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Nurse-Family Partnership® (NFP) International

Phase Two Annual Report

Phase Two: Feasibility and Acceptability through Pilot Testing and Evaluation
Conduct a pilot test of the adapted Nurse-Family Partnership (NFP) program to inform what additional adaptations may be needed to ensure the feasibility and acceptability of the adapted NFP program.

- Some information may not be applicable in which case note it as N/A
- If you don't have the requested information, you may leave the section blank

PART ONE: PROGRAM OVERVIEW

Name of country: Ontario Canada

Dates report covers: Oct 1, 2018 OR Jan 1, 2019 to Dec 31, 2019*

Report completed by: Lindsay Croswell – NFP Ontario Nursing Practice Lead

*NOTE: Any data reported by the Hamilton site (one of five sites) includes data from the 2019 calendar year only. This note also applies to any TOTAL data reported.

The size of our program:

	# Who work exclusively in NFP	# Who have additional assignments	**Total**
Fulltime NFP Public Health Nurses (PHNs)	**24.5***	**0**	**24.5**
Part time NFP PHNs	**0**	**0**	**0**
Fulltime NFP Supervisors	**1**	**5****	**6**
Part time NFP Supervisors	**0.5*****	**0**	**0.5**
Total	**26**	**5**	**31**

**Public Health program managers with additional responsibility that provide NFP supervisor role
***shared model of supervision in Niagara, 1 PHN is carrying a caseload halftime and acting as team lead (providing reflective supervision) to 3 additional PHNs halftime

- 5 teams (supervisor-led groups of NFP PHNs)
- Average Supervisor to NFP PHN (+ other staff) ratio: 4.9 to 1.3
- 311 clients were enrolled during the CaNE pilot project (as reported in our last annual report) and 289 new clients were enrolled during this reporting period. In total, 600 NFP clients have enrolled since starting Phase Two (under the licence held by Middlesex-London Health Unit).

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

Clinical leadership, support and guidance:

For the duration of the CaNE pilot, a public health nurse was seconded from the City of Hamilton Public Health Services by the Middlesex-London Health Unit (MLHU) to fill the role of the Provincial Clinical Lead. At the end of the CaNE pilot, MLHU hired a Community Health Nurse Specialist as the Ontario Nursing Practice Lead to fulfil the responsibilities of an NFP Clinical Lead. Funding for this position is shared among NFP implementing sites in Ontario. The successful candidate had previous experience in the role as the Provincial Clinical Lead during the CaNE pilot and has 6 years of NFP home visiting experience she brings to the role.

Nursing Practice Lead responsibilities:

- Educator
    - Develop and revise curriculum
    - Plan, coordinate, and deliver face-to-face education sessions
- Coordinator/Liaison
    - Liaise between work groups, committees and sub-groups
    - Organize meetings, chair/co-chair, draft agendas and record minutes
    - Act as liaison between health units
    - Act as liaison between NFP International and pilot stakeholders
    - Act as liaison between sites and McMaster School of Nursing (NFP Canada website provider)
    - Coordinate NFP Annual Report writing
- Nursing Practice Consultant
    - Provide nursing practice consultation and support to sites (e.g. practice and fidelity questions), by phone and in-person
- Implementation Consultant
    - Develop implementation resources
    - Advise on resources and incentives for sites
    - Lead and coordinate Ontario NFP Data Collection workgroup in the development of a shared data dictionary and revision of NFP data collection and nursing assessment forms
    - Initiate CQI activities that contribute to overall CQI process (e.g. documentation scan, education evaluations, site report templates etc.)
    - Provide guidance regarding documentation
    - Provide guidance for the development of program material
    - Create reference documents for practice consultation
- Marketing & Communication
    - Maintain and provide shared access to marketing templates for service providers and clients, and provide consultation regarding marketing materials
    - Facilitate approval by NFP International and NSO
    - Ensure timely communication of program updates to sites (e.g. newsletter for teams)
- Education Website management
    - Upload website content
    - Provide website access for all new/ongoing NFP PHN's and supervisors

See attached (Table 1) for 2019 Governance summary notes.

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Description of our National implementing capacity and roles (how these functions are organised):

Service / implementing agency development:

See Table 1 for leadership that supports site implementation. Site implementation is led by the Nursing Practice Lead (role described above). The Provincial Nursing Practice Lead is in the process of transforming the draft Implementation Manual developed during the CaNE pilot into individual implementation resource documents accessible online and modelled after the NFP International guidance documents. There are no plans for additional sites to begin any implementation until the results from the RCT in BC are shared and reviewed by the current sites and NFP leaders in Canada.

Information system and analysis and reporting:

During this first-year post-pilot the same pilot version of the NFP Nursing Assessment & Data Collection Forms was used to collect data, and former pilot sites continued to use the Excel spreadsheet developed for the pilot to input a large portion of data from these forms. Hamilton Public Health (now under the license held by MLHU) utilized their electronic client record system (where NFP forms are completed electronically) to produce the requested program data. Our provincial database (ISCIS) also continued to be utilized to collect data and provide monitoring reports related to program standards, expectations and CQI. During this year, the Ontario Data collection workgroup was established and worked together to develop a shared data dictionary to guide the process of data reporting and analysis across multiple databases and documentation systems. The group also took this opportunity to review and revise all the data collection forms. The revised forms and data dictionary will have been implemented in all sites as of Jan 1, 2020. Although the reporting period for this report does not utilize the newly developed dictionary, the work of the group positively impacted the preparations for the data reported here and newly developed site templates for data were used to generate a combined data report. See table 2 for the CQI process visual.

Senior Nursing Leadership:

Heather Lokko is a public health Program Director and the Chief Nursing Officer for MLHU, the license holder and lead organization for the CaNE pilot, and the current Ontario NFP license holder. The Directors/Chief Nursing Officers for each site's public health department are all members of the Steering Committee and the Provincial Advisory Committee (PAC).

License holder:

In 2019, we successfully integrated all Ontario sites under a single license held by MLHU, who holds a signed MOU with each of the other four sites (Hamilton, York, Toronto, Niagara). Each site has representation at all appropriate committees. See Table 1 for additional details.

Other (please describe):

Dr. Susan Jack was the principle investigator for the CaNE pilot, and due to her NFP expertise, she has continued to provide significant guidance, leadership, education facilitation and support to the NFP program delivery in Ontario. In addition, she continues to contract staff and experts to design and maintain the technical components of the education platform. She is currently working

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on behalf of the McMaster School of Nursing, with the Nursing Practice Lead, on curriculum refinement and further transformation of the curriculum into an e-learning format.

Description of our local and national NFP funding arrangements, including plans for funding for a randomized controlled trial:

The Ministry of Children, Community and Social Services (MCCSS) has approved allocation of nurses, managers and administrative staff from the Healthy Babies Healthy Children (HBHC) Program to implement the NFP. In addition to funds received from MCCSS, some of the sites allocate cost-shared monies received from the Ministry of Health and local municipalities to fund nurses, managers, and administrative staff for the full implementation of the NFP program. They also leveraged in-kind contributions from many community partnerships. For example, Hamilton received a $41,000 grant in 2019 from the Hamilton Community Foundation for operational needs.

The Province of British Columbia is funding an RCT, called the British Columbia Healthy Connections Project (BCHCP), to evaluate NFP in Canada, compared to usual services. A parallel process evaluation is also being completed in BC.

Description of our research team and capacity to conduct quantitative and qualitative evaluation (feasibility and acceptability study):

There is no formal research team specific to the NFP program in Ontario however, researchers from McMaster University (Dr. Susan Jack, Dr. Harriet MacMillian and their colleagues) have always led research conducted in Ontario to date. In 2019, we did not complete any additional feasibility or acceptability evaluation. We are still awaiting the dissemination of the results from the BCHCP RCT and continuing to utilize the results from the Canadian Nurse-Family Partnership Education (CaNE) pilot project to inform on-going CQI for sites in Ontario. Details of a case study on a shared supervision module being conducted in one Ontario site are provided in section four.

Current policy/government support for NFP: (Including plans for responding to challenges and opportunities in government policy, funding constraints, professional changes):

The collaborations and foundational infrastructure developed during the CaNE pilot remains in place at present and could be used in scaling-up the NFP program across the province. NFP complements the existing home visiting program Healthy Babies Healthy Children (HBHC), which is funded by the Ministry of Children, Community and Social Services and offered by all public health units across Ontario. Ontario invests over $80 million annually in the HBHC home visiting program for families in the early years. The HBHC program is initiated through a universal screen which identifies parents and children at-risk, and services are delivered to eligible 'with risk' clients. HBHC is a voluntary home visiting program in which a PHN completes assessments, education and nursing support, and service coordination, and a Family Home Visitor paraprofessional (FHV) provides hands-on application of teaching and social connection. Families can receive visits starting during pregnancy until school entry, and involvement typically ranges from 1 month to 1 year. Involvement (content and duration) is directed by the family's goals and focuses on learning about healthy pregnancy and birth, connecting with their baby, how children grow and develop, being a parent, breastfeeding, healthy nutrition, creating a safe environment, self-care, and other community services for children and families. PHNs generally visit once every 3-5 weeks and FHVs visit every 2 weeks.

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In comparison to HBHC, NFP provides PHN-only home visits, has a narrower target population, offers more frequent home visits over a 2 ½ year period, provides more structure within the home visits, and has a stronger evidence base. The addition of NFP to current home visiting programs in Ontario has the potential to strengthen the services provided to families in Ontario by public health units. Given the success of the feasibility and acceptability pilot study completed in Hamilton, evaluation/research being conducted in BC, and the educational framework established by the CaNE project, NFP is well-positioned for future expansion in Ontario and other provinces, pending the outcomes of the BC RCT in the next couple years.

Home Visiting funding in general has been sustained in Ontario public health units since the 1990s.

At the current time, in Ontario, NFP is being delivered through only five of Ontario's 35 public health units. The introduction of NFP into this province has occurred at the grassroots level and has not been an initiative of the Provincial Government. However, the McMaster-based NFP research team, as well as local NFP champions from participating health units, continue to increase awareness about NFP with key policy leaders in the Ministry of Health and the Ministry of Children, Community and Social Services. Over the last 2 years, interest and engagement from Ministry staff has progressively increased and there has been a real focus on the successful integration of the home visiting programs within the 5 health units delivering the NFP program. There has very recently been a funding commitment made by the MCCSS to enhance the online education modules for the NFP education curriculum developed during the CaNE project.

The Ontario government is currently undergoing a consultation process in efforts to modernize public health in the province. It is possible that this could result in the amalgamation of some of the participating sites with other health units. Should this occur, there would be a natural opportunity to expand the implementation of NFP in Ontario. For example, if York Region public health (an NFP site) was amalgamated with Peel Region public health (currently not an NFP site), there could be an opportunity for Peel Region to implement NFP once the amalgamation was completed and the MOU with MLHU is being renewed, should this be allowed by the licensor. Results of the modernization consultation are not expected until at least the fall of 2020.

Description of our implementing agencies/sites:

High level description of our implementing agencies/sites: 5 Ontario public Health units

http://www.health.gov.on.ca/en/common/system/services/phu/default.aspx

5 implementation sites:

Middlesex-London Health Unit (license holder)

Regional Municipality of York, Public Health Branch

City of Toronto (Public Health Division)

Niagara Region Public Health

City of Hamilton, Public Health Services (Healthy and Safe Communities Department)

Current number of implementing agencies/sites delivering NFP: 5

How we select and develop new sites: We are not currently supporting the expansion of NFP implementation in new sites until the RCT is completed in BC.

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

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Successes:

- First group of graduates from the CaNE pilot cohort of clients has been reported and Hamilton site reporting successful retention rates (39 of the 41 clients that consented in 2019 remain active; 22 graduations in 2019 (45.8%)
- Early outcome data indicates *possible* positive trends in decreased substance use during pregnancy, healthy birth weights (not considered low birth weight), fewer preterm births (reported by one site), increased breastfeeding rates, increased engagement with other services/providers and completion of high school education among participants
- NFP PHNs are skilled at developing therapeutic relationships with clients
- NFP PHNs follow their clients when they move around the city/community whenever possible to maintain consistency of service provider
- Successful engagement of the NFP Community Advisory Board in London, meeting 3 times a year
- NFP PHNs are well connected to key community agencies and internal health unit partners and programs (maternity homes for young mothers, prenatal clinics, child protection, health unit outreach teams, school teams, prenatal health programs), these connections have positive program impacts, for example:
    - Increased volume of referrals and diverse referral sources reported by sites
    - Working with child protection workers proactively for support in pregnancy mitigating crises response at birth and plans of care for families with infants
    - Advocacy for client re income assistance (accessing additional funding) and housing (threatened eviction without good cause)
    - Promotion of birth control and advocating for client accessing birth control through public health sexuality clinics (waiving costs associated with IUD)
- Use of mobile technology (laptops or tablets) enable staff to work in community with the intent of increasing efficiency
- Documentation is now fully (or soon to be) electronic at all sites with the aim of improving time management in documentation and data collection
- Connecting/meeting with NFP program staff across sites to share ideas, strategies, opportunities for shared education/training to continue building shared provincial capacity and strengthen program implementation in Ontario
- Collaboration with home visiting programs within each site to increase site capacity to provide services to families within local communities (e.g. shared education and client events)

Challenges:

- Geographical spread of clients and when clients frequently move within the community resulting in large mileage/parking costs and travel time
- Keeping clients engaged in the program until graduation when the client obtains full time day-care and has returned to work/school (and/or perceives goal attainment)
- Volume of documentation and data collection
- Engaging clients who are mandated by child protection to participate in program
- Lower referral rate prior to 16 weeks
- Vicarious trauma and stress experienced by PHNs working with clients who are experiencing increasingly more complex challenges, struggling with negative impacts related to the social determinants of health and high ACE's scores
- Differing referral rates across sites and challenges associated with each (e.g. managing waitlists or lower caseloads)

Other relevant/important information regarding our NFP program: none

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PART TWO: NFP CORE MODEL ELEMENTS (CMEs)

Core Model Element	Successes (including progress against benchmarks) ***all data referenced is included in the attached data report, reporting period Oct 1, 2018 – Dec 31, 2019***	Challenges and suggested actions to address these
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100% of clients are reported to be participating voluntarily.	There are some reports of workers from some child protection agencies mandating the involvement of clients. We have discussed how to address this challenge with providers during collaborative work (case consultation, service planning etc.) and will continue to provide support to teams dealing with this challenge.
2. Client is a first-time mother	99% of clients (average across sites) are reported to be participating as a first-time parent.	One site (out of five) has reported less than 100% of clients met this eligibility criteria. During Annual Report Data Review (ARDR) with sites, we will review cases at the site where eligibility was not met and facilitate reflection. It is acknowledged that compliance with this CME can and needs to be enhanced to ensure all sites maintain fidelity.
3. Client meets socioeconomic disadvantage criteria at intake	100% of clients are reported to have meet this eligibility criteria.	Without using/assessing a self-reported income threshold at intake there is a degree of subjectivity by the team/nurse

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	Our socioeconomic disadvantage criteria: Not independently financially secure (e.g. receiving income assistance or reliant on caregivers/parents) as indicated by a “with-risk” Healthy Babies Healthy Children prenatal screen. Contextual factors that are taken into consideration to reach the decision that the client is experiencing socioeconomic disadvantage may also include any/all of the following factors: lone parent, completion of < grade 12, socially isolated with no financial support from partner or extended family, indication of financial stress (food insecurity, difficulties in paying rent, homeless), or expressed plans to move towards independent living (e.g. move out of parent’s home).	Reviewing income data from enrolled clients (on NFP forms) will provide some assurance of income assessment consistency.
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.	97% of clients (range across sites was 94-100%) are reported to have had their first visit no later than the 28th week of pregnancy. 29% of clients (range across sites was 21-39%) are reported to have been enrolled before 16 weeks gestation. On average, 45% of clients (data was missing for one site) are reportedly being referred prior to 16 weeks gestation with one site reporting that 81% of clients are referred prior to 16 weeks.	Challenges/context reported by sites that enrolled clients after the 28th week of pregnancy included: inability to locate client right after referral is received; high-risk and receptive to program but referred late; and low caseloads at time of referral. During ARDR with sites, we will review cases at the site where eligibility was not met. In addition, we will review the difference in referral and enrollment rates prior to 16 weeks gestation and facilitate reflection. It is acknowledged that compliance with this CME can and needs to be enhanced to ensure all sites maintain fidelity.

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5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	All clients were assigned an identified NFP nurse during the during the reporting period who provided individual NFP home visits.	Data is not available on clients transferred to another NFP nurse in terms of retention rates although this did occur on occasion. There were also instances of transfers between sites. It was identified on last year's annual report that data on transfers would be ideal. As part of the NFP data collection form updates completed in 2019, data will now be collected as part of the referral form (for use starting in 2020).
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.	A total of 5441 visits were completed across all five sites. Of these completed visits, the majority (76%) were completed in the client's home.	One site reported that just under half (47%) of completed visits were completed in the client's home. As an outlier we are interested in exploring the other locations for visits and discuss the impact this may have had on program delivery. During ARDR with the site, we will review this data and facilitate reflection.
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.	There were 328 active clients at the time of submission for the report (Dec 31, 2019) and total number of graduates during the reporting period was 37.	Sites continue to report that the visiting schedule is discussed with clients at intake and negotiated with the client based on client's availability and needs. This is often re-negotiated at check-in often when "how is it going between us" facilitator is completed. Although data was not formally collected from sites on the number of clients on an "alternative schedule," in speaking with sites,

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		there are none at the time of the report. It remains that the standard schedule is being adjusted as needed instead of an alternative schedule being offered formally. This year, emphasis was placed on the use of the STAR framework to support decision-making around the visit schedule. Discussion at the ONCOP will continue this year regarding the use of a formal alternative visit schedule and the collection of data. Accurate data on the on-going graduation rate is not yet available across the sites however this data has been identified as a priority moving forward.
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	All NFP nurses and supervisors met the minimum education/degree requirement. Meeting this CME is not a challenge because PHNs in home visiting in Ontario have the same minimum requirement for hiring.	No challenges identified
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	All PHNs and supervisors have completed the Ontario model of the core NFP education (as developed during the pilot). During the reporting period there were 6 new PHNs and 1 supervisor that completed NFP PHN Foundations (online) and NFP PHN Fundamentals (in-person) education. There were 4 supervisors that completed NFP Supervisor Foundations (online) and 5 supervisors that completed NFP Supervisor Fundamentals (in-person) education.100% of all	Ensuring the benefits of group-based learning is challenging with small cohorts. We have opted to wait and facilitate in-person education when there is a minimum of 3 participants. To date, the longest any one PHN has had to wait is 6 months and this has been identified as the maximum acceptable wait period.

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	teams participated in on-going education as part of NFP Integration (third phase of education).	
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.	Of the stages that were reported correctly, PHNs achieved the benchmarks in 47% of the domains and 43% of the reported domains were within 5% of the benchmarks. Please table below for ranges reported by sites.	The reported estimated time spent in the Environmental health domain across all stages needs exploring with sites. During Annual Report Data Review (APDR), domains where benchmarks were not achieved will be prioritized for review with sites to facilitate reflection on how time is spent and how it is estimated. In addition, discussion about reporting the sum of total time spent will be on the agenda at the next Data Collection workgroup as multiple sites reported totals that did not equal 100 and were not able to identify the error. It is acknowledged that compliance with this CME can and needs to be reviewed using accurate data to ensure all sites maintain fidelity.
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	All foundational theories were included in the core NFP education that was completed by all PHNs and supervisors. Positive feedback on the inclusion of the Critical Caring Theory was given during the pilot.	No challenges identified
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	All teams have between 3 (where the variance has been previously approved) and 7 PHNs to 1 supervisor that provides them with clinical and	One site continues to experience lower rates of referrals and subsequent caseloads. The result is a lack of demonstrated need in that

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	reflective supervision. Two sites have additional Program Managers (that have completed NFP core education for PHNs and supervisors) and provide clinical and reflective supervision for the designated supervisor. Average number of observed joint home visits was 1.8 per PHN annually (range 1-3 per PHN annually) and an average of 27 RS sessions per PHN was completed for the reporting period. Average of 29.6 team meetings and 14.8 case conferences completed per site for the reporting period. One site report that a 2.5-hour team meeting every other week works better than 1-hour team meeting every week (geographical area of team a considerable factor).	community for a 4th fulltime PHN. We have previously delivered the program with an approved variance for this CME. See updated variance request attached. ONCOP is prioritizing review of the international RS documents and templates in 2020 and part of this review will be to reflect on data from CME 12 and develop strategies to improve observed joint home visit rates It is acknowledged that compliance with this CME can and needs to be enhanced to ensure all sites maintain fidelity.
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.	The establishment of the Ontario Data Collection Workgroup in 2019 and development of a shared data dictionary helped to ensure data was available for this report and has been invaluable in the creation of a data collection, analysis and CQI draft plan moving forward.	See section "Information System and Analytical Capacity" for details, reflections and plans.
14. High quality NFP implementation is developed and sustained through national and local organized support	We have been able to maintain participation and engagement in all provincial committees that were established during the pilot during our first-year post pilot. In addition, we have expanded membership of the Provincial Advisory Committee to gain broader perspective and strengthen community partnerships and collaborative work. We are also in the process	The NFP Collaborative in Canada has been successful in 2020 with gaining clarity and consensus on shared goals, objectives and responsibilities.

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	of finalizing a draft term of reference for the NFP Collaborative in Canada with BC.	

CME 10 Table:

PREGNANCY						
	Distinct visits (n)	**Personal Health (%)**	**Environmental Health (%)**	**Life Course Development (%)**	**Maternal Role (%)**	**Family & Friends (%)**
Benchmark		35-40%	5-7%	10-15%	23-25%	10-15%
Range 2019	1,831	30-53%	10-20%	10-21%	19-33%	15-27%
Total/Mean 2018	1,433	41%	13%	12%	21%	13%
INFANCY						
Benchmark		14-20%	7-10%	10-15%	45-50%	10-15%
Range 2019	2,763	18-31%	10-23%	11-18%	32-56%	11-27%
Total/Mean 2018	1,375	23%	9%	13%	43%	12%
TODDLERHOOD						
Benchmark		10-15%	7-10%	18-20%	45-50%	10-15%
Range 2019	841	17-19%	13-16%	13-19%	27-47%	9-32%
Total/Mean 2018	10	16%	12%	19%	42%	11%

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Any requested CME variance(s): ☐ No √ Yes (please attach completed variance request form)

Request for
Variance - Core Moc

Where CME variances have previously been granted, please add date of review of the evaluation of these here: variance granted in 2018, date of review was 2019

Any Additional Approved Model Elements (AAMEs): √ No ☐ Yes

Where AAMEs have been granted please attach completed document and comment on progress with these below:

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PART THREE: PROGRAM IMPLEMENTATION

Reflections on clients, family members, and the community

# of NFP clients participating in the program over the last year:

There was a total of 289 new clients enrolled during the reporting period. There was a total of 328 active clients (not discharged/graduated) at the time of the site data report submission on Dec 31, 2019.

% of those eligible clients offered the program who have enrolled over the last year: 90% (increase from 88% during pilot)

total clients referred (both eligible and in eligible) = 343, an average of 83% (across sites) of those referred were eligible (range 62-99%)

total of eligible clients who enrolled/consented = 289

Our (sites) initial reflections regarding the characteristics of our NFP clients (per site):

Niagara:

- Mostly young (under 21) and low levels of education
- Significant mental health issues
- PHNs observing more IPV/relationship issues
- Child protection agency involvement
- Strained familial relationships

Toronto:

- Age range 14 – 22
- Majority identify as single
- Most unemployed or underemployed
- Multiple complex issues
- Most clients are attending high school/post-secondary education
- Many in alternative format classrooms

Hamilton:

of the 75 active clients (as reported by PHNs):

- 8 were born outside of Canada
- 9 identify as Indigenous
- 29 were enrolled in some type of school program and 6 were enrolled in college specifically
- 23 had disclosed exposure to IPV
- 60 were living with a mental health diagnosis
- 43 were identified by their nurse as having "minimal supports"
- 31 had a history of abuse
- 5 were either currently pregnant or had a second child
- Average age 18.2 years (15-21 years at time of consent)
- 2 clients were non-English speaking requiring translator
- Clients are experiencing increasingly more complex challenges

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- Struggling with negative impacts related to the social determinants of health and high ACE's scores resulting in increasing challenges for NFP PHNs delivering the program

London:

- NFP clients experience multiple complex challenges in their lives (i.e. mental health challenges, limited supports, IPV, history of childhood abuse or neglect, high ACE scores)

York:

- Clients are spontaneous, things come up causing changes in HV schedule
- Client often in crisis mode, interferes with HV plan, resulting in planned HV agenda content not getting covered
- Clients often have difficulty in trusting PHN, takes time to "open up" often not until therapeutic relationship is established

Common themes identified by sites: very high number living with mental health concerns/diagnosis, high incident of IPV exposure, many have a history of abuse, majority have complex issues and support needs

Client engagement in the program (including client retention) (per site):

Niagara:

- Client engagement higher than in HBHC home visiting program
- Connecting with nurses frequently (by text, etc.)
- Less "no shows" than in HBHC home visiting program
- Clients often requesting NFP nurse attends other appointments and visits with them (with other service providers)

Toronto:

- Client attrition high when an NFP PHN leaves the program, most clients will not accept a new NFP PHN and are not receptive to HBHC home visiting program
- Engagement decreases when assigned NFP PHN goes on leave, prefer to 'wait' until their PHN comes back instead of accepting service from covering PHN
- Many clients requesting discharge before baby is 2 years as they perceive their goals have been met

Hamilton:

Of the 75 active clients:

- only 2 of those referred in 2019 have left program after initial consent (both moved out of area)

Of the 50 new referrals in 2019:

- 41 consented
- 8 declined
- 1 consent pending at end of 2019
- 2018 retention: 51 consented; 17 declined; 21 discharged prior to graduation
- 2017 retention: 32% graduated +6 pending = Potential for 45.4%

London:

- Gate keeper buy-in is important (i.e. partners, parents)

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- Incentives help with engagement
- Importance of engaging clients early in the prenatal period for better overall engagement
- Some challenges engaging clients during toddler period because of busier schedules (i.e. return to work/school)

York:

- Enrolment can be a challenge when initiated by some health care providers (primary care provider, obstetrician or child protection worker) if client is feeling pressure to say yes
- Extraordinary measures are taken by NFP PHNs to keep clients engaged and sometimes it requires months to re-engage when out of contact (working through loss/change of phone number, moving, client not prioritizing HV)
- Great flexibility from PHNs is needed to work with client schedule (school, work and not prioritizing HV as important)
- Keeping client file open for services despite lack of contact has resulted in re-engagement because of PHN collaborating with other service providers to learn updated contact information; able to successfully re-engage when client in crisis and seeks PHN support and advocacy
- Home visits often requested by clients to take place in a neutral setting (e.g. coffee shop), sometimes exclusively until baby is born
- Once NFP services are established (i.e. trust is built) clients are very appreciative of services (e.g. HVs, relationship with PHN, PHN contact and advocacy, food coupons, gas card to access community programs)

Engagement of fathers (partners/support people) and other family members (per site):

Niagara:

- Dynamics with maternal grandmother can be challenging (e.g. nurse receiving text communication from parents of a client that is overly personal/inappropriate with questions/concerns about client being expressed to nurse "in confidence")
- Can be difficult to get time with client alone (parents, partner, friends/other family members present)
- PHN's opinion is held in high regard by partners, support people

Toronto:

- Few fathers/partners participate in visits as they are at work/school
- Receptive and appreciative of facilitators for Dads/partners
- Clients report that partners do attend doctor/midwife appointments
- When baby is born fathers/partners are supportive and do participate in day to day care of baby if they are able to
- Many clients do not live with baby's father (either they are in maternity homes or they live with family)
- Other family members often do not engage with program

Hamilton:

- PHN’s continue to include fathers/partners, and family members in visit as requested by client
- Most clients brought their partner or a family member to the Young Parent holiday event
- Family members are included as requested by client

London:

- Follow client’s lead/desire to include baby’s father

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- Try to engage partners prenatally
- Using facilitators specifically for dads has helped
- PHN’s follow the client's lead and their desire to include other supports in visits

York:

- Engagement of client's partner happens (and they are generally well engaged) when client desires their involvement
- Approximately one-third of families include active participation by partners (either present during HVs or client reports actively sharing info with them)
- Clients mother/grandmother is most likely to be engaged in NFP as an active family participant on HVs - on one occasion, when client was in a crisis (mental health), client's mother reached out to NFP PHN to request support/advocacy

Engagement of community, in particular, primary care providers and child welfare agencies (per site):

Niagara:

- Hearing positive feedback from community partners
- Child protection agency involved and engaged
- Midwife referrals have increased
- A few Obstetricians have increased referrals
- Team provided feedback to a couple of referral sources regarding referrals and disposition (i.e. Sexual Health program, midwives)

Toronto:

- Introduction letter send to all primary care providers for NFP clients
- Recent team building completed with Native Child and Family services
- Formal linkages of NFP PHNs to community agencies that service NFP population

Hamilton:

- Continue to collaborate with family physicians/health care providers as required with client's permission
- Collaborate with child protection workers as required
- Participate in case conferences
- PHNs continue to notify family physician if there are any abnormal screens by both phone and faxed letter with copy of assessment screen
- Continue to encourage voluntary prenatal referral to child protection agency, if applicable, for supportive services
- Home Visiting program has a well-established liaison committee with child protection agencies and maintains a current protocol for collaborative service delivery

London:

- With client consent, a letter is sent to all primary care providers letting them know their patient has enrolled with the NFP program and provide the NFP nurse’s contact information
- Primary Care Providers are also sent letters following assessments that require follow-up (i.e. GAD, PHQ, ASQs)
- With client consent, PHN’s work collaboratively with child protection to identify strengths and provide support; attend community plan meetings

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- There is representation from primary care and child protection on the local NFP Community Advisory Board

York:

- Presentations to OB/GYNs and midwives associated with local hospitals, has resulted in a limited number of referrals
- Literature and posters (client tear off to access York NFP directly) attempted to increase referrals with limited success
- Child protection has been difficult to engage, despite NFP Supervisor attempts by email and phone to increase workers awareness of NFP to initiate referrals
- When child protection is involved with NFP clients, a strong collaborative relationship with individual worker is evident that supports client's success as well as mitigating crisis response at time of birth
- Following up with Health Care Provider when initiated referrals are not successful supports Health Care Provider to reinforce/encourage uptake of referral made but has had limited success

Across sites: Success in securing additional members on the Provincial Advisory Committee in 2019 is evidence of increasing engagement at both provincial and local levels.

Success/challenges with receiving referrals (per site):

Niagara:

- Although 1-2 Obstetricians send referrals, others in area have not been sending them and this has resulted in missed opportunities for some clients (e.g., eligible clients did not come to the attention of the health unit until they were screened through the universal HBHC postpartum process)

TPH:

- Newly launched on-line referral process which has increased referrals to all programs
- Referrals are often provided directly to NFP PHNs when in the community

Hamilton:

- Referral rate decreased in 2019 however, there was an 8-week period where referrals were not accepted due to a 50% turnover in PHNs
- The referral freeze allowed new staff to complete orientation without over burdening the remaining PHNs who took over the NFP clients from staff who left the program
- The total pregnancy rate for 21 and under first time mothers has also decreased in the city in 2018; data for 2019 is not yet available to identify if this trend will continue
- Commenced taking an incentive gift to first consent visit to encourage participation and sign up and this has generated a positive response
- Clients are phoned immediately when referral is received so more success connecting with potential clients
- Plan for 2020 is to increase early referral rate, prior to 16 weeks by advocating for early referral through Safe Transition workgroup
- Implementation of a trial allowing phone line nursing staff to pre-book 2 consent visits weekly with new NFP referrals to reduce the risk of not being able to reach clients after the referral is triaged to the NFP team to book this initial visit

MLHU:

- Success with engaging new partners (i.e. prenatal clinic for young mothers)

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- Would like to increase referrals, especially of clients under 21 years old and less than 16 weeks gestation; plan to work with Health Care Provider Outreach Team as one strategy to achieve this

York:

- NFP PHNs find that clients will agree to NFP referral initiated by community partner (Obstetricians in particular) but decline offer of consent HV by NFP PHN when initial contact is made
- Warm transfers with agencies (e.g., Program Coordinator from community organization connecting with NFP PHN regarding receipt of referrals) are beneficial
- Central Intake process has been beneficial; directly forwarding NFP eligible referrals to NFP team rather than usual process of involving Health Connection PHN calling client to engage
- Allowances made for community partners to bypass standard referral process, enabling them to email the NFP PHN directly, prompting NFP PHN to reach out to client directly (with client consent)
- Several referrals from prenatal program activities and maternity agencies
- Low referral rates continue, despite outreach measures taken (e.g. presentation to community partners)
- Often clients do not see OB/GYN until late in pregnancy, often as late as 24 weeks gestation, which may impact NFP eligibility
- Getting referrals early enough in pregnancy can be a challenge

Program Implementation

Any adaptations, changes, enhancements made to: Visit-to-Visit Guidelines (V2VG), Nursing Assessment/Data Collection Forms etc.:

- Development of guidelines for revisions to V2VG with BC (as the NFP Collaborative in Canada Clinical working group), currently discussing the capacity for structured on-going guideline review by stage while prioritizing updates in the following areas across stages: 2019 Canadian Food Guide, BFI compliance, vaping and e-cigarettes, circumcision
- Data Collection + Nursing Assessment Forms updated for 2019 to reflect move to electronic record keeping at sites, gender neutral language (for clients and PHNs), compliance with information collection policies and to better inform data analysis
- Drafted a CQI process, data dictionary and templates for fidelity and outcome indicator reports

Brief description of our nursing education program (as described in the upcoming CaNE summary report 2 that summarizes the curriculum development and components as piloted in Ontario):
PHNs and supervisors' competencies:

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

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

1. ***NFP Foundations***: Completion of short chapters (currently being transformed into E-Learning modules as described below), augmented by independent reflection and team-based discussions, accessed through the NFP Canada web-based learning management system. This educational phase (20-25 hrs) is focused on increasing knowledge of: NFP history, evidence, core model elements, theories and visit-to-visit guidelines; client-centered principles, reflection, parenting, attachment, communication, recruitment and retention, intimate partner violence (IPV), and nursing assessment forms. Learners are introduced to a Canadian NFP program model, a nursing theory (Critical Caring Theory), and principles of trauma-and-violence informed care.
2. ***NFP Fundamentals***: Engagement in a five-day face-to-face, interactive learning environment, expertly facilitated by an NFP Educator. Includes an additional one-day face-to-face encounter (4-6 months later) to consolidate learning related to the IPV intervention. The focus is on the development of the specialized nursing skills required to deliver NFP. Learners have an opportunity to discuss, practice, and apply their knowledge of the NFP program through group reflection, role playing, and completion of NFP tools, resources, and assessment forms. The integration of new program innovations is highlighted, including use of the NFP program's Strengths and Risk (STAR) framework.
3. ***NFP Consolidation and Integration***: Consolidation and application in practice of knowledge and skills acquired in the first two phases of education. Phased professional development completed at the local public health unit and coordinated by the NFP Supervisor. Learning strategies include: job shadowing with experienced NFP PHNs, completion of NFP team meeting education modules, guest speakers to provide additional content on priority topics, site visits to community partner agencies, and technical support/mentorship from the NFP Nursing Practice Lead.

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

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

Any enhancements we have made to the program:

- Mental Health Innovation (MHI) introduction in the Fall of 2019: Teams are currently reviewing the modules and providing feedback to inform the decision to include or adapt the US-based MHI modules as part of the core education for new staff moving forward, in addition to reviewing individual health unit policy and procedures related to mental health assessment and responses for compliance/congruence with guidance provided in modules

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- Annual Team Education Day (as part of NFP Integration) Oct 2019: Teams all participated in a half day in-person/teleconference to share, review and learn from one another; the agenda for this first annual day prioritized the review of the NFP form updates, feedback received so far was positive but insistent on the next event being all day and in-person only
- Education recommendations for 2020:
    - Indigenous Cultural Safety online courses for all NFP PHNs and supervisors, with steps underway currently to review options and provide recommendations
    - Pilot PIPE online training for 3 staff, who will provide feedback to Ontario and BC to inform PIPE education moving forward
    - Continue Annual Team Education Day, with format in-person and all-day format (the limiting factor for execution is site budgets)
- Implementation of the results of the CaNE pilot (see description below of E-Learning enhancement currently in-progress)

Brief Project Description (Year 1 November 1, 2019-March 31, 2020)

With a funding contract from the Ontario Ministry of Children, Community and Social Services, Dr. Susan Jack, Professor, School of Nursing, McMaster University will establish a project team to create 18-25 e-learning modules for public health nurses and supervisors, employed to deliver the Nurse-Family Partnership (NFP) program through Ontario public health units, to complete the first phase (NFP Introduction) of the program's core nursing education. These modules will utilize the existing CaNE curriculum as the content foundation. The current e-learning management system will also be updated and revised to accommodate the addition of these e-learning modules.

During this period of time, the team convened will consist of Dr. Susan Jack (project lead), Lindsay Croswell (NFP Ontario Nursing Practice Lead), Heather Lokko, Director, Healthy Start and administrator responsible for the Ontario NFP License, an instructional designer and support from the information technology (IT) team at McMaster University. In November 2019, Park Education was hired to provide instructional design services and is meeting weekly with the NFP Ontario Nursing Practice Lead to develop the e-learning modules. Dr. Jack and Lindsay have been involved in reviewing and updating content in the modules developed for NFP Fundamentals as part of the CaNE project.

Deliverables:

1. Development of NFP Introduction E-Learning Modules with updated content for use by supervisors and public health nurses in Ontario
2. Two-page summary of the work completed, with appendices including screen shots of front pages of the e-learning modules

As of Jan 31, 2019, the project is currently revising the final draft template for module 1, incorporating feedback from a group of 5 test users (current NFP PHNs and supervisors), with this final draft acting as template for all additional modules

Program Fidelity

Our assessment of program dosage patterns and length of visits in relation to client strengths and risks to date:

- The average length of visits (across stages and 4 sites) was 71 minutes (range was 69-76 minutes)

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- One site was unable to provide data on visit length but anecdotally confirmed similar visit lengths
- Average total number of visits per client for the reporting period = 12.7 (missing data for one site, range 11 – 16.1)
    - Average number of visits during pregnancy per client = 5.8 (range 5.3 – 6.1)
    - Average number of visits during infancy per client = 9.3 (range 6.9 – 12.3)
    - Average number of visits during toddlerhood per client = 5.8 (range 3 – 9.7)
- These averages include all clients that were active at some point during the reporting period (including those that did not graduate and those that enrolled late during the year)
- Moving forward, we will attempt to analyse visit dosage retrospectively for clients once they have been discharged to learn about dosage patterns over time as they relate to program outcome data
- There were 37 graduates during the reporting period, we are unable to determine an accurate "graduation rate" as our data reporting and analysis process has not been in place long enough to report on-going graduation rates
- Hamilton was able to provide additional graduation rates from previous years:
    - 2016 cohort: 45%
    - 2017 cohort: 32% (+6 pending) Potential for 45.4%
    - 26 clients discharged in 2019 prior to graduation
- London was able to provide additional graduation data on the 80 previously enrolled clients that have been discharged:
    - 8 graduated
    - 1 timed out at 2 years (1%)
    - 16 were client-initiated discharges (20%)
    - 21 moved out of service area (26%)
    - 22 were lost to follow-up (28%)
    - 6 no longer had custody of infant (8%)
    - 6 were pregnancy loss (8%)

Our assessment of program content delivered to date (domains): See CME 10 table

- Overall, of the stages that were reported correctly (7 sets of reported time spent per domain within program phases that equalled 100%), PHNs achieved the benchmarks in 47% of the domains and 43% of the reported domains were within 5% of the benchmarks
- Refer to the data report for details of reported time spent per domains
- The data require further discussion with the sites to determine if estimates are being calculated consistently, if content areas are being categorized consistently across sites and in accordance with guidelines, and if there are any estimates unique to Ontario and rationale for any differences between the data and the benchmarks

Our assessment of any other program fidelity benchmarks:

- 90% of eligible clients who were offered the program have enrolled (above benchmark of 75% and an increase since last report)
- 29% (range 21 – 37%) were enrolled less than or equal to 16 weeks gestation (below benchmark of 60% and decrease since last report)
- 97% (3 of out 5 sites reported less than the benchmark of 100%) of clients had their first visit completed by 28 weeks gestation
- 99% (1 of out 5 sites reported less than the benchmark of 100%) of clients were reported as being first time parents

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Our reflections on the issues revealed and actions we are taking /planning in response to these:

- Even though 29% (range 21-37%) were *enrolled* less than or equal to 16 weeks gestation, 45% (data missing from one site, range 24 – 81%) were *referred* prior to 16 weeks gestation; we can utilize this data to explore the loss of any clients from time of referral to enrollment with sites during ARDR to inform actions we can take to address improving our early enrollment rate
- There will be great value in exploring the strategy and process implemented by the site reporting that 81% of referrals were made are prior to 16 weeks gestation, to facilitate learning across all sites
- There is a need to explore the few cases where enrolled clients were reported as not meeting all eligibility criteria; we will review the rationale and context of decision-making the goal of improving our eligibility compliance
- Although there is no international benchmark for age eligibility, our Provincial Advisory Committee has committed in 2020 to review data on the age of clients enrolled and the cohort of clients that were not enrolled due to age only, to inform a discussion on age as an eligibility criteria moving forward in Ontario
- Development of benchmarks for Canada – as part of discussing the results from the BC RCT we will have to address the question of whether to develop benchmarks across the provinces currently delivering the NFP in the areas suggested by the International CME Guidance Document

Client and Child Program Impacts

Please provide a summary of your annual program client and child outcome indicators, collected through your NFP information system or attach a copy of your annual data report – *see attached*

Our reflections and key learning from our data regarding program impact:
Across sites:

- Highlighted data on attached report indicates areas of interest for reflection and discussion during site ARDR
- Aware that BC RCT is intended to provide evidence of program impact and as such, our outcome data has little context within Canada to assess effectiveness and has no real benchmarks yet for comparison (within Canada)
- May be evidence of reductions in substance use and enhanced breastfeeding rates (if compared to local peer groups)
- More detailed retention and attrition data required to help inform practice and program planning
- More discussion and guidance may be needed from Provincial Lead to support decision-making regarding eligibility fidelity
- New data collection tools/process will enable the utilization of data quarterly to inform practice in a timely manner
- Need to formalize support for data analysis at all sites and at MLHU in particular (to support work of Provincial Lead)
- Need to review data reporting and analysis process and plans for 2020 in the context of this 2019 annual report and accompanying data
- Need to explore data with each site during ARDR meeting to further reflect and inform practice for 2020

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- Percentage of time spent across domains reported by sites (averages) do not total 100% in every stage, during ARDR meetings need to determine where errors occurred (e.g. PHN's estimates, data inputting etc.)

Per site:

London:

- Reductions in substance use during pregnancy
- Rate of preterm births slightly elevated among NFP group vs local peer group (89% vs 92%)
- Enhanced exclusive breastfeeding rates at 6 months compared to local peer group (22% vs 9.8%)
- NFP clients face multiple complex challenges in their lives
- Need to be cautious when interpreting data from small sample size

Toronto:

- PHNs find the 36 week and 12-month time periods difficult to connect with clients and form completion rates are lower at those times points resulting in less data overall – team committed to focusing on improving completion rates
- Practices changed (site specific) mid 2019 regarding the discharging of clients - with current practices now focusing on improving client retention, the next data set expected to show significant improvement

Hamilton:

- Commitment to focus on decreasing attrition and increasing graduation rate; reasons for leaving included: moved out of area, loss of contact, baby no longer in clients' care, refused further service as has supports
- Goal for 2020 is to decrease "loss of contact" and "refused further service" attrition rates by identifying strategies to keep clients engaged and to ensure contact is not lost
  - PHN identify plan early as to how to connect with client should their phone number change/change address
  - advocate for continuation of program by identifying reasons to continue NFP even if client feels they are adequately supported e.g. focus on education as infant/toddler continually changing baby's different stages and challenges as baby gets older
- Supporting staff to fully implement community-based working model was a CQI initiative in 2019, activities included: eliminating remaining hard copy charting, ensuring staff were using technology to its' fullest capability, encouraging staff to connect in the community for consultation and support
- Improve accuracy of data collection forms and identify practice consistency/differences
  - Review current forms and processes regularly to identify challenges and how to address

Niagara:

- Significant gap between percentage of clients referred before 16 weeks gestation and those enrolled before 16 weeks gestation
- 65% of those referred are eligible (consider opportunity to increase awareness regarding eligibly amongst referral sources)

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- Excellent uptake of visits in the home (99%)
- Percentage of time spent in each domain not recorded correctly, as the total is greater than 100%; need to address this to enable comparison to the benchmarks
- Outcome indicators as reported do not provide comprehensive picture, it may be more helpful to analyse these as a proportion of clients rather than as counts

York:

- Low percentage of clients enrolled in NFP prior to 16 weeks gestation
- A higher percentage of clients receiving first face to face contact at 29 weeks gestation or more was identified through data analysis - related to difficulties in reaching client, and accommodated on occasion due to space in PHN’s workload capacity; accommodation such as this will need to be minimized to adhere to fidelity
- Lower percentages of time spent in certain domains (i.e. Maternal Role - Infancy and Toddlerhood); discussion with PHNs may provide greater insight into why this is

Our reflections on what we could do in addition to enhance program impacts for clients:
Across sites:

- Work to support sites (both supporting one another and support from the Nursing Practice Lead) with planned program changes and commitments outlined below
- Coordinate and implement planned quarterly data review/site visits
- Plan, develop and implement formal process for collection and integration of the client’s experience (this commitment has also been made by the Provincial Advisory Committee)

Per site:

London:

- Increase number of clients enrolled prior to 16 weeks gestation; work with referral sources to get referrals earlier
- Increase case conferences to 2 x's/month
- Increase frequency of observed home visits to min 2 x's/year
- Number of visits per client seems low; likely due to outliers/attrition; take a closer look at attrition data and modifiable attrition to identify strategies to mitigate
- Percentage time per domain: high in personal health and environmental health and low in maternal role; work with the team to explore potential reasons why and strategies to balance these two domains

Toronto:

- Recruiting clients before 16 weeks gestation: repeat outreach efforts to key community stakeholders, put articles in health unit news, NFP PHNs to send letter to client's health care provider, NFP update on Physicians page
- Focus on client centered approach to keep client's engaged in program - flexibility in visiting schedules

Hamilton:

- Aim to complete client event x 2 annually in collaboration with HBHC PHNs for all young parents engaged in home visiting
- Continue to increase engagement by offering incentives frequently
- New initiative: Offer incentive at consent visit to improve engagement

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- Continue to encourage hoteling/community-based model to enhance time management
- Complete Mental Health Innovation modules on Moodle to further improve competency in dealing with complex Mental Health issues – planned to complete Feb 2020
- Streamline NFP documentation with HBHC and commence NFP adjusted Client Centered Documentation System
- Continue to encourage early referrals by advocating program at Safe Transitions Workgroup Continue to complete weekly reflective supervision and bi-weekly Team Case Conference to enhance supportive environment and emotional self-care and assist PHNs identify strategies to assist their clients who are faced with multiple complex challenges

Niagara:

- Consider opportunities to enrol referred clients before 16 weeks - may even be through office/clinic visit and/or at school
- Increased outreach opportunities with primary care and other referral sources to increase awareness of eligibility criteria
- Consider some further data analysis locally to understand retention, discharge disposition of clients, outcomes
- Incorporate discussion regarding percentage of time spent in each domain into team meetings - work on calibrating PHN definition(s) of each domains

York:

- Further outreach to community partners who are working with clients earlier in pregnancy needs to be done to increase percentage of early NFP involvement (<16 weeks gestation)
- Referrals from Obstetricians have been received and were targeted during outreach activities, which may account for later gestational age referrals
- More attention will be placed on continued outreach with family physicians, who provide medical care to clients earlier in pregnancy, often referring to Obstetricians at 20 weeks gestation

Client Experiences

1) Feedback received from clients in 2019 enrolled in the program in York:

From an NFP client via text to NFP PHN: *"Happy birthday! I hope you had a great day 😁 I was trying to message you earlier but today has been a really busy day lol anywho thanks for all the amazing things you do for 'T' and I, you really make this crazy thing called motherhood so much easier I feel if I didn't have the support and knowledge I get from you everything would be a lot harder and so stressful. so thank you for all you do not just for me but for all of the other mothers as well"*

From an NFP client via text to NFP PHN: *"On a side note thank you for being like a second mom to me Stacey* [NFP PHN] *not having mine around since 'L's' been born has been extra hard but whenever I've needed someone u have always been there to turn to so thank you so much especially for always being so understanding all the time ❤️"*

NFP client feedback via text to NFP supervisor when asked for feedback on NFP services she receives: *"when I'm stuck I can reach out to my nurse and she can help me, the worksheets helped me when pregnant, she is a really good support, someone I can trust"*

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NFP client feedback via text to NFP supervisor when asked for feedback on NFP services she receives: *"Hey yea I love her she's amazing she's helped me so much with so many different things and I really do feel like she's there for me whenever I need someone to talk to about things that worry me like when my son had to get his first needles I was so scared and she* [NFP PHN] *really helped me mentally proper for that and even when I was about to have my son she was really there for me and able to answer all of my questions having her there made a huge difference and I bet I'm not the only one who feels that way.* 😁 *"*

"She's really great and super sweet!"

"When I first started meeting with her I was really shy but she really helped me get out of my shell and I can't thank her enough for that."
"So all in all I love having her apart of my life and my sons life and he just loves her he gets the biggest smile ever every time he sees her it's great"

2) Feedback received from clients in 2019 enrolled in the program in Niagara:

"Rose [NFP PHN] is one of the people that supported me through breastfeeding. She's my go-to. If I have any questions, I know I can text her." This same client was invited to speak during a local, level 1 breastfeeding training for professionals about her experience with feeding, and was so well received by the facilitator and participants. It was an empowering experience for her as well.

"[Referring to NFP PHN] You're always welcome here. You're the only one who has been here with me since day 1"

3) A scanned copy of the facilitator "How's it Going Between Us?" completed by a client in 2019 who is enrolled in the program at TPH:

hows_it_going_between_us_TPH2019.p

4) A short, informational video (made during the CaNE pilot) about the NFP program featuring a client's (and first graduate of the pilot) experience in the program at MLHU:

NFP program innovations

We are using/plan to use the following program innovations/enhancements (e.g. STAR Framework, DANCE, IPV, Mental Health, other):

We are currently using the following:

- STAR Framework – current international version
- IPV – update completed via teleconference with Dr. Susan Jack in Fall 2019
- MHI – teams begin accessing modules in Fall 2019
- Shared mode of supervision at the Niagara site

Assessment of our successes/challenges in implementing/adapting these program innovations:

- STAR:

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Challenges: PHNs report challenges related to the time it takes to complete coding and the perception that coding can be “double documentation” contrasted with the experience that coding does not provide a greater understanding and assessment of clients than the usual documentation process; there has also been challenges in the format of the coding sheets (PHN preference and usability)
Successes: supervisors have reported that PHNs sharing completed STAR coding helps to deepen their understanding of clients during case consultation and provide evidence for nursing decisions and interventions used by the PHN; providing alternate coding sheet formats (e.g. electronic and hard copy) and encouraging PHNs to create alternate version of coding sheets to share has helped alleviate some challenges with the format

- MHI – extensive technical challenges in the transfer, modification (removing US survey link) and uploading of the modules developed in the US, however, this was successfully completed in 2019 and teams are now reviewing

Any alternate tools we will use/are using and why:

- Nursing Child Assessment Satellite Training (NCAST) Feeding and Teaching scales (as an alternative to DANCE) – as explained in the last annual report there has been significant provincial investment over the last several years, and there is provincial support to continue (certification is paid by the Ontario Ministry of Children, Community of Social Services (MCCSS) and training occurs in each health unit). Using NCAST also creates stronger integration with other home visiting programs. Since both tools are validated and evidence-based, the decision to use NCAST was made provincially

Reflections on use of these alternate tools to date:

- 4 of the 5 sites have only used and obtained certification in NCAST (and not DANCE) so it is not viewed as an alternate tool for most and very few have had the ability to compare
- Hamilton is the only site with PHNs and supervisor that have been certified in both, the remaining team members are completing NCAST recertification in early 2020
- Thus far, there have been no concerns expressed with the use of NCAST as the dyadic assessment tool for NFP in Ontario and we will continue to engage with teams to elicit feedback

Our information system and analytical capacity:

How we are currently collecting, analysing and using NFP program data (information system, data quality, how it is used at NFP nurse, supervisor, team/site, national levels etc.):

Current (for this reporting period):

Data in British Columbia and Ontario continue to be collected and analysed separately. In Ontario, we have not had a consistent and efficient way to analyse data at a provincial level. The sites are mandated to utilize a provincial data system (called ISCIS) as part of the larger home visiting service program. We are able to pull reports from this provincial database per site regarding the number of completed visits, referrals, travel time and visit time, however, we are not able to add the NFP data collection forms into this system or pull the analysed data back out. In addition, each site utilizes a different system to support nursing documentation and health unit specific assessments and forms.

For the pilot, an excel spreadsheet was developed to collect all relevant data from the NFP Nursing Assessment + Data Collection Forms. Three dashboards (a reporting tool to provide visual display of information) were integrated into this excel document to display the most relevant data

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in an accessible way for the PHNs, Supervisors and site administration. The "PHN" dashboard provides information on visit locations, phase of the program and time spent in each domain. The "Supervisor" dashboard provides information on client statuses, gestation age at referral, discharge reasons and referral sources. The "Program" dashboard provides information on education level, housing status, income level, substance use, infant birthweight and gestational age at birth.

For this reporting period, site data report templates were created for sites to complete and sent to the Nursing Practice Lead to compile into one report for Ontario (attached). The reports included fidelity indicators, outcome indicators and site-specific reflections using the data collected by the forms and excel document mentioned above. The work of the data collection workgroup during 2019 helped to inform the process for this reporting period. Hamilton was the only site that was not already utilizing the pilot excel document (having not been a pilot participant) and therefore was not able to pull and report on all indicators or for the full reporting period (2019 calendar year only).

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

- Data analysis in Ontario until now has been linked only to research or the universal home visiting program
- More formalized data collection and CQI "process" that is specific to NFP data has been missing in general - this reporting period was leveraged to develop a process for use in 2020 for data collection and analysis, including the development of the data dictionary and update to forms (made possible by the in-kind contributions of data analysts from participating sites and the additional work and commitment of NFP supervisors)
- Varying capacity across sites for support with data analysis and reporting is challenging
- Inability to send data outside of each site (compliance with PHIPA) means that internal site data support is needed

Our plans to develop a Continuous Quality Improvement process:
2020 CQI process

1. Share final annual report and data report with all sites for review and reflection within context of each site and across sites
2. Provincial lead booking first site visit/meeting of the year in March to discuss report and reflections and develop plan collaboratively with sites for changes and enhancements to program implementation and data collection/analysis
3. Consideration will be given to which actions/changes need to be implemented and monitored across all sites, and which will be implemented and monitored at specific sites
4. Provincial lead will support sites to finalize plans, with involvement of Directors as needed
5. Action plans will be shared with sites, ONCOP and Steering Committee
6. Sites will begin implementing action plan
7. Sites to submit quarterly data reports in 2020 and Provincial Lead to compile, share and partner in reflection at quarterly site visits

Back to CMEs

Nursing Workforce

Reflections on NFP nurse/supervisor turnover/retention during reporting year and plans to address nursing workforce issues: (per site):

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Niagara:

- One NFP nurse off for extended period creating pressure to cover their caseload; ending year at maximum capacity for all PHNs and advocated successfully for an additional fulltime PHN moving into 2020.

Toronto:

- Smooth transition to new NFP supervisor
- New PHN joined team early in 2019 and has integrated well into team

Hamilton:

- Three new PHNs joined the team in 2019, two PHNs returned from 18 months maternity leave, new acting supervisor successfully transitioned
- Turnover of PHNs was mostly due to temporary PHNs being successful in obtaining permanent positions outside of home visiting, although staff did not want to leave the NFP program, they felt compelled to prioritize job security over role
- Orientation of new PHNs to NFP team went very well
- Identified a lack of structure regarding clinical orientation (outside of the NFP core education)
- Plan for 2020: identify learning and development gaps and implement clinical orientation and learning guidelines for PHNs new to the NFP team to improve transition to this new role (plan to set up internal workgroup, identify what other sites use, identify gaps and draft guidelines)

MLHU: no turnover or workforce issues

York:

- Have found the following strategies help with nurse retention:
- Frequency in meeting regularly
- Frequent team debriefs helps to mitigate secondary trauma
- Positive feedback and learning from each other (with client case reviews, informal debriefing)
- Open communication, team approachability and cohesiveness

Successes/challenges with NFP nurse/supervisor recruitment:

- Sites have previously reported that within health units, perceived stress and workload of NFP team members can deter applicants however despite this report, all vacancies were filled in a timely manner
- Two sites were successful in advocating for additional full-time PHNs however at other sites, there have been on-going staff hiring restrictions due to budget restraints

Successes/challenges with delivery of core NFP nurse/supervisor education:

- Delivery of NFP Foundations (phase 1) in an online, self-study format has allowed for new staff to begin education upon hire and work at their own pace, in addition it has allowed for current staff to review core concepts as needed
- Balance of achieving a minimum number of participants for an NFP Fundamentals (phase 2, in-person) cohort while planning for completion of this phase no more than 6 months from hire date is challenging

Successes/challenges with ongoing (integration phase) NFP nurse/supervisor education:

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- As previously mentioned, the opportunity for sites to travel to one location for the Annual NFP Team Education Day was limited by some of the sites travel budget, and this resulted in a hybrid format (3 locations and 2 of those hosted 2 teams each) of in-person and teleconference; feedback is that this hybrid format is not nearly as effective in accomplishing the stated objectives
- Sites have been successful in participating in relevant on-going education as a team. Here is a sample of reported on-going education activities/in-services completed by sites during the reporting period (offered/organized through individual health units):
  - Anti- Racism
  - Sexual Health Update
  - Birthmark Doula services (community partner)
  - WebEx training
  - Meeting the Nutritional needs of Pregnant women in Shelters
  - Engaging fathers and fathering programs
  - HIV
  - Cyber security
  - Breastfeeding and infant feeding
  - Foundations of Mental Health
  - CNO (College of Nurses of Ontario) code of conduct
  - Influenza vaccination
  - Cultural diversity and cultural safety training
  - ASQSE2 training
  - Fluoride Varnish
  - Let's Talk Twitter
  - ASQ3
  - Nicotine Replacement Therapy
  - Contraception
  - Cognitive Behavioural Therapy

Successes/challenges with delivery of NFP nurse reflective supervision:

- The average number of completed RS sessions for the reporting period was 27 per PHN (range 16-36)
- Factors that impact the number of completed sessions (for both PHNs and supervisors): annual vacation entitlement (2-8 weeks), sick leave, holiday/stat closures and cancellations
- Most often reported challenges in completing RS sessions are time constraints and geography (if staff are in multiple offices or telecommuting)
- One site reported that 1-hour weekly sessions is very challenging and a strategy to address this that has worked is 1 hour face-to-face every 2 weeks and telephone sessions on the alternate weeks (usually around 30 minutes)

Successes/challenges with delivery of reflective supervision to our supervisors:

- Not addressed in 2019 as planned, due to competing priorities
- still no formal process for delivery of reflective supervision for all supervisors however, in 2 of 5 sites that have both a designated supervisor and program manager (Hamilton and Niagara), the program manager completes reflective supervision with the supervisor
- plan to discuss further with the ONCOP during our review of the International RS project documents

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Summary

Summary of main achievements this year:

- Successful transition to a single license for Ontario
- Successful transition to post-pilot delivery of NFP in the participating sites
- Support for and maintenance of the NFP Clinical Lead position (referred to as the Ontario NFP Nursing Practice Lead)
- Establishment of the Ontario Data Collection Workgroup and successful achievement of first objective (creation and adoption of a Data Dictionary)
- Progress in education refinement activities (E-Learning Project funded by the Ministry of Health, Annual Team Education Day)
- Clarity and consensus between Ontario and BC in finalizing a draft terms of reference for the NFP Collaborative in Canada

Governance (working groups, committees and sub-groups)

Name of group	Number of completed meetings during reporting period
Ontario NFP Community of Practice (ONCOP)	15
Provincial Clinical Lead Meetings (Lindsay and Donna)	3
Ontario NFP Steering Committee	6
Ontario Provincial Advisory Committee (PAC)	2
Canadian Clinical working group	6
NFP International Participation (Clinical Advisory Group, Reflective Supervision Working group, Research and Analytical Lead Forum)	10
NFP Collaborative in Canada (NFPCC)	3 (1 in-person)

Highlighted achievements reported per site:

Niagara:

- The NFP team in Niagara faced a significant traumatic event that shook the team, however is a success story in terms of the support provided - the team was able to rally together, support each other, and learn together
- Shared supervision research project with McMaster has also been a success

Toronto:

- Revised promotional materials to be gender neutral
- Effective new supervisor transition largely attributed to the invaluable support from Ontario NFP Nursing Practice Lead

Hamilton:

- Moved to paperless, fully electronic documentation

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- Celebrated 22 client graduations in 2019
- Welcomed three new PHNs to team and return of two PHN from maternity leave
- Great Holiday Event - attended by approximately 35 clients, plus infants and support persons
- All PHN's completed training for NCAST in Jan 2020
- Telecommuting/community-based model improved time management
- Continued to provide opportunities for joint training and sharing of expertise/case discussion across our home visiting program teams (HBHC/NFP)

London:

- First annual summer picnic
- First year of graduates
- Seeing positive outcomes (i.e. finishing school; breastfeeding; anecdotally - ASQ screens are positive; reduced smoking and other substance use during pregnancy)
- Added a fifth PHN to the team in 2019
- Received Board approval to hire a permanent Community Health Nursing Specialist (the Ontario Provincial Nursing Practice Lead), using a cost-shared model approved by all other NFP sites

What challenges do we face?

The overarching challenge faced by Ontario is finding a balance between maintaining and developing new capacity and infrastructure while waiting for the RCT results in BC to support continued implementation and eventual expansion.

Any other relevant information: none

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PART FOUR: ASSESSMENT OF PROGRAM TESTING AND EVALUATION

Current research being conducted in Ontario (not a formal feasibility & acceptability study as that was completed previously in Hamilton)

Shared Supervision in Nurse-Family Partnership (SHIP): A Descriptive Case Study
Study Highlights December 2019

Susan Jack, Andrea Gonzalez, Karen Campbell, Lindsay Croswell & Sonya Strohm

Study purpose: To describe the unique model of shared supervision within the NFP program at Niagara Region Public Health. Within this case study research, we will also explore and document how this model has been used to integrate NFP into the existing family health programs offered by this health unit and to provide all supervisory functions, outlined in the NFP CMEs to public health nurses on the team.

The primary research questions for this single descriptive case study are:

1. What are the characteristics of a shared model of NFP supervision as implemented by Niagara Region Public Health?

2. What are NFP public health nurses' and supervisors' experiences of implementing and delivering the NFP program within the context of this shared model of supervision.

3. How has Niagara Region Public Health integrated the NFP home visitation program with their existing Healthy Babies Healthy Children program?

Research Design

A single, descriptive case study (Yin, 2014) is being conducted to answer these research questions. Case study involves the description, exploration, or explanation of a contemporary phenomenon within its real-life context (Yin, 2014). It is a particularly useful method of investigation when the phenomenon of interest involves complex social interactions, when investigators have minimal control over variables and when boundaries between the phenomenon under study and the context in which it is situated are not clearly delineated (Yin, 2014). Data triangulation, or the use of multiple data sources and data types, is a key characteristic of case study research (Yin, 2014) and is used to gain understanding, to ensure completeness, and to confirm the credibility of findings (Krefting, 1991). Data sources for this study include NFP public health nurses, supervisor/manager and other identified stakeholders. Data type triangulation will be achieved through the collection, review and analysis of interviews and documents.

In this study, the case under evaluation will be a description of a model of shared NFP supervision. This case is bounded by both time (2018-2019) and location, as this single public health unit is the only NFP site in Canada using this novel approach to supervision. Embedded within this case study, elements related to program implementation are also being explored and described.

Data collection and analysis:

Semi-structured interviews were conducted between June and November 2019. The whole population of the NFP team (n=5) was interviewed. Each NFP nurse/supervisor/manager was individually interviewed on two separate occasions. Additional program stakeholders were individually interviewed (n=8); their positions ranged from front line nurses to senior decision makers. Analysis of the qualitative data has been initiated with all interviews transcribed and

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cleaned; transcripts have been reviewed for high level codes. General program implementation data are also being collected and have been transferred from the health unit.

Key findings:

Based on an early and preliminary analysis of the qualitative interviews, three high level themes are being developed. A brief summary of each is provided below. The final analysis will be completed in 2020.

1) Value of Reflective Supervision: Beyond the benefits to the immediate team, public health nurses working in other areas of public health (external to NFP) are showing interest and desire to engage in reflective supervision and organized reflective practices. Reflective supervision is an antecedent to quality home visitation for new mothers. The shared model is highly acceptable with nurses and has also been integrated into existing Healthy Babies Healthy Children program with non-nursing staff and initial anecdotal reports of their experiences are positive.

2) Importance of Relational Intelligence: The NFP team lead must exhibit high levels of relational intelligence to support nurses through reflective supervision and maintain an open line of communication with the program manager. Participants report higher levels of comfort in reflective supervision when it occurs with someone they trust regardless of their position (team lead or manager) and recognize that reflective supervision is not safe with management when the individual is not trusted. Participants indicated that they are more likely to share sensitive information with the team lead yet would be equally comfortable receiving reflective supervision from the program manager. Both the NFP team lead and program manager were described as having high levels of relational intelligence. Relational intelligence is defined as, a "combination of emotional and ethical intelligence; be able to understand their own and others emotions, values, interests, and demands, to discriminate among them, to critically reflect on them and to use this information to guide one's action" (Pless & Maak, 2005, p.I2).

3) Hiring for fit: For the shared supervision model to be accepted by the team, the NFP team lead and manager must have a strong professional working relationship characterized by trust, regular communication and strong rapport. Program managers should be involved in the recruitment of a team lead. The NFP nurses expressed high levels of comfort with each other, the team lead, and the program manager. All NFP team participants expressed concerns that if the team lead position was filled based solely on seniority, important characteristics could be missing (e.g., sensitive, good listener, confidential). NFP nurses indicated that if the team lead role was filled by an individual missing the necessary qualities for this role, they would consider leaving the NFP team. This finding reinforces the need for hiring practices that support choosing the ideal candidate for the team lead position. On small teams where the nurses are also sharing in group settings, hiring practices may also affect the dynamics and quality of the team.

Background

In the Canadian NFP pilot to determine the feasibility of delivering NFP within an Ontario public health unit, the NFP team achieved a high level of success in conducting the required number of team meetings and case conferences (Jack et al., 2012). However, an optimal number of joint home visits were not completed (Jack et al., 2012). Generally, public health nurses participated in weekly reflective supervision on a consistent basis (Jack et al., 2012), yet nurses expressed that it was often difficult to schedule a session at the times they most need the opportunity to reflect and explore their feelings towards a challenging clinical situation (Dmytryshyn et al.,2015). Some nurses also expressed that it was difficult to honestly engage in the process of reflective

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supervision with an individual also responsible for their performance appraisal (Dmytryshyn et al., 2015).

Preliminary findings from the British Columbia Healthy Connections process evaluation provide insights that a range of contextual factors may influence an NFP team's capacity to maintain fidelity to CME 12. In a large geographical health region, the NFP supervisor might not be physically situated in the same office as all of the public health nurses reporting into her. This then requires that some weekly 1:1 supervision be completed via telephone/Skype rather than face-to-face, and due to travel/weather barriers, may limit flexibility to schedule or complete all of the required joint visits. In implementing agencies with small NFP teams or with a number of nurses working part-time in NFP, flexibility to schedule 1:1 reflective supervision or participate in all team meetings/ case conferences was a limiting factor. Supervisors, managing multiple responsibilities, also reported that they were in the position to re-schedule supervisory sessions due to competing agency demands.

Time, flexibility, and a broad range of skills is required for a single supervisor to successfully manage the administrative, clinical, and reflective supervisory functions required of this NFP role. Factors related to geography, organizational policies, union contract agreements, workload and staffing may influence the capacity of a team to meet all supervisory functions with strict fidelity to the core model element (CME) and organizations that staff the NFP program with part-time nurses, may find that it is difficult for these nurses to successfully provide direct client care through home visits and participate in all required supervisory and education activities within their scheduled work-time.

Nurse-Family Partnership in Ontario

As part of the Canadian NFP Education (CaNE) pilot study, four Ontario public health units originally participated, with a fifth health unit (Niagara Region Public Health) joining as a fifth participating unit in 2018. As the NFP program was being implemented into Niagara's Healthy Babies, Healthy Children program, a decision was made to use a shared supervision model. In this model, two public health nurses designated as an NFP Team Lead and an NFP Program Manager, are each responsible for a set of supervisory responsibilities as outlined in the NFP CMEs. For the NFP Team Lead, 0.5 FTE of her position is dedicated to supervisory responsibilities and the remaining 0.5FTE is then spent as an NFP public health nurse, delivering the program to a small caseload of clients. The NFP Program Manager is then responsible for providing overall leadership to the NFP program, participating on the Ontario NFP Steering Committee and Provincial Advisory Committee, as well as other non-NFP management roles. Given this variation from the NFP CMEs, there is a requirement to evaluate the benefits and outcomes related to the variation in practice.

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PART FIVE: ACTION PLANNING FOR NEXT YEAR

Our planned program priorities for next year:

1. Implement planned data collection and analysis process to evaluate the newly developed data dictionary, report templates, updated forms and procedures.
2. Utilize and strengthen process to better understand and target referral sources and improve early (before 16 weeks gestation) referral and enrolment rate.
3. Carry forward from 2018 priorities: review NFP Community Advisory Boards (CABs) in Ontario (using Terms of Reference from 2 current sites) and support the establishment of appropriate CAB(s).
4. Evaluate MHI modules using team feedback and plan for their integration into the Ontario NFP education model.
5. Strengthen RS component by reviewing updated international Framework and plan for adapting forms for use in Ontario.
6. Review age eligibility criteria with the Steering Committee, on advisement of the Provincial Advisory Committee, including an analysis of the data on clients that are referred and that are not being referred based on age eligibility.
7. Develop process for gathering data on the experience of clients in the program, in particular, priority populations.
8. Continue to participate in NFP initiatives between BC and Ontario (e.g., implement process for Canadian revisions to program content).
9. Continue to liaise with the Ontario Ministry of Children, Community and Social Services (MCCSS) and support their deliberations and partnerships (e.g. with McMaster), as requested. The priority during this year is the planned enhancements to the NFP nursing curriculum through the development of e-learning modules.

2018 Annual Report planned program priorities (for reference):

1. Finalize guidelines for NFP Community Advisory Boards (CABs) in Ontario (using Terms of Reference from 2 current sites) and support the establishment of appropriate CAB(s)
2. Strengthen data collection: establish workgroup, develop data dictionary, develop template and process for aggregate report to be sent to license holder (MLHU) from each site (informed by International Guidance Documents), review of all data collection forms and guidelines to improve consistency at all points of time in process, engage end users (e.g. PHNs) in process of report development.
3. Develop routine data analysis: Agree capacity and capability of analytical support for Ontario and develop systems to ensure that regular reporting for improvement is developed
4. Successfully obtain single provincial license and complete MOUs with all sites

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5. Establish fulltime Ontario NFP Clinical Lead role
6. Work with BC to reach mutually agreeable approach regarding provincial / national websites, and ensure sustainability of Ontario/Canadian website and Education website
7. Provide access to MHI modules to NFP teams in Canada
8. Continue to participate in national NFP initiatives (e.g., finalize process for Canadian revisions to program content and begin using process at Canadian Clinical working group)
9. Continue to liaise with the Ontario Ministry of Children, Community and Social Services (MCCSS) and support their deliberations, as requested

Any plans/requests to UCD for program expansion/adaptation?

Currently, the Ontario Government is undergoing a process of public health modernization. It is possible that this process will result in amalgamations. Should amalgamations occur, and should current NFP sites be involved in amalgamations, there may be a request to expand to other sites that are amalgamated with existing NFP sites. It is not expected that information about any amalgamations will be available until Fall 2020.

This is what we think we need to be doing next year to adapt and improve the quality of our NFP program in the coming year:

Utilize the availability of timely program data to ensure we are always striving to improve on program fidelity indicators and make informed program planning decisions to maintain and continually improve program impact for clients.

1. Improve "16 week" indicator by 5% closer to international benchmark
2. Define process for collecting on-going graduation rates and rates of attrition by type and update data dictionary
3. Define process for collecting outcome indicators as proportions and update data dictionary
4. As part of the focus on implementation of the new International RS Framework, carry forward indicators from 2018:
   Develop process for Reflective Supervision for Supervisors (informed by results of International project)
   Develop plan to address nurse recruitment/retention issues expressed by sites

2018 Annual Report indicators for review/reference and status:
1. Improve data collection consistency (see #2 in planned program priorities) – achieved as per plan
2. Improve "16 week" indicator by 10% closer to international benchmark – not achieved
3. Improve % time spent per Domain indicators by 2% closer to international benchmarks – unable to determine due to inaccurate data
4. Develop process for Reflective Supervision for Supervisors (informed by results of International project) – not started
5. Develop plan to address nurse recruitment/retention issues expressed by sites – not started

Our research/program evaluation priorities for next year:
- Complete three planned CaNE pilot summary reports, and confirm development and implementation of dissemination plan
- Help support completion of the SHIP study and participate in the dissemination of the results

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How we will know if we have been successful in meeting our objectives?

We will focus on the priorities indicated in this annual report and report back on our progress on each objective during our next report.

2018 Annual Report indicators for reference/review and status:

1. Final Guidelines for NFP CABs in Ontario completed – *not completed*
2. Data collection: Workgroup is meeting and has developed shared data dictionary, template for aggregate report, process for sending and data is being utilized successfully by sites - *completed*
3. MLHU holds provincial license and MOUs with each participating site - *completed*
4. Fulltime Provincial Clinical Lead is supporting sites and coordinating Ontario education (at least 1 cohort completed in 2019) - *completed*
5. Canadian website and Education website have sustainable funding and human capacity to manage sites (likely Clinical Lead providing coordination), with consensus reached between BC and ON regarding our national approach to websites – *in-progress*
6. MHI modules are accessible to Canadian NFP teams (likely on current CaNE Moodle site) - *completed*
7. Canadian Clinical working group using final process to review, and revise program material as needed – *in-progress*
8. Active participation in national NFP initiatives – *completed and on-going*
9. Ongoing consultations completed with MCCSS, as requested – *completed and on-going*

This what we would like from UCD through our Support Services Agreement for next year:

- Priority: Continued regular consultation joint calls with BC
- Priority: Continued email communication with Gail Radford-Trotter as needed
- Continue guidance and participation at NFPCC as determined by the needs of the Collaborative
- Areas of support that will be of particular interest are the transition of program delivery in Ontario after the BC RCT results are published; understanding the expectations and role of MLHU as the Ontario (and second Canadian) license holder in making changes to program implementation based on the RCT results
- Should amalgamation impact existing NFP sites through the Ontario public health modernization process, consideration of approval of minimal NFP expansion

Our suggestions for how NFP could be developed and improved internationally are:

- Utilize the work and experience of newly formed Research and Data Analysis Forum to update and develop International guidance (specific steps in the process e.g. template for each report type) on Data collection, Analysis and Reporting
- Review of Annual Report templates to ensure 1. consistent language for license holder representation; not use "country" but instead use term "license holder" and 2. Reduce repetition in information requested (e.g. CME section and program fidelity section requires some of the same information) *A helpful proposal which we will take forward*
- Review of approved variances and variations to the international replication model as discussion and sharing between international sites prompts review and reflection among international colleagues
- Ensure appropriate balance between NFP program innovation and adherence to evidence-base which gives credibility to the NFP intervention

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PART SIX: ANNUAL REPORT FROM UCD DAVID to review

(To be completed by UCD following meeting to review annual report)

Brief summary of services/support provided by UCD over the last year:

- Clinical Support from International Consultant (Gail Radford-Trotter) GRT Support via 1:1 meeting
- Dr Olds and Gail Radford-Trotter Joined Collaborative meetings via teleconferencing
- Both GRT and DO reviewed and commented on documents provided by the collaborative
- Both provided ad hoc guidance as requested on clinical and procedural issues.
- GRT Facilitated meetings that Ontario Clinical Lead attended on the International Reflective Supervision Project and followed up RS working group meetings; both attended by Clinical Lead
- Clinical Lead attended and contributed to the bi-monthly Clinical Advisory Group Chaired by GRT

Identified strengths of program:

- Strong consistent NFP Leadership provided by Clinical Lead (and wider research team)
- Close links with academic and research colleagues, enhancing reviews and evaluation across all areas of NFP practice
- Significant improvement in development of clinical information system
- Collegial working relationship with BC and agreed areas of emerging shared work re: NFP implementation
- Blended and complimentary working relationships with PHNs
- NFP Education moving toward a new framework for learning that is on track and being well received by learners
- Continuity in addressing outstanding actions for improvement (from 2018 annual review)
- Progressive and forward planning re: outcomes of RCT and potential impact for Ontario

Areas for further work:

- Continue to develop and apply clinical information system
- Consider the use of DANCE as the assessment tool of choice for measuring parent-child interaction; consideration of USA Oregon model, where DANCE is used across a number of different home visiting programs in the state.
- Continue close working and monitoring of relationships with Child Protection Services, particularly where there is a perception held by the client that NFP is a mandatory component to their care and support when it is not mandatory.
- Share learning with International community around the case study on reflective Supervision

Agreed upon priorities for country to focus on during the coming year:

- Improve “16 week-gestation” enrolment criterion to get closer to international benchmark
- Define process for collecting on-going graduation rates and rates of attrition by type and update the corresponding data dictionary
- Define process for collecting outcome indicators as proportions and update data dictionary
- Develop process for Reflective Supervision for Supervisors (informed by results of International project)
- Develop plan to address nurse recruitment/retention issues expressed by sites

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- Approved Core Model Element #12 Variance (minimum team size): Approved at this annual review.
- Monitor the impact of smaller ratio of nurse to Supervisor and any wider organisational challenges for this ratio

This what we would like from UCD through our Support Services Agreement for next year:

- Priority: Continued regular consultation joint calls with BC
- Priority: Continued email communication with Gail Radford-Trotter as needed
- Continue guidance and participation at NFPCC as determined by the needs of the Collaborative
- Areas of support that will be of particular interest are the transition of program delivery in Ontario after the BC RCT results are published; understanding the expectations and role of MLHU as the Ontario (and second Canadian) license holder in making changes to program implementation based on the RCT results
- Should amalgamation impact existing NFP sites through the Ontario public health modernization process, consideration of approval of minimal NFP expansion

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Table 1

Group	Purpose/Objectives	Membership	Frequency/Format	Chair/Recorder
Ontario NFP Steering Committee	To provide strategic oversight for NFP in Ontario. To ensure fidelity to the NFP program and licensing requirements To provide consultative support for province-wide challenges or issues (and local challenges, as needed). To act as decision-making body for NFP in Ontario. To promote excellence in nursing practice	• License-holder (MLHU) • NFP Ontario Provincial Clinical Lead • Director and/or alternate from all participating Health Units • Research consultant (School of Nursing, McMaster)	• Teleconference • Bi-Monthly meetings for 1.5 hours or at the discretion of the membership.	• License-holder to chair • Provincial Clinical Lead to record
NFP Provincial Advisory Committee (PAC)	To advise Ontario NFP Steering Committee regarding strategic, policy, and province-wide issues To support cohesiveness, and promote effective provincial collaboration and communication To inform long-term visioning for NFP in Ontario To enhance alignment of NFP with existing services and systems	• All members of the Ontario NFP Steering Committee • Managers/Supervisors from all participating Health Units • MOH's/AMOH's from all participating health units • Director, or alternate, Ministry of Children, Community and Social Services • NFP Provincial Coordinator, Ministry of Health, British Columbia • Faculty, Offord Centre for Child Studies, McMaster University • Chief, Health Promotion, Chronic Disease and Injury Prevention, Public Health Ontario • Researcher, School of Nursing, York University	• In-person • 2x/yr • Approximately 10am – 3pm	• License holder to chair and take minutes

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		• Provincial representative from midwifery and Indigenous health care • Provincial representative from child protection services • Local representation from child protection services • NFP International Consultant, Prevention Research Center, University of Colorado at Denver (ad hoc) • Executive Director, Healthy Populations and Development, Ministry of Health, British Columbia (ad hoc) Proposed additions for 2020: • Provincial poverty-reduction representative • Provincial representative from primary care		

Ontario NFP Community of Practice (ONCOP)	To ensure fidelity to the NFP program, excellence in nursing practice, and consistency in program implementation across the province.
	
	To create a safe environment for exploring, sharing, learning, and engaging in reflective practice and professional growth.
	
	To keep informed of and provide perspective on provincial, national and international NFP initiatives.
	
	To build and maintain positive relationships between and to provide mutual support for all Health Units implementing NFP.
		• All NFP supervisors working in Ontario
		  ○ Program Managers
		  ○ Supervisors
		• Ontario Provincial Clinical Lead
		• Research representative (x2/year)
			• teleconference
			• will attempt to meet every month or as determined by the members.
				• Ontario Provincial Clinical Lead
				• Minute-taking will be rotated among participants

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	To contribute meaningfully to the development of tools and resources to strengthen the program in Ontario for clients and PHNs. To clarify and enhance how NFP aligns, complements, and integrates with HBHC. To ensure connectivity between NFP research and practice.			
Canadian NFP Clinical Workgroup (interim group reporting to CCNFP)	To increase communication, information sharing and cohesion between Hamilton, British Columbia, CaNE pilot and McMaster. To engage in joint planning and decision-making related to resources, innovations and clinical practice To respond to requests from the Canadian NFP Governance Committee on an ad hoc basis To bring forward and address general clinical / nursing practice issues	• BC license holder • Ontario license holder • Ontario Provincial Clinical Lead • BC Provincial Clinical Lead • McMaster Researcher • University of Colorado Denver (NFP International Consultant) (ad hoc)	• Teleconference • every 2-3 months	•
Canadian Collaborative for NFP (CCNFP) (interim group in place until after	The Terms of Reference for this committee are in a draft as of Oct 2019.	• **Denver, Colorado**: University of Colorado Denver (2) • **Ontario**: Middlesex-London Health Unit (3) Ontario Public Health Unit Directors-implementation sites (2); McMaster University (2); • **British Columbia**: Ministry of Mental Health and Addiction (1); Ministry of Children and	• Teleconference or in-person • Meet at minimum 3 times per year	•

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completion of the BC trial)		Family Development (1); Ministry of Health (2); Simon Fraser University (3) • **Other Agencies/Affiliations**: As invited by membership. • **Guests:** As invited by membership		

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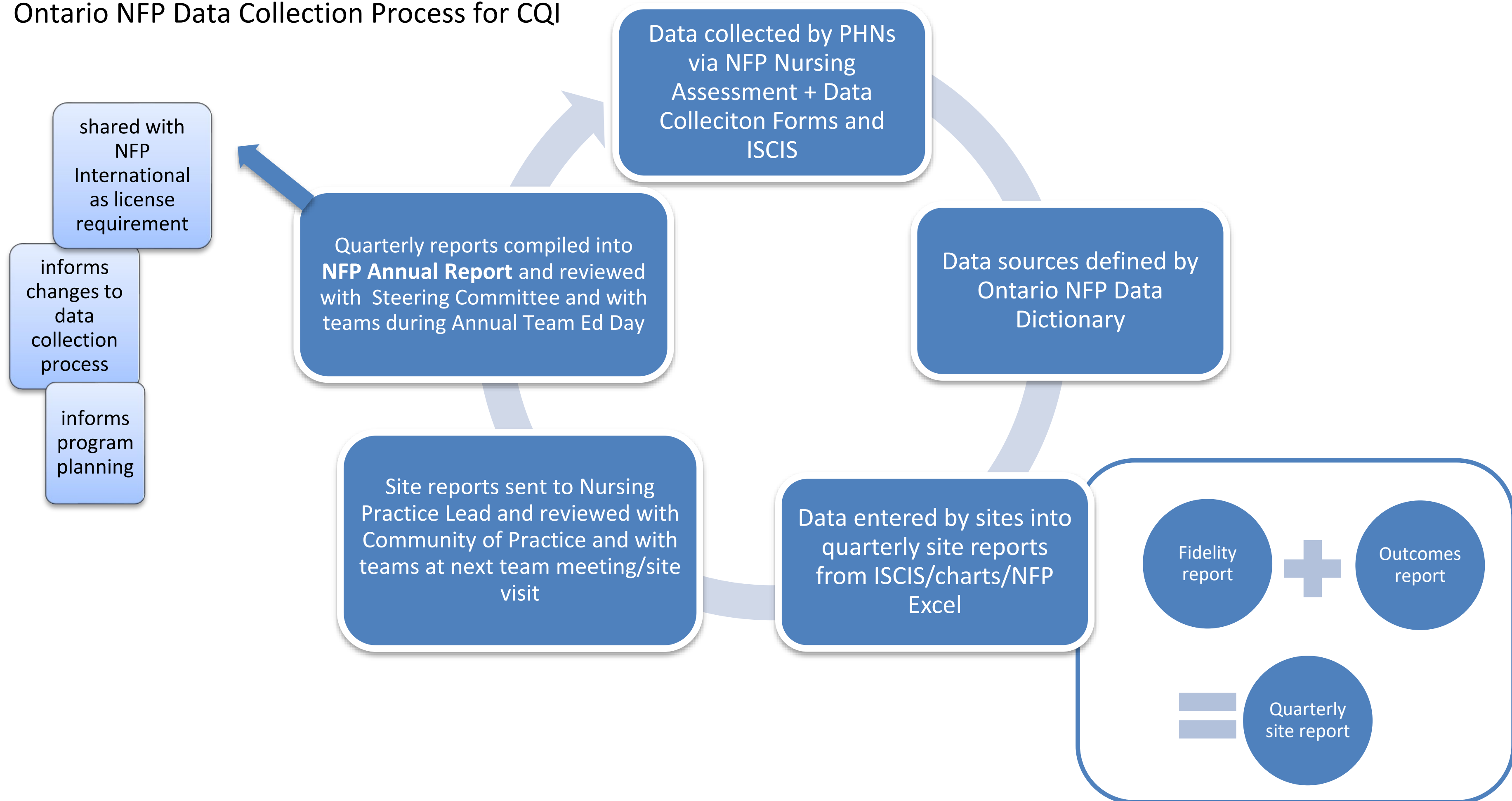
Table 2

Ontario NFP Data Collection Process for CQI



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