver (UC Denver)
- Prior to completing DANCE fundamentals, nurses collaborate with supervisors to review Keys to Infant Caregiving education curriculum materials provided through Parent-Child Relationship Programs at the Barnard Center.

Date	Education	Cohort Attending	No. of Nurses
	Monthly DANCE Integration (Facilitated by NFP nurse supervisor)		
March & Sept 2024	Unit 1 (completed on own time) Unit 2/Fundamentals (virtual)	Cohort 18	4 (Interior Health) 2 (Interior Health-Sept); 2 (Fraser)-March
	NFP Supervisor Fundamentals Education (virtual)		1 (interior Health)
	IPV Unit 2/Fundamental (virtual)		2 (Interior Health)
Nov 2024	IPV Ongoing education	All	11 (FH) 9 (Interior Health)
	PIPE e-training (via *How to Read Your Baby*)		3 (Interior Health)
December 2024	DANCE Reassessments		3 (Island Health) 11 (Fraser Health) 5 (Interior Health)

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

Other relevant/important information regarding our NFP program:

PART TWO: PROGRAM IMPLEMENTATION

Clients

Number (#) of NFP clients participating in the program at any point over the last year: **466 clients** received at least one NFP visit during the reporting period (a client refers to the young pregnant person enrolled in the program. The children born into the program are not included in this data).

- **Current clients: Pregnancy phase** (n/%): 42 (16%) at Dec 31, 2024
- **Current clients: Infancy phase** (n/%): 117 (43%) at Dec 31, 2024
- **Current clients: Toddler phase** (n/%): 106 (39%) at Dec 31, 2024

Nursing Workforce

- Average client caseload per nurse: 14
- 2024 Average nurse caseload: The average nurse caseload based on total full-time equivalent (FTE) is 14 clients per nurse. Averages range from as low as 13 clients to as high as 15 across health authorities in 2024 (average caseload does not include casual/vacation relief nurses and is based on total number of nurse FTEs, not the total number of nurses). This remained constant from 2023 in which the average nurse caseload was 14 clients per nurse FTE.

- **Reflections on NFP nurse/supervisor turnover/retention during reporting year:**

	Nurses	SVs	Other	Total
# of staff at start of reporting year:	24	5	n/a	29
# of staff who left during reporting period	4	0		4
% annual turnover	16%	0		13%
# of replacement staff hired during reporting period	4	0		4
# of staff at end of reporting period:	21	5		26
# of vacant positions	0	0		0

In 2024 one region supported an NFP nurse to receive NFP supervisor training to provide vacation relief and temporary support. This health authority is also considering succession planning for NFP supervisors and nurses approaching retirement.

Another health authority has faced staffing challenges due to uncertainty with their program after an organizational decision to pause client enrollment into the program in May 2024. They provided moral distress support through their ethics team to the NFP nurses. Supervisors have faced challenges supporting the nurses with their feelings of grief and loss over the impending sunsetting of the program. NFP Nurses are beginning to consider other role opportunities post-program cessation.

One health authority described staff turnover in the last couple years due to various reasons (e.g.,

retirement, other job opportunities for professional growth). Other disruptions of note included a nurse on a two-person team taking an extended leave which caused disruption to referrals and client engagement. They also found that new NFP team members are learning quickly, engaging with clients, and offering a renewed sense of learning to the team.

- **Successes/challenges with NFP nurse/supervisor recruitment:**

  Regions identified various challenges related to filling NFP nursing vacancies. These included, difficulty filling an extended medical leave, a position being put on hold due to staffing constraints, inability to participate in NFP education, and positions not being posted after nurses took temporary or permanent positions elsewhere.

  They also identified success in their ability to adapt, and to recruit new NFP nurses. For example, when one nurse went on a medical leave, they were able to transition an entire caseload to the remaining team. Another health authority had success establishing three part time dedicated NFP positions and filled vacancies.

- **Any plans to address workforce issues:**

  Strategies to address workforce issues are addressed at the health authority level and described in the previous section.

NFP education

- **Briefly describe your NFP education curricula** (nurse and supervisor, plus any additional education for associated team members (Family Partnership Worker/Mediators) or others (e.g., Local Advisory Group members).

Unit/Name	Delivery Method	Content Covered
• **Phase 1 – Foundations (self-study)**		
Introduction to NFP/Unit 1 (Nurse-Family Partnership Education Curriculum for Use in Canada[CaNE curriculum])	Self-study online modules	• NFP history, evidence, fidelity • Excellence in nursing practice • Program theories • Client-centered principles • Reflective practice • Therapeutic relationships • Maternal Role • PIPE • Content domains • Visit to visit guidelines • Client recruitment and engagement • Documentation
IPV (CaNE curriculum)	Self-study online modules	• Module 1: Intro to the NFP IPV Intervention • Module 2: Characteristics of an abusive relationship • Module 3: Responding to a disclosure • Module 4: Identifying IPV • Module 5: Introduction to the Danger Assessment – including completed of Danger • Assessment
Supervisor NFP Foundations (CaNE curriculum)	Self-study online modules	• Introduction to supervisor role • Reflective supervision • Client recruitment and referrals
• **Phase 2 – Fundamentals (face-to-face / virtual)**		

NFP Fundamentals/ Unit 2 (BC and ON NFP Educators)	Face-to-Face (virtual since 2020) • 6 half-day virtual sessions facilitated with ON	• NFP Model • Client-Centered Principles in Practice • Cultural Responsiveness • Trauma-informed Practice • Therapeutic Relationships in NFP • Motivational Interviewing practice • Reflective Practice • Maternal Role • Domains • First Four Visits and Structure of Forms • Client Recruitment • Client Retention • Compassion Capacity for Self • Visit to Visit Guidelines
IPV (BC and ON NFP Educators)	Face-to-Face (virtual since 2020) • 2-4 half-day virtual sessions facilitated with ON (sometimes split into 2 parts over 4-6 months)	• IPV review • Tele-practice/virtual visiting • Building the foundation • University assessment of safety • Indicator based assessment / clinical IPV assessment • Risk assessment: Danger assessment • Review of risk assessment • Stages of readiness to address safety • Mental health and substance use assessment and referral • Implementing nursing intervention
PIPE (How to Read Your Baby)	PIPE Comprehensive E-Training course • 8-week online course	• Module 1: Welcome • Module 2: PIPE Foundations: Part One • Module 3: PIPE Foundations: Part Two • Module 4: The PIPE Curriculum • Module 5: The PIPE Instructional Model • Module 6: Emotional Development • Module 7: Overview of “Love is Layers of Sharing” • Module 8: Overview of “Listen, Listen, Listen” • Module 9: Overview of “Playing is Learning” • Module 10: Step Two: Demonstration • Module 11: Step Three: Parent-Child Interactions • Module 12: Step Four: Evaluation (Reflection and Feedback) • Module 13: Planning & Practicing a PIPE Session (role play video) • Module 14: Closure
Supervisor NFP Fundamentals (CaNE curriculum)	Face-to-Face (virtual since 2021) • 4 half-day virtual sessions facilitated with ON	• Leadership and NFP Supervisor Role • Reflection in Practice • Core Model Elements • Compassion Fatigue • Data Collections • Facilitating On-Going Education

		• IPV Supervisor Fundamentals • Continuous Quality Improvement
• **Phase 3 – Integration**		
Keys to Infant Caregiving (Parent-Child Relationship Programs at the Bernard Center)	Video and study guide, self/team- based learning	• Infant State • Infant Behavior • Infant Cues • State Modulation • Feeding is More than Just Eating • Nurse-Parent Communication
DANCE Fundamentals (CU-Denver)	5-week eLearning course provided by CU Denver: • 6 monthly teleconferences after completed of online modules/course	• Module 1: Introduction to DANCE • Module 2: Emotional Quality Dimension • Module 3: Sensitivity and Responsivity Dimension • Module 4: Behavior and Emotional Regulation • Module 5: Promotion of Developmental Growth • Module 6: All Coding and Getting Started with DANCE
DANCE Reassessments (CU-Denver)	Self-study and online coding assessment: • Annually 3 years then every two years after	• DANCE coding
Mental Health Innovation for NFP (optional) (CaNE Curriculum adapted by US NFP Mental Health modules)	Self-study online modules	• Mental Health – Introduction • Learning About Depression and Anxiety • Integrating Mental Health Nursing Care into NFP Practice • Practicing Mental Health Nursing • Self-Care for Nurses
NFP **Documentation** (Supervisor/local health unit)	Self-study and review with Supervisor 1:1	• NFP Nursing assessment forms
Supervisor NFP Integration (BC educators)	Various: • Team-based learning Face-to-face	• Coordinate IPV System Navigation activities • Mandatory Annual Skills Training for Supervisors – scheduled for Nov 2023 but cancelled due to changes in supervisor • staffing
Other Public Health Learning (optional – provided from health authority) (Supervisor/local health unit/third-party agencies)	Various: • Self-study • Online Team based learning	• Cultural Safety, ACEs, etc.

- **Changes/improvements to NFP education since the last report:** N/A

- **Successes/challenges with delivery of NFP education and CPD**: Success included the continued collaboration and joint education with Ontario and Nova Scotia educators and nurses. Nurses have

also found PIPE training via How to Read Your Baby to be a successful education program. One region found a successful approach to allow supervisors to deliver interim in-house orientation education for new nurses while awaiting Unit 2. Some of the content they covered included introductions to V2V Guidelines, the NFP Model, PIPE, and Keys to Caregiving. Nurses were then able to follow up by completing Unit 2 education in the fall with Ontario.

- One health authority successfully hosted a two day in-person gathering which included updates and education to support the team. Topics included: perinatal substance use, IPV, child abuse and neglect, duty to report, self-care (related to compassion fatigue), a review of 2023 NFP Annual report (for their region), and QI discussion.
- Teams have found that case conferencing provides an organic platform to reflect on content in the education modules and allows for more experiential learning.
- Some regions identified challenges completing onboarding education due to the short notice and infrequent timing (twice a year), or when NFP education competed with other mandatory health authority education related to core programs like immunizations. The one health authority that will not continue with NFP faced challenges related to expiring DANCE licenses that were not planned to be renewed. Another region found that the variations in NFP experience within the team makes it challenging to offer continuing education that meets the needs of everyone on a small team.

Reflective Supervision

- **Successes/challenges with NFP nurse reflective supervision:** Overall reflective practice is identified as a valued program component that is still needed by nurses on a regular basis. Some strategies to maintain consistency and commitment include setting a weekly schedule, or having supervisors provide coverage during their own leaves. Supervisors identified challenges that included the travel required, challenges meeting benchmarks due to nurse availability (long vacations, sick leaves, redeployment in the health authority), or challenges that arise when nurses are struggling with either personal or professional issues beyond the scope of the NFP reflective practice sessions.

- **Successes/challenges with reflective supervision provided to NFP supervisors:** Overall teams expressed that supervisors are successfully supporting one another and value having this peer relationship. One region identified that reflective supervision was further supported by both a new NFP Manager and the amalgamation of NFP into a perinatal team.

- Successes/challenges with delivery of reflective supervision to our associated team members (Family Partnership Worker/Mediator): n/a

NFP Information System

- **High level description of our NFP information system, including how data are entered:** Two public health electronic medical records systems are used in BC for collection and reporting on NFP assessment data (PARIS and Panorama). Nurses enter data after the client visit, either at the office or offsite using portable laptops through a secure network. Both systems have NFP forms, other client assessment forms, and narrative note sections for documentation. Additionally, supervisors update a monthly Excel spreadsheet with nurse and client enrolment/attrition/graduation data.

- **Commentary on data completeness and/ or accuracy**: There has been continuous work to update and improve current health authority reporting forms/systems. One health authority reports utilizing a public health clinical informatics expert for data access support using their PARIS system. Throughout 2024 nurse supervisors worked to improve IPV forms to improve useability and hopefully increase completion and accuracy by nurses.

- One region reported poor completion of their NFP electronic forms (e.g., Nursing Assessment & Healthy Habits form), despite having confidence that program fidelity is being maintained; they found that complete care assessments are consistently documented in the Nursing Care Plan as per BCCNM Nursing Practice Standards. Supervisors attempted various strategies to improve documentation including having targeted discussions and PowerPoint presentations on the importance of completing assessment forms. Teams plan to have intentional and continued discussion with nurses at monthly team meetings, during case conferencing, and one-to-one discussions during reflections and during joint visits.

- **Description of reports that are generated, how often, and for whom:** Data is pulled from client assessment forms to run reports. Some of the reports provide individual client data, aggregated data, and data by community. NFP supervisors and electronic data system leads run the reports. The report generation frequency varies depending on the report and need of the staff member. The annual report data is generated in January for the previous year, but it can be run more frequently if required. The Provincial Health Services Authority and regional health authorities continue to meet with the electronic documentation system leads in BC to develop new and/or improve existing NFP data extract reporting processes and reports.

- Our reflections on our information system - what we need to do to improve its functionality, utility, and quality: The information system could benefit from a quality improvement initiative.

- NFP electronic forms have had limited updates since 2012 in BC and do not adequately reflect changes within public health and NFP nursing practice. Nurses also find the documentation system, which requires them to navigate multiple screens to document their visits, results in data errors and omissions in charting/documentation. Provincially, NFP teams are challenged to modify electronic forms due to the long delays ranging from months to years to have forms revised on the electronic documentation system due to multiple competing priorities and requests for same for other clinical programs.
- This year supervisors in one region faced challenges with extracting data for the annual report requiring manually counting several items such as encounters. Specifically, they faced challenges with three reports pulling outdated information (FH091, FH093 & FH094), and some of the new NFP encounter data not being pulled into the NFP Encounter Report. This heath authority identified the need for further collaboration with their data team in improving the extract reports required for annual reporting.
- The BC NFP Documentation Manual (nursing assessment data collection forms) for BC is outdated, posing a challenge for many of the newer nurses. Some progress has been made this year as a small working group of NFP supervisors have come together to review, enhance, and update the BC NFP Documentation Manual as it is an important reference tool for nurses.

Any other relevant information:

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 Monitored/assured by:	**100%** first time mothers	
3. Client meets socioeconomic disadvantage criteria at intake	The eligibility criteria for inclusion in the program in our country are: This includes the socioeconomic criteria of: (See appendix 4) • Homeless • 19 or younger • 20-24 and meets 2 of 3: 1) lone parent, 2) <grade 12, 3) low income Application of these criteria are assured and monitored by: Local prenatal registration forms	**97%** clients enrolled who meet the country's socio-economic disadvantage criteria	

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.	100% of NFP clients receive their first home visit no later than the 28th week of pregnancy. 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program. 60% of pregnant women are enrolled by 16 weeks' gestation or earlier	**76%** of NFP clients receive their first home visit no later than the 28th week of pregnancy % of eligible referrals who are intended to be recruited to NFP are enrolled in the program- **Data not collected** **27%** of pregnant women are enrolled by 16 weeks' gestation or earlier 114 clients were enrolled in 2024	National benchmarks do not apply. In November 2021, BC began trialing a variance to CME 4 allowing a small number of clients to enroll after the 28th week. Each late enrolment was reviewed by supervisors to determine identified client need and suitability. The variance has been extended for 2024. Data capturing eligible referrals is not reflective of program capacity given that some areas with no capacity stop taking referrals for screening; therefore, not able to collect this data accurately at this time.
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	
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.	National/ Country benchmark set is: >50% visits take place in the home	**63**% visits take place in the home % breakdown of where visits are being conducted other than in the client's home: **2%** - family/ friends home **1%** - doctor/clinic/hospital/ treatment facility	

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Commentary: Challenges + suggested actions to address these
		8% - public health office **1 %** - school **11 %** - "other" location **13 %** telehealth visits completed (video/phone/text) **18%** of visits where second parent of child is present **13%** of visits where other family members are present	
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.	National/Country benchmarks for: Length of visits by phase - our country benchmarks: not determined Client attrition by program phase – our country benchmarks: not determined	**N/A** % of clients being visited on standard visit schedule **N/A** % of clients being visited on alternate visit schedule Average number of visits by program phase for clients on standard or alternate visit schedule is: Pregnancy: 7 Infancy: 21.7 Toddler: 14.7 Length of visits by phase (average and range): Pregnancy phase: **71 mins**	BC doesn't differentiate between standard and alternate visit schedules as the program is flexible to meet the client's needs. All clients are offered a standard visit schedule upon enrolment and supported/visited throughout the program depending on needs and client preference. Average number of visits by program phase is based on clients who have completed the program phase. Attrition is calculated using the total number of clients who left the program for reasons other than graduation/transition to another health unit and the total number of clients served (received at least one NFP visit) throughout 2024.

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Commentary: Challenges + suggested actions to address these
		Infancy phase: **70 mins** Toddler phase: **69 mins** Client attrition by phase and reasons: **3%** attrition in Pregnancy phase (client request, moved, too busy, termination, lost to follow up) **10%** attrition in Infancy phase (moved, out of province treatment program, lost to follow up, death, lost custody, nurse left & declined new nurse) **5%** attrition in Toddler phase (moved, incarcerated, lost to follow up, apprehension, client request) *attrition is calculated by the # of clients who were discharged prior to graduation by phase (in the reporting year), divided by the total # of clients served in the reporting year	87 clients completed/graduated from NFP in 2024.
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate/bachelor's degree.	100% of NFP nurses are registered nurses or registered midwives with a minimum of a baccalaureate /bachelor's degree. Monitored/assured by: standardized	**100%** NFP nurses are registered nurses or registered midwives 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
	job description Countries may also want to analyze other nurse variables such as age, years within profession, specialist qualifications etc		
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 No national benchmark for % of NFP team meetings, case conferences and team education sessions are completed (against expected for time period)	**95%** of NFP nurses and supervisors complete the required NFP educational curricula and participate in on-going learning activities **100%** completion of team meetings, **92%** completion of case conferences	By Dec 31, 2024, 1 nurse was waiting to complete DANCE training, (enrolled for 2025) Case conferencing was interrupted in one region due to competing health authority priorities such as providing immunization clinics during respiratory season, and in other cases because the presenting nurse was absent.
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.	See section at the end of this table*.	See section at the end of this table*.	See 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	100% of 4-monthly Accompanied Home Visits completed (against expected).	**64%** of 4-monthly Accompanied Home Visits completed	Accompanied home visit (AHV) completion has remained stable since last year (63% in 2023). Supervisors reported challenges related to geographic distance and travel time required, visits being cancelled, staff

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Commentary: Challenges + suggested actions to address these
attachment theories) to guide their clinical work and achievement of the three NFP goals			changes and program interruptions, and gaps in supervisor coverage. AHV are below benchmark and an area for improvement.
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 (calculated by time – working weeks- and number of nurse).	**100%** of NFP teams have an assigned NFP Supervisor **77%** of reflective supervision sessions conducted	Reflective supervision rates have dropped back down to 2022 levels after a brief increase in 2023 (77% in 2022, 86% in 2023). They remain below benchmark, providing an opportunity for further improvement. Some regions feel the benchmark is unrealistic given the significant amount of vacation time taken by highly experienced nurses with a lot of seniority, and challenges with small teams where supervisors do not have replacement coverage.
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: Chart audits, fidelity reports, etc.	Progress:	Regional teams did report utilizing Annual Report data during team meetings, for example to reinforce messaging around completion of required documentation forms.
14. High quality NFP implementation is developed and sustained through	(No national benchmark) % of Advisory Boards or equivalents held in	Regular meetings throughout the year with: NFP Managers working Group, NFP Supervisors Community	

Core Model Element	National/Country Benchmarks and how these are being monitored	Progress against Benchmarks	Commentary: Challenges + suggested actions to address these
national and local organized support	relation to expected (No national benchmark) % attendance at Advisory Boards held in relation to expected Monitored/assured by (including other measures used to assure high quality implementation):	of Practice, NFP BC Team meeting, Clinical & Education Leads forum, Global Collaborative Guidance Group.	

Domain coverage*

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

Domain	Pregnancy Benchmark (%)	Pregnancy actual (%)	Infancy benchmark (%)	Infancy actual (%)	Toddler benchmark (%)	Toddler actual (%)
Personal Health (My Health)	35-40%	42%	14-20%	26%	10-15%	18%
Maternal Role (My Child and Me)	23-25%	27%	45-50%	49%	40-45%	46%
Environmental Health (My Home)	5-7%	9%	7-10%	8%	7-10%	10%
My Family & Friends (Family & Friends)	10-15%	14%	10-15%	12%	10-15%	14%

Life Course Development (My Life)	10-15%	13%	10-15%	10%	18-20%	15%

Commentary: (please identify any successes and challenges highlighted for CME 10 and any suggested actions to address these here):

In 2024, there were some concerns with the accuracy of the data collected for % time spent in each domain; one of the health authorities reported totals over 100%, which also impacted the BC averages for the 2024 annual report. Supervisors report that this data was calculated manually from the new NFP Encounter report and felt the discrepancy was due to a data entry error. Despite this, based on available data, nurses continue to meet the benchmarks in time spent in most domains. It is noted that slightly more time was spent on the Personal Health topic during all phases, and on Maternal Role during the Pregnancy and Toddler phase. In contrast, less time was spent during the Toddler phase on Life Course Development, as compared to benchmarks. One region, which did not meet the benchmarks for all phases and surmise that this was due to late gestational age enrolment, which naturally shifted more time to be focused in Personal, Maternal & Environmental Domains. Errors in data reporting are expected to be improved for the 2025 year through updated Panorama extract reports.

Supervisors provide ongoing support to NFP nurses on how to provide structure to NFP visits, and to balance topics while still promoting and goal setting. Supervisors often present this data to their regional health authority managers and leadership to share ideas on how to incorporate goal setting, building self-efficacy and promoting life course development into home visit planning with clients.

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)	15-24 yrs Average age = 20 years	14-24 yrs Average age= 19 years
Race/ethnicity distribution	30% (n=54) Indigenous/First Nations/Metis/Inuit <5% Arab/West Asian (e.g., Iranian, Lebanese) 8% (n=15) Black (e.g. African, Haitian) 0% East Asian 7% South-East Asian 0% South Asian <5% (n<10) Latin-American 46% (n=83) White <5% (n<10) Other *this does not represent clients who identify as more than one ethnicity	30% (n=30) Indigenous/First Nations/Metis/Inuit <5% Arab/West Asian (e.g., Iranian, Lebanese) <5% Black (e.g., African, Haitian) 0% East Asian 0% South-East Asian 5% (n=5) South Asian 7% (n=7) Latin-American 64% (n=64) White <5% Other *this does not represent clients who identify as more than one ethnicity

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)**	**Current Period (n/%)**
Income (please state how this is defined)	29% (n=49) No annual income 7% (n=12) Annual income under $5k 8% (n<13) Annual income $ 5k-$9.9K 13% (n=21) Annual income $ 10k-$14.9k 11% (n=19) Annual income $ 15k-$19.9k <5% (n<10) Annual income $ 20k-$24.9k <3% (n<10) Annual income $ 25K-$29.9k	30% (n=29) No annual income 4% (n=4) Annual income under $5k 7% (n=7) Annual income $ 5k-$9.9K 13% (n=13) Annual income $ 10k-$14.9k 14% (n=14) Annual income $ 15k-$19.9k 5% (n=5) Annual income $ 20k-$24.9k 4 % (n=4) Annual income $ 25K-$29.9k 4% (n=4) Annual income $30k or more
Inadequate Housing (please define)	Data not available	Data not available
Educational Achievement (please specify)	26% (n=51) enrolled in any kind of school, vocational or educational program 51% completed high school	31% (n=100) enrolled in any kind of school, vocational or educational program 53% (n=93) completed high school
Employment status	25% (n=46) working full or part-time	28% (n=26) working full or part-time
Food Insecurity (please define)	Data not available	Data not available
Ever in care of the State (as a child or currently)	Data not available	Data not available
Frequency of contact with biological father of the child	Data not available	Data not available
Obesity (BMI of 30 or more)	Data not available	Data not available

Characteristics of our clients at enrolment		
Health, Social and economic Conditions at enrolment	**Previous year(s) (n/%)**	**Current Period (n/%)**
Severe Obesity (BMI of 40 or more)	Data not available	Data not available
Underweight (BMI of 18.5 or less)	Data not available	Data not available
Heart Disease	<5% (n<10)	<5% (n<10)
Hypertension	<5% (n<10)	<5% (n<10)
Diabetes – T1	0%	0%
Diabetes – T2	0%	0%
Kidney disease	0%	0%
Epilepsy	<5% (n<10)	<5% (n<10)
Sickle cell Disease	0%	0%
Chronic Gastrointestinal disease	<5% (n<10)	<5% (n<10)
Asthma/other chronic pulmonary Disease	17% (n=26)	26% (n=20)
Chronic Urinary Tract Infections	7%	8%
Chronic Vaginal Infections (e.g., yeast infections)	<5% (n<10)	7% (n<10)
Sexually Transmitted Infections	9%	13%
Substance Use Disorder	Data not available	Data not available

Mental Illness	59% (n=89)	80% (n=61)
Other (please define)	20% (n=30)	13% (n=10)

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:

- *The extent to which your data indicates that your program is serving families with multiple overlapping needs*
- *What you know about the characteristics of eligible families who are offered the program, but decline to participate*

It is important to note that the health authority reported client characteristics data is not necessarily representative of all BC NFP clients. The data reported at different time intervals is not representative of the same client(s) over time. Also, the data does not include clients that declined to answer or were not eligible to answer. Therefore, BC can't draw interpretations from these data sources.

Data suggests newly enrolled NFP clients are less ethnically diverse in 2024 compared to 2023, with the most noticeable shift being an increase in clients describing their race/ethnicity as "White" (64% in 2024 compared to 46% in 2023). This may be correlated to the BC's largest health authority pausing new enrolments into the NFP Program that statistically serves an ethnically diverse population with greater representation of racialized populations. The data also suggests that NFP clients are experiencing higher rates of mental illness and certain types of infections including STIs. The data also identified a higher percentage reporting annual income over $10,000, working full or part-time, and completing grade 12 or participating in education or training (compared to 2023); however, data may not be an accurate representation and should be interpreted with caution as described previously. BC does not use the STAR framework at present.

Anecdotally, nursing teams reported that many of their clients are experiencing challenges related to their mental health, income, housing, and access to a primary health care provider. For example, many clients reported significant mental health symptoms at enrolment including psychosis, phobias, and ADHD for example, which in many cases were not diagnosed or treated. These conditions not only impact their ability to engage and focus on NFP activities, but they also experience further instability related to their medications during pregnancy and in the postpartum period. Income and overall affordability of essentials, including housing, continues to be a concern in our province and for NFP clients. One region reported that 38% of their clients reported having no income or needing to access multiple sources of income to survive. Limited income is further compounded by the cost and availability of safe housing. For those who require and have access to supportive housing options, these come with significant expectations around attending daily programming. Attendance at these programs can conflict with client's ability to pursue their goals around education and work. A supportive factor identified by one region included having access to Community Integration Specialists who can support clients to access income assistance. A further compounding factor is that most new clients have either time-limited care (e.g., midwife) or no primary care provider.

These complex and overlapping inequities have also led NFP nurses in some regions to feel that taking late referrals instead of declining NFP service is an

ethical decision, especially when other enhanced family visiting services are not offered due to nursing workloads.

Alterable Maternal Behavior/ program impacts for clients **(please complete for all the time periods where the data is collected)** (numerator = # clients who answered question; denominator = # clients who completed assessment)					
	Intake	**36 Weeks of Pregnancy**	**Postpartum**	**12 months**	**18 months**
Anxiety, (n, % moderate + clinical range)	N/A	N/A	N/A	N/A	N/A
Depression, (n, % moderate + clinical range)	**21 %** (n=14) EPDS score =>12	N/A	**26 %** (n=36)	**16 %** (n=9)	N/A
Cigarette Smoking, (n, % 1+ during pregnancy, mean number /48 hours)	**31%** (n=23)	**31 %** (n=17)	N/A	**20%** (n=14)	N/A
Alcohol, (n, % during pregnancy, units/last 14 days)	**31%** (n=23)	**7 %** (n=4)	N/A	**23%** (n=17)	N/A
Marijuana, (n, % used in pregnancy, days used last 14 days)	**61%** (n=45)	**17 %** (n=9)	N/A	**31%** (n=22)	N/A
Cocaine, (n, % used in pregnancy, days used last 14 days)	**5 %** (n=5)	0%	N/A	0%	N/A
Other street drugs, (n, % used in pregnancy, days used last 14 days)	**6%** (n=4)	<5% (n=1)	N/A	**<5%** (n=1)	N/A
Excessive Weight Gain from baseline BMI during pregnancy (n, %)	N/A	N/A	N/A	N/A	N/A
Mastery, (n, mean)	N/A	N/A	N/A	N/A	N/A

Alterable Maternal Behavior/ program impacts for clients **(please complete for all the time periods where the data is collected)** (numerator = # clients who answered question; denominator = # clients who completed assessment)					
	Intake	**36 Weeks of Pregnancy**	**Postpartum**	**12 months**	**18 months**
IPV disclosure, (n, %)	**63%** (n=26) Disclosure at pregnancy (of IPV within last 12 months)		**51 %** (n=28) Disclosure at Infancy (of IPV within last 12 months)	N/A	**41 %** (n=20) Disclosure at Toddlerhood (of IPV within last 12 months)
Reliable Birth Control use, (n, %)	79% (n=85)	84% (n=94)	79% (n=66)	86% (n=62)	
Subsequent pregnancies, (n, %)	<5% (n=4)	12% (n=13)	24% (n=20)	21% (n=15)	
Breast/chestfeeding, (n, %)	57% (n=63)	36% (n=38)	24% (n=19)	1% (n=12)	
Involvement in Education, (n, %)	21% (n=23)	37% (n=41)	40% (n=34)	31% (n=22)	
Employed, (n, %)	<5% (n=3)	19% (n=20)	31% (n=23)	39% (n=26)	
Housing needs, (n, %)	Data not available	Data not available	Data not available	Data not available	
DANCE (or equivalent), (mean - 2, 9, 15, 22 months).	Data not available	Data not available	Data not available	Data not available	
Father's involvement in care of child, (n, %)	77% (n=85)	74% (n=77)	69% (n=54)	77% (n=50)	

Alterable Maternal Behavior/ program impacts for clients **(please complete for all the time periods where the data is collected)** (numerator = # clients who answered question; denominator = # clients who completed assessment)					
	Intake	**36 Weeks of Pregnancy**	**Postpartum**	**12 months**	**18 months**
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.): It is important to note that the health authority reported client characteristics data is not necessarily representative of all BC NFP clients. The data reported at different time intervals is not representative of the same client(s) over time. Also, the data does not include clients that declined to answer or were not eligible to answer. Therefore, BC can't draw interpretations from these data sources.

Compared to assessment at intake, the data indicates there is improvement in several impact areas at various subsequent time points. These include decreases in: depression, cigarette smoking (12 months), alcohol, marijuana, cocaine, and other street drugs (36 weeks pregnancy and 12 months), and IPV disclosure (infancy and toddlerhood).

Data from 2024, as compared to 2023, suggest NFP clients (who responded) are reporting lower overall rates of depression, alcohol use and cigarette smoking; they are reporting overall higher rates of marijuana use and IPV disclosure. Compared to 2023, NFP clients assessed in 2024 reported higher rates of subsequent pregnancies (at 18 and 24 months), breast/chestfeeding (all time points), involvement in education (at 12 and 18 months), employment (at 6, 12, 18 months), and father's involvement in child's care (at 6 and 12 months). Data related to cigarette smoking should be interpreted with caution, as the current NFP forms (e.g., Healthy Habits form) do not adequately capture or allow for quantifying behaviors related to vaping tobacco using e-cigarettes which many people use as an alternative to smoking conventional cigarettes.

In which areas is the program having greatest impact on maternal behaviors?

Researchers in BC as part of the Healthy Connections Project, published data in 2020 from their RCT conducted in BC between 2013-2019. The authors reported that the NFP program in BC, led to reductions in prenatal substance exposure, specifically decreasing cannabis exposure and also reducing cigarette use in smokers (Catherine et al., 2020). In 2025, the same authors published findings of a parallel arm of the same Healthy Connections Project which reported positive impacts of the NFP program on four pre-specified exploratory outcomes including: a decrease in self-reported exposure to IPV at 24 months, and positive impacts on income, psychological distress and self-efficacy at 34-36 weeks (Catherine et al., 2025).

Individually some regions reported an increase in clients pursuing higher education (including post-secondary), achieving employment, an overall decrease in subsequent pregnancies compared to previous years, and an ongoing interest in learning how to communicate with the child's father who may also be experiencing adversity (e.g., mental health challenges, unemployment or substance use disorder). One region reported that they anecdotally see improvements in mental health outcomes in terms of being able to connect with clients in a relational way to encourage them to access supports. They also notice that through the parenting and attachment interventions, clients seem more willing to access supports or make the necessary changes to support their child. The nurses also report observing the greater gain in the Maternal Role domain where they anecdotally report positive parenting behaviors.

In order to better serve some of the more complex needs of their clients and improve outcomes related to maternal behaviors, one region offered NFP nurses additional learning opportunities during a two day in person education session, around perinatal substance use and IPV to increase their knowledge and competency working with clients experiencing these challenges.

Which are the areas of challenge?

- One challenge identified is that many NFP clients experience multiple layers of adversity such as: growing up in foster care system, ACES, loss of parents/immediate family members/friends to toxic drug crisis, dual diagnoses of mental health conditions, and housing instability. While this is a challenge, nurses not only recognize that these clients receive the greatest benefit from NFP, but they are able to adjust the dosage (visits) and increase client engagement.
- Despite the offering of free contraception options provincially, clients continue to have barriers in accessing this. NFP nurses' efforts towards advocacy and ensuring follow-up seems to improve clients receiving contraception.
- Nurses noted that data is not reported for Tdap vaccine offered and given during pregnancy (this is a routine recommendation in BC), yet anecdotally the nurses state that almost all their clients are receiving this immunization. This is a successful health intervention that is not captured in reporting.
- While data reporting is improving for BC's NFP program, work is still underway to improve data accuracy.
- NFP nurses continue to serve clients, and attempt to provide consistency, for those facing difficulty accessing a primary care provider. This continues to require NFP nurses to expand their roles around health assessments and interventions and "bridge the gap" until the client can find a primary care provider (e.g., midwife, family doctor).

Birth data		
	Number	**% of total births for year**
Extremely preterm (less than 28 weeks' gestation)	N/A	N/A
Very preterm (28-32 weeks' gestation)	N/A	N/A
Moderate to late preterm (32-37 weeks' gestation)[1]	11	8%
Low birthweight (<2.5kg)	10	7%
Large for Gestational Age (LGA) (>4kg)	10	7%
Other (please define)		

Please comment below on your birth data:
Health authorities are unable to report on extremely preterm or very preterm birth data. There was a decrease in moderate to late preterm (8% of total births in 2024 compared to 16% in 2023), and in low birthweights (7% in 2024 compared to 9% of total births in 2023), with one region identifying only one out of 53 births as "very low birthweight". There was a slight increase in LGA babies (7% in 2024 compared to 6% in 2023). Some NFP teams hypothesize that

interventions that enhance food security such as access to Farmers' Market Nutrition Coupons may support improved birthweights, as one region reported supporting over 90 families with the program.
One region also noted that two late enrollments also had preterm deliveries, impacting the number and potential impact of pregnancy visits.

Child Health/Development (numerator = # clients who answered question; denominator = # clients who completed assessment)				
	6 months (% of total)	**12 months (% of total)**	**18 months (% of total)**	**24 months (% of total)**
Immunizations Up to Date	81% (n=89)	80% (n=85)	79% (n=65)	83% (n=60)
Hospitalization for Injuries	<10% (n=8)	<10% (n=10)	<10% (n=4)	<10% (n=3)
ASQ scores requiring monitoring (grey zone)	11% (n=12)	19% (n=19)	12% (n=10)	11% (n=17)
ASQ scores requiring further assessment/referral	<10% (n=5)	<10% (n=5)	23% (n=20)	16% (n=10)
ASQ-SE scores requiring monitoring (grey zone)	13% (n=15)	12% (n=14)	<10% (n=8)	14% (n=10)
ASQ-SE scores requiring further assessment/referral	<10% (n=10)	<10% (n=7)	10% (n=10)	<10% (n=6)
Child Protection (please define for your context) # of PHNs selecting "yes" to initiating referral or being aware of any referrals regarding mother/family to family services for concerns regarding suspected abuse or neglect of child	3.5 % aware (n=2) 16 % initiated (n= 9) 19 % total (aware or initiated) (n= 11)	2 % aware (n= 1) 20 % initiated (n= 10) 22 % total (aware or initiated) (n= 11)	6 % aware (n= 2) 31 % initiated (n= 10) 37 % total (aware or initiated) (n= 12)	7 % aware (n= 2) 33 % initiated (n= 9) 41 % total (aware or initiated) (n= 11)

since the birth				
Other (please define)				

Please comment below on your child health/development data:
It is important to note that the health authority reported client characteristics data is not necessarily representative of all BC NFP clients. The data reported at different time intervals is not representative of the same client(s) over time. Also, the data does not include clients that declined to answer or were not eligible to answer. Therefore, BC can't draw strong interpretations from these data sources.

Nurses report that the ongoing provision of PIPE, DANCE, and ASQ screening has resulted in a very small amount of NFP infants and toddlers requiring referrals to Infant Development Programs (IDP). When referrals are made nurses may partner with IDP workers during joint visits, and if referrals are made close to graduation, nurses will continue visits until IDP is established.

Nurses have been applying multiple strategies to promote uptake of childhood immunizations including using their motivational interviewing skills and offering flexible appointment times and locations for immunizations. Multiple regions reported that immunization rates are comparable or higher than their health authority's general immunization rates. In previous years teams have felt that documentation (form FH091) was not correctly reporting on immunization rates, with nurses anecdotally reporting that immunization rates were higher than reported. A trend of increasing immunization rates is also reflected in the data, with immunizations-up to date for age reported around the 80% mark for all time points compared to a range of 51-80% for various time points in 2023.

Regions also reported high rates of initiation of breast/chest feeding (between 86-92%) with one region reporting breast/chestfeeding continuing at 6 months (58%) and another region reporting 38% at 12 months.

Additional analyses
Please insert here any additional analyses undertaken to further explore program impacts: n/a
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.: • See Appendix 5 for photos and testimonials. • In October-November 2024, PHSA conducted an Enhanced Family Health Engagement Survey to engage existing families within the NFP

Program, families who have graduated from NFP, and other families currently enrolled in a health authority specific Enhanced Family Health Program. Objective of the survey was to ascertain their experiences with the programs, the perceived benefits/strengths, opportunities for further enhancements, and what they project their support needs may be once graduated from the programs to help inform strategies to further extend reach to structurally disadvantaged and marginalized families, explore additional innovations in service delivery and to advance quality improvement efforts.

- Some of the quotes related to NFP are included below:
  - *"I had the most amazing experience with the NFP program. I only wish I could have been in it for longer."*
  - *"We have been graduated from the program for 4 years, and to this day, I use the skills and information I learned through NFP. I recommend it to many people and feel that it set myself and my son up for long-term success."*
  - *This quote is assumed to refer to NFP as it relates specifically to NFP's unique eligibility criteria: "Didn't really need anything but I was hoping to go through it with my second child, but it was only for first-time moms."*

Sentinel / Significant events that deserve review:

Event	**Number**	**What** was the learning?
Child death	2	1- Congenital anomaly; 1 - influenza
Maternal death	2	1- Prior NFP graduate died from toxic drug supply; 1- overdose post apprehension of baby
Other	1	Mother incarcerated and under investigation for production and distribution of child pornography

Any other relevant information or other events to report: n/a

PART FOUR: PROGRAM IMPROVEMENT & EVALUATION

Continuous Quality Improvement (CQI) program

- **Briefly describe your system for monitoring implementation quality:** Monitoring implementation quality is conducted through ongoing collaboration, self-assessment and reflection with health authority and national partners, chart audits, and using fidelity reports to provide a tool for data analysis. This data is then used to ensure a high-quality program is being delivered. A CQI logic model was created and updated as required (see Appendix 3 for more detail).
- **Goals and Objectives for CQI program during the reporting period**: There are three primary focus areas for CQI including client interaction, program implementation, and outcome achievement:

Client Interaction

o Home Visit Plan every visit

o Facilitator: How is it going between us

o Client exit survey

Program Implementation

o One-to-one clinical supervision weekly, 1 hr

o Case conferences twice a month, 1½ - 2 hrs

o Team meetings at least twice a month or weekly, 1 hr

o Field supervision (joint visits) every 4 months, minimum 2-3 hrs & 1 client

o Nurse consultation

o Education evaluation

o HA/Provincial CoP twice a month

o Fidelity/attrition reports (Panorama/Paris)

o Annual Implementation Plan

o Annual fidelity report (Dr. Olds)

o Documentation

Outcome Achievement

o Fidelity outcomes

o Pregnancy outcomes

o Maternal outcomes

o Child health & development outcomes

- **Outcomes of CQI program for the reporting period**
  - **Client Interaction:** In-person visits were strong between nurses and clients in 2024, with 85% of all nurse-client visits taking place in-person (63% took place in the home and 23% took

place in other locations outside of the home such as clinics, schools, parks, etc.); this helped maintain positive therapeutic relationships between nurses and clients. BC, Ontario, and Nova Scotia have been in discussions to re-establish a strategy to improve and update nursing facilitators; however, there have been some barriers to ensuring all facilitators are up to date due to capacity of BC, Ontario, and Nova Scotia NFP Teams. There are plans to convene a time-limited working group to update nursing facilitators between the three provinces in Fall 2025.

- **Program Implementation**: Participant feedback was positive regarding NFP provider education despite being delivered in some cases. Nursing teams experienced challenges building time for reflective supervision mostly due limited supervisors' capacity and teams supporting other public health initiatives including immunizations. However, supervisors found creative solutions and completed 77% of reflective supervision overall in 2024, which is a decrease from 2023 (86%). Case conference and accompanied home visit completion rates remain below benchmarks at 92% and 64% respectively; however, case conferencing completion has improved since 2023 (from 78%). Teams have also indicated that in some cases, when case conferencing didn't occur due to the presenting nurse being absent, teams continued to utilize the time to discuss "hot topics" or to seek team advice on "challenges" with clients.
- In 2024 there was an overall decrease of 13% in the total number of clients served (from 536 in 2023 to 466 in 2024). There was a 46% decrease in the number of new enrolments (from 210 in 2023 to 114 in 2024). This decline in enrolments and clients served is attributable to one of BC's largest health authorities pausing enrollment into the NFP Program in May 2024 as they prepared to sunset its NFP Program operations in March 2025.
- In Fall 2021, the BC NFP Program was approved for a variance to CME 4. Given this variance, 76% of NFP clients receive their first home visit no later than the 28th week of pregnancy. In 2024, only 24% of new enrolments were enrolled after 28 weeks gestation but before birth (3% were enrolled after 35 weeks gestation). Additionally, 27% of new enrolments were enrolled before 16 weeks gestation which is similar with reports from 2021-2023. Even with the variance, NFP nursing teams continue to collaborate hard with community partners to promote early referrals, while prioritizing client-centered care and building strong therapeutic nurse-client relationships for clients who enroll late and have fewer visits in the pregnancy phase.
- Teams report using the Annual Report to reflect on data remediation and data completion issues with nurses. Some teams are also exploring ways to build efficiencies around documentation (e.g., use of dictation).
- One region reported utilizing client demographic data to improve NFP nurse education, training and improving clinical practice. This region identified that Indigenous clients are overrepresented in the NFP Program compared to the general population. They used this information to identify learning needs within the team and improve their ability to provide culturally responsive supports to NFP families. This included enhancing partnerships with Indigenous health organizations and providers (e.g., First Nations Health Authority, Indigenous health liaisons, etc.).
- One region also described accepting an increased number of late gestation referrals, as they identified that declining NFP service to these clients was unethical, where no adequate service would meet their needs.
- **Outcome Achievement**: During the 2024 reporting year, most CME benchmarks were met and, in some cases, surpassed (i.e., CME 6 – face to face visits in the home). Some benchmarks were not met, including: completion of required educational criteria (95% compared to 100% benchmark) due to some nurses waiting to complete DANCE fundamentals (CME 9),

accompanied home visits (64% compared to 100% benchmark), due to staff turnover/geographic challenges, cancelled visits, supervisor coverage (CME 11), and reflective supervision (77% sessions conducted compared to 100% benchmark) (CME 12). These achievements do not include the variance (CME 4) which is covered in other sections of the report. Achievement of most of these CME benchmarks has remained stable over the last one to two reporting years (2022 and 2023).

- **Lessons learned from CQI initiatives and how these will be applied in future***:* BC will work with existing and graduated NFP clients, as well as health authority and national partners on approaches that help ensure that families have access to high quality supports during pregnancy and early parenting, which will also give these children the best start in life.
- One region identified an increasing number of late referrals. This region plans to engage Urgent and Primary Care Centers, community agencies and other referral sources to increase awareness of the NFP Program and encourage referrals to be made earlier in gestation.
- One region plans to review options for monthly monitoring of NFP data to support documentation completion and remediation with their nurses.
- The Provincial NFP leadership team will continue to collaborate with nursing supervisors and various electronic medical records documentation system teams (PARIS and Panorama) to streamline documentation to improve completion and ensure consistency in data entry and reporting.
- **Goals for CQI in next year:** PHSA is committed to providing high quality, equitable services and culturally-centered, responsive and trauma-informed care to families who need it the most.
- Take concrete actions to improve completeness of nursing documentation within NFP assessment forms that are required for reporting and data collection by reducing documentation burden. Specific actions include:
  - Explore options to streamline and refresh electronic forms such as the Nursing Care Plan by adding multiple assessment domains to a single form to reduce navigation burden of opening multiple forms during a single assessment (i.e., integrate additional assessment domains into the Nursing Care Plan by adding drop down menus to include: PIPE, EPDS, IPV, Healthy Habits, postpartum assessment, etc.).
  - Request revisions to electronic assessment forms (e.g., Healthy Habits) to ensure relevance to the population (i.e., including data related to naturopathic treatments, prescription medications, vaping, etc.).
  - Explore the utility of including a “summary narrative” within documentation at the end of each phase (i.e., pregnancy, infancy, toddler phase, etc.) to reduce time burden for nurses associated with reviewing documentation, nursing handover and preparation for home visits.
  - Explore whether Referral & Service Utilization form can be embedded within Encounter form which would support a “visual prompt” and remind nurses to follow up with clients on referral and service utilization needs.
- **Re-establish NFP Collaborative in Canada Clinical Leads Working Group to improve program materials and service**
  - To support continuous quality improvement and development of program materials (e.g., visit to visit guidelines, facilitators, etc.). BC, Ontario and Nova Scotia Provincial Clinical Leads plan to convene time-limited working groups in 2025, with regional participation from experienced NFP supervisors and/or frontline nurses to revise and update materials to improve relevance for the current state of Canadian public health nursing services, and to align with population changes and trends.

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

Program innovations implemented:

- One region continued to request any surplus health authority funding available be re-directed to support nurses with client engagement. Having this funding for clients provides the nurses with a "connection" that goes beyond the monetary value of gift cards, purchase of baby books & materials and engages the client into the therapeutic relationship. In addition, it prevents nurses from spending their own money to support client engagement.

- Grants and funding received for 2024 included: Farmers' Market Nutrition Coupon Grant (approximately: $26,000 accessible to families in multiple regions), transportation grant ($200), 10 infant car seats provided through United Way, cash for coffee gift cards provided by Vernon Hospital and Royal Inland Hospital ($400 from each hospital), and First Books Canada Book Bank Grant funded though Bank of Montreal ($500 to purchase books to give clients with PIPE lessons).
- Enhanced Family Health Engagement Survey – PHSA launched a provincial survey in Fall 2024 to engage existing families within the NFP Program, families who have graduated from NFP, and other families currently enrolled in a health authority specific Enhanced Family Health Program. Objective of the survey was to ascertain their experiences with the programs, the perceived benefits/strengths, opportunities for further enhancements, and what they project their support needs may be once graduated from the programs to help inform strategies to further extend reach to structurally disadvantaged and marginalized families, explore additional innovations in service delivery and to advance quality improvement efforts.

Findings and next steps:

- Continuation of virtual education in collaboration with Ontario and Nova Scotia – Utilizing Ontario's Learning Management System (Moodle) and Nurse-Family Partnership Education Curriculum for use in Canada (CaNE curriculum).
- Continue to leverage recurring provincial, national and international connections via meetings (NFP Supervisors Community of Practice, NFP Managers Working Group, NFP Collaborative in Canada, NFP International Clinical Working Group) to network, learn from and share strategies for continuous quality improvement, and access local, provincial, and international evidence and education to support service delivery.
- Review and analyze results from the Family Engagement Survey and explore the development of a provincial strategy to further extend services to families who would benefit from an enhanced family health program in BC.

Temporary Variances to CMEs

CME 4: Client is enrolled early in pregnancy and received home visit no later than the 28th week of pregnancy.
• BC has a temporary variance to offer, in individual circumstances, a small, infrequent number of clients (e.g., projected estimate to be 5-10% of all new enrolments) the ability to enrol in the NFP past 28 weeks + 6 days gestation but before birth. These late enrolment opportunities will be reviewed on a case-by-case basis by NFP Nurse supervisors/managers.

See Appendix 2 for more information on the CME variance.

Additional Approved Model Elements (AAMEs)

Please attach a summary of findings in relation to any Additional Approved Model Elements in Appendix 3 to this document

Research and evaluation

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

- In 2024, researchers continued work on the following report: Catherine et al. "Effects of nurse-home visiting on intimate partner violence and maternal income, mental health and self-efficacy by 24 months postpartum: A randomised controlled trial (British Columbia Healthy Connections Project)" – (published in January 2025)
- In 2024, Catherine et al., also continued to work with Indigenous scholars to prepare a report on the BCHCP RCT findings related to Indigenous Children and Mothers in BC – "Understanding the experiences of young, urban, Indigenous mothers-to-be in British Columbia, Canada"- published in January 2025
- In 2024, Catherine et al. published a rapid review of effective home visiting programs, which highlighted the NFP program: "Effective Home Visiting Programs for Children and Mothers Experiencing Adversities".

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

PART FIVE: ACTION PLANS

LAST YEAR:

Our planned objectives for last year:

The BC Ministry of Health (MoH) was transitioning the Nurse-Family Partnership program to the Provincial Health Services Authority's (PHSA) Child Health BC (CHBC) and Perinatal Services BC (PSBC) to support continued NFP services for families. CHBC and PSBC are both well positioned to oversee the program as provincial health improvement networks specialized in supporting regional coordination, facilitating province wide solutions for the maternal child population, and its expansive connections and networks with perinatal, infant and child experts.

To support this change in oversight, the MoH developed a transition plan with the following objectives/goals:

• Complete discussions/negotiations to transition the license and clinical oversight for NFP to the proposed partner organization.

• Develop communications materials and undertake communications with key partners.

• Orient health authority partners to the NFP transition.

• Transition existing NFP Website agreement.

• Share existing agreements, program material and reports.

• Update and/or review existing research agreements and work plan to support approach and transition.

• Ensure PHSA has appropriate resources (project coordinator and clinical lead) in place to deliver on project outcomes.

• Transfer knowledge, share best practices, facilitate information sharing to support transition and provide introduction to CHBC/PSBC to NFP Ontario and Nova Scotia teams.

Progress against those objectives:

- **Complete discussions/negotiations to transition the license and clinical oversight for NFP to the proposed partner organization:** The licensing agreement between NFP International and PHSA was finalized in May 2024 as planned.
- **Develop communications materials and undertake communications with key partners:** In May 2024, the BC Ministry of Health circulated key messages describing the program transition from MoH to PHSA to the regional health authorities. In July of 2024, the MoH and PHSA had meetings with the three regional health authorities delivering NFP to further discuss the transition.
- **Orient health authority partners to PHSA as Provincial NFP Lead**: By fall 2024, PHSA actively sought to engage with partners to inform them of the transition of the NFP program and further streamlined committees. This included engagement with: the BC Healthy Connections Project research team, NFP Canada PIPE Working Group, NFP Collaborative in Canada (NFPCC), and NFP Managers Working Group, and NFP Supervisors Community of Practice.
- **Transition existing NFP Website agreement:** In June 2024, oversight of NFP proprietary materials on the NFP Canada website was transitioned by the MoH to PHSA, and NFP Canada website server and hosting fees for 2024 were paid for. Initial steps were taken to transition oversight of the NFP Sharepoint site to PHSA, and this is still in progress.
- **Share existing agreements, program material and reports:** In June 2024, the NFP data reporting process was transitioned from MoH to PHSA. At this time, it was also agreed upon through

discussion at the Supervisors CoP that the regional health authorities would continue to update the monthly report templates.

- **Update and/or review existing research agreements and work plan to support approach and transition:** PHSA secured a dedicated project coordinator and clinical lead to support NFP operations.
- **Transfer knowledge, share best practices, facilitate information sharing to support transition and provide introduction to CHBC/PSBC to NFP Ontario and Nova Scotia teams:** PHSA is facilitating recurring monthly meetings with NFP Ontario and Nova Scotia teams for knowledge translation, mobilization, and quality improvement purposes

Reflections on our progress:

BC is proud of its success this year in managing the transition of NFP oversight in the province from the MoH to PHSA. We are especially proud of the immense amount of work and commitment of the nursing teams and supervisors in providing quality care to their clients, continued support of PHSA as the new Provincial NFP Lead, and their resiliency during this transition.

NEXT YEAR:

Our planned objectives for next year (2025):

- PHSA will work with health authority partners on strategies to ensure that families have access to low-barrier/barrier-free perinatal services during pregnancy and early parenting, which will also give these children the best start in life. The province is committed to providing high quality, equitable, culturally-centred, responsive, and trauma-informed care and services to families who need it the most.
- PHSA will review and analyze results from the Family Engagement Survey and explore the development of a provincial strategy to further extend services to families who would benefit from an enhanced family health program in BC.
- CHBC Provincial Director for Primary Care, Public Health & Prevention to support transition of NFP operations to Clinical Lead.
- PHSA will provide required NFP education to Clinical Lead (e.g., NFP Fundamentals, IPV Fundamentals, PIPE training, NFP Supervisor Training).
- PHSA will continue conversations with Canadian partners on management and payment for NFP Canada Website fees for 2025.
- CME #13 – PHSA will continue to work to improve data collection and reporting through a variety of approaches. These approaches could include updating monthly reporting forms and requirements to increase usability by supervisors and the province; updating nursing assessment forms to improve efficiency to better support data completeness and accuracy; reviewing the approach to collecting and reporting outcome data for the annual report, to improve data quality and usability by health authorities and the province.
- CME #14 – PHSA will continue to support high quality program implementation and sustainability through national and local health authority networks and connections. Specifically, PHSA will work with NFP Ontario and Nova Scotia leadership to strengthen national collaboration for NFP in Canada (e.g., this could be through a formal agreement, coordinated planning/meetings, etc.).
- PHSA will collaborate with health system partners (health authority leadership, operations

leads, front line service providers, and primary care partners) through a number of in-person and virtual engagements to determine strategies to obtain a higher rate of early prenatal referrals.

- CME #9 – PHSA will work to enhance/improve NFP education for nurses and supervisors and will begin a plan for and/or implement prioritized actions from the Sustainable Education Plan. This could include building a business case to find third-party education delivery/funding sources, planning and designing a more sustainable approach to PIPE education in Canada, and/or developing a succession plan and/or tools for educators.
- PHSA will focus on improving supervisor education, which has been delayed in recent years due to the pandemic. PHSA will also work with Ontario and Nova Scotia partners to explore and support a shift from the existing NFP Canada website host location and provide the necessary training and resources to support the transition to a new site. NFP nurses currently use the NFP Canada website to access program materials for home visits.

Actions not completed from 2023 action plan:

- Produce new NFP promotional brochures and pamphlets. This will involve removing MoH logos and adjusting images from source files, posting to the NFP Sharepoint site, determining responsibility for printing, communicating change with regional health authorities (including managers and supervisors).

Measures planned for evaluating our success:

Provincial Health Services Authority to explore and develop metrics for 2025.

Objectives related to the 2025 NFP Action Plan will be actioned, monitored, and evaluated by the BC NFP Provincial team members (Project Coordinator, Clinical Lead, Provincial Director, Executive Sponsors). Additional feedback from NFP Supervisors and Managers will be solicited to help inform validation and achievement of action plan objectives. These objectives will be evaluated on a quarterly basis. Progress will be reported in the 2025 NFP Annual Report.

Any plans/requests for program expansion? N/A

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 

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.	

References

Catherine, N.L.A., Leason, J, Marsden N, Barker B, Cullen A, Simpson A, Berry B.A., Mohns E, Yung D, Zhen Y, MacMillan H., & Waddell C. (2025). Understanding the experiences of young, urban, Indigenous mothers-to-be in British Columbia, Canada. BMC Pregnancy and Childbirth, 25, 1–12, https://doi.org/10.1186/s12884-024-07070-1

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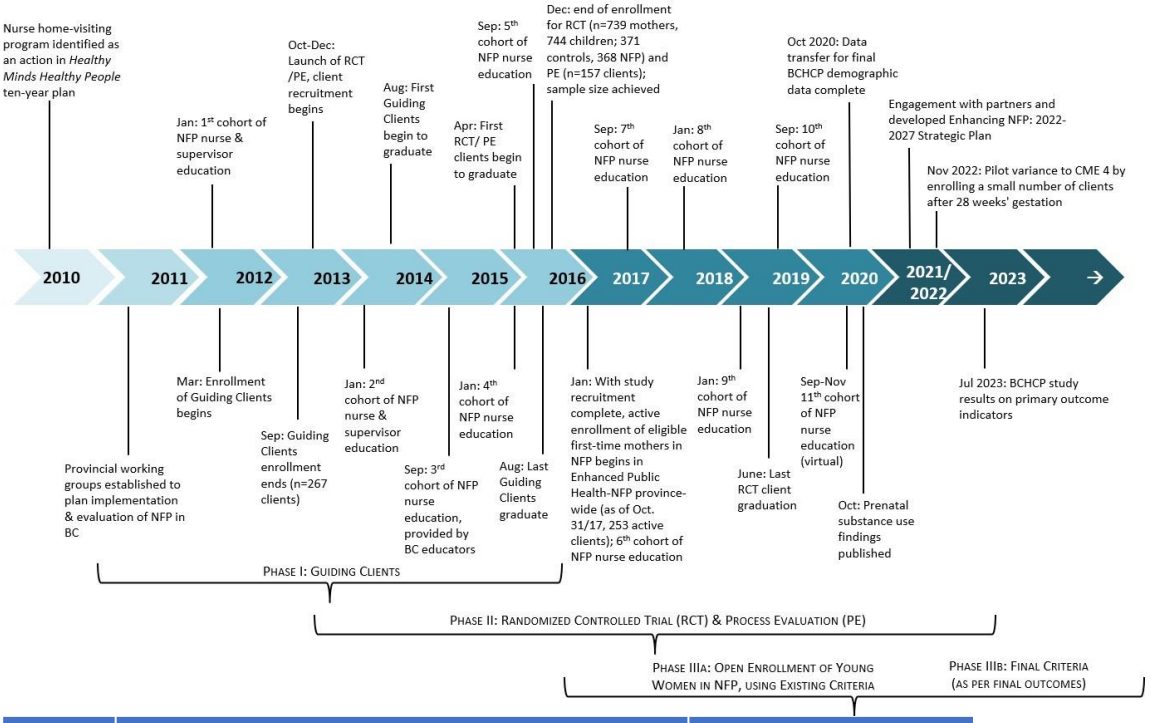
Appendix 1: Additional data analyses and /or graphic representations of the data

B.C. Nurse-Family Partnership Timeline



RHA	Communities Offering NFP (as of June 2023)			First Nations Communities
FHA	• Abbotsford • Agassiz-Harrison • Anmore • Belcarra • Boston Bar • Burnaby • Chilliwack • Cloverdale	• Coquitlam • Delta • Hope • Langley • Maple Ridge • Mission • New Westminster	• North Surrey • Pitt Meadows • Port Coquitlam • Port Moody • Tsawwassen • Surrey (North and South) • White Rock	• Katzie First Nation • Kwikwetlem First Nation • Seabird Island First Nation • Soowahlie First Nation • Squiala First Nation • Sto:lo First Nation • Peters First Nation • Cheam First Nation • Semiahmoo First Nation
IHA	• Armstrong • Castlegar • Cranbrook • Creston • Enderby • Kamloops/ vicinity • Kelowna	• Keremeos • Kimberly • Lake Country • Lumby • Nelson • Oliver • Osoyoos • Penticton	• Salmo • Summerland/ Peachland • Trail • Vernon • West Kelowna • Williams Lake & District	Clients visited in First Nations communities in: • Central Okanagan • South Okanagan • North Okanagan • Thompson-Cariboo-Shuswap • East Kootenay/ Kootenay Boundary
Island Health	• Campbell River • Cowichan Valley/Lake Cowichan	• Nanaimo-Ladysmith • Comox Valley	• Saanich Peninsula • Westshore/ Sooke • Victoria and surrounding	Clients visited in First Nations communities in: • North Vancouver Island • Central Vancouver Island • South Vancouver Island

Appendix 2: Evaluation of temporary CME variances

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

CME #:
CME 4: Client is enrolled early in pregnancy and received first home visit no later than the 28th week of pregnancy.
Temporary Variance to CME agreed:
Temporary variance to offer, in individual circumstances, a small number of clients (i.e., ideally no more 5-10% of all new enrolments) the ability to enroll in the NFP past 28 weeks + 6 days gestation but before birth. These late enrolment opportunities will be reviewed on a case-by-case basis by NFP Nurse Supervisors/Managers.
Brief description of approach taken to testing the variance:
BC has collaborated on guidelines to support nurses, supervisors, and managers in making decisions to enroll clients on a case-by-case basis, support caseload management, and emphasize client-centered care and therapeutic relationships. The guidelines also encourage NFP nursing teams to consider other perinatal services and programs that may be more appropriate for clients later in pregnancy, and to prioritize efforts to improve outreach to early prenatal clients and support enrolment into the NFP program as early in pregnancy as possible, recognizing that program effectiveness improves with earlier engagement. For the small number of clients enrolled beyond their 28th week of pregnancy, efforts are made to enroll and complete the first visit with clients as soon as possible before birth, recognizing the importance of regular prenatal care and the impacts on fetal development. To be considered for enrolment past the 28th week of pregnancy, supervisors/managers ensure clients meet all other eligibility criteria, show evidence of experiencing barriers to accessing the program in early pregnancy and/or experience multiple adversities/vulnerabilities. Barriers to accessing the program may include: clients living in rural locations (late referrals, limited access to health services, NFP nurse is away), late referrals from referral agencies and partners, late knowledge of pregnancy, clients are highly mobile/difficult to locate, or clients have limited access to telecommunications. Nursing teams also consider the client's capacity to benefit from the program and receive sufficient visits to achieve the pregnancy goals.
Methods for evaluating impact of variance:
Currently, NFP supervisors keep track of client enrolment, which includes the number of clients enrolled in the program after the 28th week of pregnancy, why they were enrolled late, and how many of those clients left before graduation and the number of visits completed in each program phase
Findings of evaluation to date:
In 2024, a total of 27 clients were enrolled after 28 weeks gestation, which is 24% of all new enrolments for the year. Since the official variance approval in November 2021, 101 clients have been enrolled in NFP after 28 weeks gestation. In 2024, the average age of these clients was 20 years, ranging from 15-24 years old, which is comparable to all new enrolments (average 19, range 14-24). Clients who enrolled late into the program were on average 33 weeks gestation (range 29 to 38 weeks). For clients who enrolled late, an average of 4 pregnancy visits, 18 infancy visits and 11 toddler visits were completed (the general

number of visits completed for each phase is 7 pregnancy visits, 22 infancy visits and 15 toddler). In 2024, 4 clients who enrolled late left the program early and 1 graduated (cumulative total since late 2021: 39 clients left the program, 6 graduate). Clients enrolled into the program later in pregnancy fit all other eligibility criteria, demonstrate evidence of access challenges, and/or experience multiple adversities arising from structural or systemic inequities.

The primary reason for late enrolment reported by supervisors is that clients are presenting later in their pregnancy to prenatal healthcare services in some cases due to a lack of antenatal providers, but also that clients are presenting increasingly with overlapping complex issues triggering an ethical dilemma when considering the option to decline them service.

Nurses report that it can be challenging to explore long term health and wellness goals with clients within limited pregnancy visits due to the resource demands required to address more acute and complex concerns (e.g., housing, food insecurity, community supports). However, nursing teams also found that their nurses are highly skilled and able to quickly establish rapport and trust with clients through engagement in flexible settings (e.g., clinics, school, complex care meetings). There has been success in engaging clients in early postpartum, through "hooking" clients with their nursing knowledge and skills. Nurses have also found success through making rapid referrals and connecting clients to other community resources (i.e., for food security, housing, social work, Indigenous doulas, prenatal classes, and resources).

Appendix 3: Nurse-Family Partnership (NFP) in British Columbia Continuous Quality Improvement Summary

Draft dated July 22, 2014; Updated January 2023

Quality refers to the degree to which program implementation occurs as designed, interventions meet model fidelity and outcomes are achieved. Quality Improvement is not an evaluation of the program but is instead a formal approach to analysis of performance and systematic efforts to improve effectiveness of the program. Within NFP, analysis of program performance occurs through reflection and collaboration on multiple levels, and fidelity reports provide a tool for data analysis. The NFP teams use data to implement a high-quality and effective program.

Comprehensive Tools and Reports to Assure NFP Program Quality

Quality is monitored at every phase of Nurse-Family Partnership and focuses on client interactions, program implementation and outcome achievement.

Pre-Implementation 2010 to 2011	**Step I: Guiding Clients 2012 to 2015**	**Step II: RCT and PE (PHASE III) 2013- 2016 (Recruitment Window) to 2019 (last RCT client graduates)**	**Step III+: Ongoing Enrolment* Starts December 17, 2016 (RCT enrolment closed Dec. 16, 2016)**	**Phase IV: Replication and Expansion 2022 and beyond**
Implementation Plan Feasibility Assessment Project Charter Licensing Agreements	Focal CQI Area: **Client Interaction** • Home Visit Plan every visit • Facilitator: How is it going between us Focal CQI Area: **Program Implementation** • One-to-one clinical supervision weekly, 1 hr • Case conferences twice a month, 1½ - 2 hrs • Team meetings at least twice a month, 1 hr • Field supervision: joint visits every 4 months, minimum 2-3 hrs & 1 client • Nurse consultation • Education evaluation	Focal CQI Area: **Client Interaction** • Home Visit Plan every visit • Facilitator: How is it going between us • RCT client interviews Focal CQI Area: **Program Implementation** • One-to-one clinical supervision weekly, 1 hr • Case conferences twice a month, 1½-2 hrs • Team meetings at least twice a month or weekly, 1 hr • Field supervision (joint visits) every 4 months, minimum 2-3 hrs & 1 client • Nurse interviews every 6 months • Nurse consultation • Education evaluation • HA/Provincial COP twice a month	*ongoing enrolment of clients who meet study criteria (upon reaching study sample size) Focal CQI Area: **Client Interaction** • Home Visit Plan every visit • Facilitator: How is it going between us • Client exit survey Focal CQI Area: **Program Implementation** • One-to-one clinical supervision weekly, 1 hr • Case conferences twice a month, 1½ - 2 hrs • Team meetings at least twice a month or weekly, 1 hr • Field supervision (joint visits) every 4 months, minimum 2-3 hrs & 1 client • Nurse consultation	Focal CQI Area: **Client Interaction** Focal CQI Area: **Program Implementation** Focal CQI Area: **Outcome Achievement**

	• Dialogue sessions with nurses/supervisors • HA/Provincial COP twice a month • Quarterly attrition reporting • Quarterly fidelity reports (Panorama/Paris/Paper) • 1st year Implementation Plan • Annual fidelity report (Dr. Olds) Focal CQI Area**: Outcome Achievement** • Fidelity outcomes (paper records)	• Quarterly fidelity/attrition reports (Panorama/Paris) • 2nd year Implementation Plan • Annual fidelity report (Dr. Olds) Focal CQI Area: **Outcome Achievement** • Fidelity outcomes • Pregnancy outcomes • Maternal outcomes • Child health & development outcomes	• Education evaluation • HA/Provincial COP twice a month • Quarterly fidelity/attrition reports (Panorama/Paris) • Annual Implementation Plan • Annual fidelity report (Dr. Olds) Focal CQI Area: **Outcome Achievement** • Fidelity outcomes • Pregnancy outcomes • Maternal outcomes • Child health & development outcomes	

Appendix 4: BC's Eligibility Criteria – Detailed Information

1. Age 24 years or younger

2. Expecting first child

- The client is eligible if she has no prior live births.
- The client is eligible if previous pregnancy ended in termination, miscarriage or still birth.
- The client is eligible if she is (or was) a step-parent.
- Individual circumstances may be considered on a case-by-case basis.

3. Gestational age

- The first home visit must occur before 29 weeks gestation.
- Individual circumstances may be considered on a case-by-case basis.

4. Socioeconomic Disadvantage

4a. Homeless	eligible
4b. Age 19 years or younger	eligible
4c. Age 20 to 24 years	eligible if meets 2 of the 3 indicators below

4a. Homeless

- A client who is homeless (and aged 24 or under) is eligible for NFP, as they automatically meet the low-income criteria, and the lone parent criterion does not apply.
    - A client who is homeless cannot be considered to be in a common law relationship, no matter the length of the relationship, as they do not have a fixed place to live.
- A person is considered homeless if they:
    - are living on the streets, or
    - are living in a place not meant for people to live in (e.g., car or tent), or
    - are staying in an emergency/homeless shelter, or
    - are couch surfing (i.e., do not have a fixed place to live where they can expect to stay for more than 30 days (consecutively), or
    - do not pay rent.

4c. Indicators (eligible if meets 2 of the 3 indicators below):

I. Lone Parent
- To be a lone parent, the client cannot be legally married or in a common law relationship.
- The definition of common law is having lived with current partner for 1 year or more.
    - To be common law, the client must live with her partner now and have lived with her partner for the 12 consecutive months prior to the eligibility assessment.
    - In turn, if the client or her partner moved out (as defined by the client) during the 12 months prior to the eligibility assessment, they are not common law.

II. Less than grade 12 education
- The client meets this criterion if her highest educational attainment is less than grade 12.
- Certificates that equate to a grade 12 education:
    - Dogwood Diploma/ BC Certificate of Graduation
    - BC Secondary School Equivalency or General Educational Development Certificate
    - Adult Dogwood / BC Adult Graduation Diploma
- Certificates that are less than grade 12 education:

- School Completion Certificate
- Evergreen Certificate
- Residents of BC are able to enroll in a degree/college program at a BC university or college as a Mature Student without grade 12 education, provided they meet other institution specific requirements. In these unique situations, consider the details of the post-secondary education and make an individualized determination as to whether the client meets this criterion.

III. Low Income ("yes" response to ONE or more of the following)

1. Low Income – Assistance

The client meets this criterion if they receive one (or more) of the following three types of assistance: MSP Premium Assistance, Disability Assistance, or Income Assistance.

- The client may state that she receives, "social welfare," "welfare" or, "social assistance"
- To determine if a client receives MSP Premium Assistance, she may call the office for Medical Services Plan (Monday to Friday, 8:00 am to 4:30 pm PST, except statutory holidays. Metro Vancouver: 604-683-7151 or Toll- free: 1-800-663-7100).
- Client will be asked to provide her care card number, date of birth, name, and current address

2. Low Income – Household Income

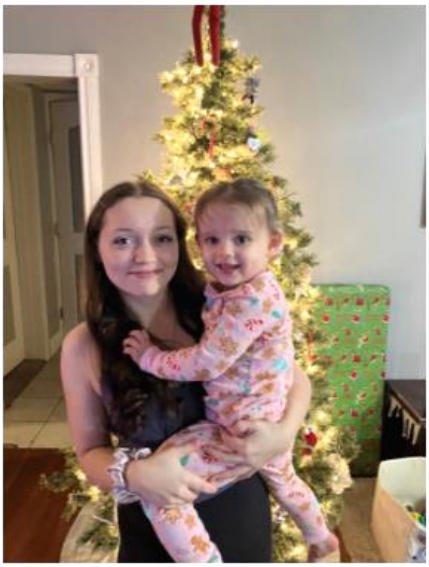
   The client meets this criterion if they have difficulty living on their household income with respect to food and/or rent

Appendix 5: Client Experiences – Teams and Testimonials

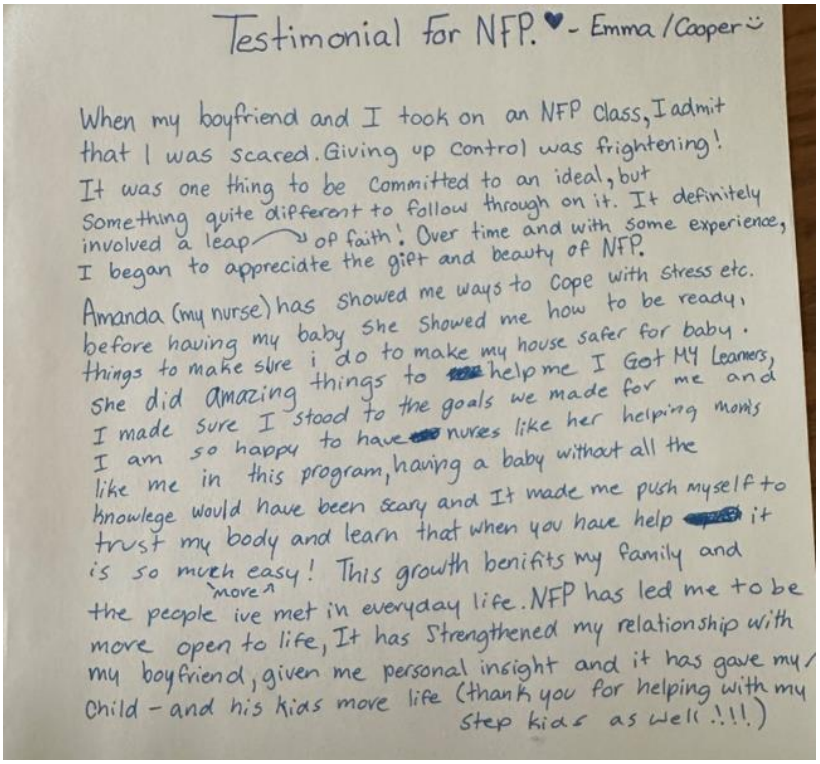
Our Interior Health NFP Team**: Kelowna, BC (Sept 2024)**

United Way Car Seat Recipients

NFP Graduates!



NFP Client Testimonials



Testimonial for NFP. ♥ - Emma / Cooper ☺

When my boyfriend and I took on an NFP class, I admit that I was scared. Giving up control was frightening! It was one thing to be committed to an ideal, but something quite different to follow through on it. It definitely involved a leap of faith! Over time and with some experience, I began to appreciate the gift and beauty of NFP.

Amanda (my nurse) has showed me ways to cope with stress etc. before having my baby she showed me how to be ready, things to make sure i do to make my house safer for baby. She did amazing things to help me I Got MY Learners, I made sure I stood to the goals we made for me and I am so happy to have nurses like her helping moms like me in this program, having a baby without all the knowlege would have been scary and It made me push myself to trust my body and learn that when you have help it is so much easy! This growth benifits my family and the people ive met in everyday life. NFP has led me to be more open to life, It has Strengthened my relationship with my boyfriend, given me personal insight and it has gave my child - and his kids more life (thank you for helping with my step kids as well !!!)

"As a single mum with not a lot of resources, NFP has been such a wonderful program for me and my daughter. It's really great to have someone see you in person, know your situation, and actually care about how you and your child are doing. There's also so much different information and opinions on what is good for raising a child, and it's really helpful to be able to bring all of my questions and get answers from someone who knows what they're talking about. Motherhood can be a very isolating journey, especially as a single mum, so I'm very thankful that I have this program as a resource."