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Nurse-Family Partnership© (NFP) International

Guidance Document – Producing Data for the Annual Report | 2018.03.05

Background

As per Core Model Element # 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* (refer to Guidance Document: Revised Set of NFP Core Model Elements 2017.06.02)

NFP nurses collect information for four distinct purposes:

1) To support and guide clinical practice
2) To assess and guide program implementation through documentation of the NFP services received by clients
3) To measure achievement of core program goals
4) To inform reflective supervision and support quality improvements

Information is recorded on nursing assessment/data collection forms, which are collated into an information system within each country. Data collected is analysed and reports are generated for individual clients, nurses and teams in a timely way. In addition, this data may be used by research teams (contingent upon adherence to required permissions for release of data), alongside other data, to inform their evaluation of the implementation of NFP.

It is expected that each country will collect, analyse, and review data reports on a regular basis at a team, regional, and national level. Reviews of this data should be used to guide adjustments in NFP implementation and/or further enquiry regarding a particular aspect of program delivery. Reporting and analysing the routinely collected program data at a national level provides an opportunity for countries to examine data reports and reflect on their meaning which is a parallel process to that expected of NFP nurses, Supervisors and sites.

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

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It is expected that each country's annual report:
1) Includes a summary of their annual program data within the body of the report or
2) Has a copy of their annual data report attached.

Individual countries are able to make their own choices regarding the analyses they feel are most helpful to them, and will be guided to some extent by their phase of program delivery.[1] However, there are some core analyses that should be included in the annual data reported by each country. These provide evidence for adherence to the Core Model Elements (CMEs) and quality of program implementation. This guidance document updates and sets out the expected data analyses for the annual review in line with the revised Core Model Elements

Core Data Reports

NFP nursing assessment/data collection forms generate two types of reports: Fidelity and Outcomes. For each type of report, it is possible to analyse the data to identify the current position as well as trends and changes over time. In addition, it is possible to create sub-analyses, where particular data from client groups are analysed and /or compared, or particular issues are analysed in more depth. It is also expected that data analysis will be undertaken to determine the impact of Quality Improvement activities identified in the previous annual report.

Fidelity Measures

Fidelity is the extent to which there is adherence to the core model elements (CMEs) alongside agency/nurse uptake, application of new research findings, and carefully developed innovations. Fidelity helps protect the integrity, quality, and effectiveness of the NFP program while being respectful and sensitive to local context. The international NFP guidance document – *Revised Set of NFP Core Model Elements* (2017.06.02) sets out the 14 Core Model Elements with detailed descriptions of each element, the rationale and evidence that underpin them, guidance to support their practical application, and establishes benchmarks when required. Data analysis is undertaken to ensure adherence to the CMEs.

Where fidelity expectations have not been met, it is expected that countries will undertake further analyses to explore the reasons for this and suggest QI measures to address the issue. Where any temporary variations to the CMEs have been agreed, the expected data analysis to identify the impact of these should also be reported and discussed as part of the annual report. The table beginning on the next page sets out the benchmarks and data that should be reported to assess fidelity for each of the fourteen CMEs.

Please note: the data sources provided in the table on the next page are drawn from the international NFP data collection forms (refer to: http://nfpinternational.ucdenver.edu/resources).

[1] Phase 1 = Adaption; Phase 2 = Feasibility and Acceptability through Pilot Testing and Evaluation; Phase 3 = Randomized Controlled Trial (RCT); Phase 4 = Continued Refinement and Expansion.

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Core Model Element, Fidelity Benchmarks, Data Sources and Indicators/Analysis

Core Model Element	Fidelity Benchmarks	Data Sources	Indicators/Analysis
1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program.	100%	• Informed Client Consent Form (or other mechanism adopted by country)	• % of clients with signed informed consent (or other mechanism utilized)
2. Client is a first-time mother	100%	• Maternal Health Assessment Form	• % of clients who are first-time mothers
3. Client meets socioeconomic disadvantage criteria at intake	• Countries will set their own socioeconomic disadvantage criteria with 100% of clients meeting this criterion. • A description of the eligibility criteria being utilized should be included in the report	• Client Intake Form	• Total # of women enrolled into the program over the last 12 months against expected recruitment • % of all women enrolled in the program who meet the country's socioeconomic disadvantage criteria • Provide analysis of any additional demographic information collected that is relevant to each country. This could include: o Client age o Client ethnicity &primary language o Client education/ work status o Housing situations and household makeup o Income status o Health status • Some countries may wish to analyze differences in demographics between different sites within a country, or over the years of program implementation to identify trends

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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.	• 75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program.	• Each country will develop their own protocols and data collection mechanisms for collating information regarding eligible referrals.	• % of clients receiving their first home visit no later than the 28th week of pregnancy. • % of all eligible women who were successfully enrolled into the program • Reasons eligible women gave for declining enrollment into NFP (if known)
	• 60% of pregnant women are enrolled by 16 weeks gestation or earlier • 100% of NFP clients receive their first home visit no later than the 28th week of pregnancy.	• Maternal Health Assessment form	• % of pregnant women are enrolled in NFP by 16 weeks gestation or earlier • % of pregnant women enrolled later than 28 weeks
5. Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits.	• 100% of clients are assigned an identified NFP nurse	• Client Intake Form	• % of clients with an identified NFP nurse
		• Home Visit Encounter Form	• Length of visits (average and range)
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.	• Countries will set their own benchmark (the benchmark should be identified in the report)	• Home Visit Encounter Form • Alternate Home Visit Encounter Form	• % of visits conducted in the client's home • % breakdown of where visits are being conducted other than in the client's home • Countries may wish to also report on % visits where fathers, other family members and/or other professionals were included in the visit
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.	• <u>No</u> benchmark should be set related to number of completed visits given the importance of adapting the program to the needs of individual clients	• Home Visit Encounter Form	• % of clients being visited on <u>standard</u> visit schedule • Average number of visits by program phase for clients on standard visit schedule • % of clients being visited on <u>alternate</u> visit schedule

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			• Average number of visits by program phase for clients on alternate visit schedule
	• Countries will set their own benchmarks for client retention/ attrition (these benchmarks should be identified in the report)	• Change of Status/Discharge Form	• % Client attrition from the program by stage and reasons
8. NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.	100%.	• Analysis of data shared by implementing sites	• % NFP nurses with baccalaureate /bachelor's degree. • Countries may also want to analyze other nurse variable such as age, years within profession, specialist qualifications etc.
9. NFP nurses and nurse supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities	• 100% of NFP nurses and supervisors will complete the required NFP educational curricula and participating in on-going learning activities. • At this time, each country will determine the specific content, teaching methods used, and when to provide it. Counties will also set their own policies for required "retraining" when nurses/supervisors leave and then return to the NFP program.	• Each country should maintain a record of nurse and supervisor NFP specific education sessions provided and their content	• % of nurses and supervisors completing the core NFP education program
		• Team Meeting, Case Conference and Education Session Form	• % team meetings, case conference and education sessions completed against expected for time period
10. NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the five program domains.	➢ See Domain Benchmark table on page 7	• Home Visit Encounter Form • Alternate Home Visit Encounter Form	• % time spent in each of the 5 program domains by the 3 program phases
11. NFP nurses and supervisors apply the theoretical framework that underpins the program (self-	• It is expected that NFP nurses and supervisors will apply the theories through current clinical methods/delivery of the	• Quarterly Supervision Record Form	• % 1:1 supervision and home visit observations undertaken against expected (calculated by time – working

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efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.	program. There is no specific benchmark for this CME.		weeks- and number of nurse)
12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision	100%	• Quarterly Supervision Record Form	• % 1:1 supervision and home visit observations undertaken against expected (calculated by time – working weeks- and number of nurses)
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.	• Although there are no objectives that relate to the collection and use of data, all the NFP benchmarks for the program are measured through use of regular standardized data collection.	• Sites should be doing chart audits and implementing quality assurance measures to assess data completeness and accuracy	• Countries will prepare site, regional, and national level data reports as outlined in this guidance document
14. High quality NFP implementation is developed and sustained through national and local organized support	• There are no related benchmarks for this CME, although countries may want to introduce these for data completeness and /or accuracy. • These could include expected frequency and attendance of National and Local Advisory Board meetings • Numbers of clients identified or referred to NFP will also provide an indication of local support for the program, as will numbers of referrals to other agencies	• Analysis of data collected from local implementing agencies within sites	• % of Advisory Boards or equivalents held against expected • % attendance at Advisory Boards held against expected
		• Referrals and Service Utilization Form	• Number of referrals (or notifications of potential clients) to NFP program compared to numbers projected for enrolment period • Number of referrals (actual and recommended) from NFP nurses to other agencies/services/ professionals etc.

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Domain Benchmarks by Program Phase

Domains	Pregnancy	Infancy	Toddler
Personal Health	35-40%	14-20%	10-15%
Maternal Role	23-25%	45-50%	40-45%
Environmental Health	5-7%	7-10%	7-10%
My Family & Friends)	10-15%	10-15%	10-15%
Life Course Development	10-15%	10-15%	18-20%
Health and Human Services *	Included in the domains above		
Total	**100%**	**100%**	**100%**

Outcome Indicators

Countries are expected to produce outcome reports to demonstrate achievement of the three NFP program goals:

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

Outcome reports summarize aggregate data related to important indicators of maternal, child, and family functioning. These reports assist national leadership and local teams to monitor the extent to which the program is achieving outcomes that can be measured while a family is active in the program. Outcomes Reports are derived from data collected from NFP nursing assessment forms such as:

- Child development outcomes (Ages and Stages Questionnaire screening results)
- Breastfeeding initiation and continuation rates
- Child immunizations status
- Childhood injuries/ingestions/ hospital admissions
- Child protection/safeguarding referrals
- Client education or workforce participation
- Client IPV disclosures by program phase
- Low birth weight
- Maternal smoking status during each program phase
- Maternal substance (including alcohol) use during each program phase
- Maternal mental health issues during each program phase
- Maternal mastery during each program phase
- Premature births
- Subsequent pregnancies

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Countries will determine what variables to include in their analysis of these outcomes (age, ethnicity, race etc.). Countries may want to add in additional outcomes that are relevant to their unique context. If it is possible to assess these outcomes against data for a comparable group within the country and context, this will assist leaders to draw inferences and conclusions about the impact of the NFP program on the local population. However, this is often not possible to do and care must be taken not to make conclusions based on limited numbers or data that is not comparable. Data that is collected at multiple points (smoking, breastfeeding, Ages and Stages, etc.) can be analysed for trends and patterns. This data can also be used to assess areas where further Quality Improvement projects are required (see below)

Strengths and Risks (STAR) Framework

Analysis of the assessment and observation data (levels of risk, protective factors, and readiness for change etc.) compiled by NFP nurses as they use the STAR Framework is a promising addition to the analysis of client demographics and outcome indicators within the NFP client population. Over time it is hoped that changes in STAR risk levels can be analysed in relation to number of visits (and other relevant aspects of program delivery), to review the impact of its use on nurse decision making.

Impact of Quality Improvement initiatives

Continuous Quality Improvement is an expected facet of all NFP programs. Over time, it is expected that all countries implementing NFP will use their data reports to identify areas of strength as well as areas that require further understanding and/or Quality Improvement (QI) measures at the local, regional, and/or national level. Analysis of data over time in any of the three areas above can assist national leaders to understand the impact of the QI projects that they undertake.

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