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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

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|---|---|---|---|
| Name of country: | Ontario, Canada (CaNE Pilot Project) | Dates report covers: | June 2017 – December 2018 |
| Report completed by: | Lindsay Croswell, CaNE Pilot Project Clinical Lead for Middlesex-London Health Unit (MLHU) | | |

NOTE: any overall "pilot" data refers to reporting period of Jan 1, 2017 to Sept 30, 2018 for 3 sites and April 25, 2018 – Sept 30, 2018 for 1 site

**The size of our program:**

| | # Who work exclusively in NFP | # Who have additional assignments in implementing agency | **Total** |
|---|---|---|---|
| Fulltime NFP Nurses | **18.5*** | **0** | **18.5** |
| Part time NFP Nurses | **0** | **0** | **0** |
| Fulltime NFP Supervisors | **0** | **4**** | **4** |
| Part time NFP Supervisors | **0.5***** | **0** | **0.5** |
| **Total** | **19** | **4** | **24** |

*includes one PHN on maternity leave and 3 new hires that will begin working in Dec
**Public Health program managers with additional responsibility provide NFP supervisor role
***shared model of supervision in Niagara, 1 PHN is carrying a caseload halftime and providing reflective supervision to 3 additional PHNs halftime

- We have 4 teams (supervisor-led groups of NFP Nurses)
- Average Supervisor to NFP nurse (+ other staff) ratio: NFP Supervisor to NFP Nurse is 1:4 on average (Supervisors who are also Public Health Program Managers have between 9-20 staff that are direct reports and include non-NFP PHNs, support/admin staff and lay home visitors).
- We have enrolled **311** NFP clients since starting our Pilot Project.

 

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

**Clinical leadership, support and guidance**:

The CaNE project team created the position of Provincial Clinical Lead in the fourth quarter of 2015. Hamilton Public Health was approached because of Hamilton's NFP team's experience in delivering the NFP program in Ontario. The CaNE project team inquired about the process for seconding an experienced NFP PHN from the Hamilton NFP team for a period of three years to support the CaNE project objectives. Leaders from Hamilton Public Health and the CaNE Project met to define roles and responsibilities and discuss a draft job description. The Boards of Health for both the City of Hamilton and the Middlesex-London Health Unit approved the secondment and the job description was finalized. Subsequently, the position was posted internally at Hamilton Public Health and candidates were interviewed jointly by a Hamilton Public Health Services Manager and the NFP International Consultant for CaNE. The successful candidate was selected and she officially began in the role of in the spring of 2016. The position has significantly evolved over the course of the CaNE project.

Provincial Clinical Lead responsibilities:

- Educator
  - Develop and revise curriculum
  - Plan, coordinate, and deliver face-to-face education sessions
- Coordinator/Liaison
  - Liaise between pilot 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
- Clinical Consultant
  - Provide clinical support to pilot sites (e.g. practice and fidelity questions)
  - Provide clinical consultation support by phone and in-person
- Implementation Consultant
  - Develop implementation manual
  - Advise on resources and incentives for pilot sites
  - Provide consultation support regarding documentation and data collection: planning, consultation (excel database), CQI initiative (dashboard feature in excel and guidelines)
- Marketing
  - Develop a template for service providers and clients
  - Consultation regarding marketing materials needed and content
  - Facilitate approval by NFP International and NSO
- Resource Development
  - Provide guidance regarding documentation (e.g. use of HBHC FSP on ISCIS by NFP)
  - Provide guidance for the development of program material (e.g. Bank of positive affirmations)
- Website management
  - Upload website content
  - Provide website access for all new/ongoing NFP PHN's and supervisors

See attached (Table 1) for CaNE pilot Governance summary notes.

**Description of our National implementing capacity and roles:**

**Service / implementing agency development**:

 

See Table 1 for leadership that supported site implementation (e.g. CaNE Implementation Workgroup). Site implementation was led by the Clinical Lead (role described above). The Clinical Lead developed several versions of a draft Canadian Implementation Manual during the course of the pilot that was shared with the Implementation workgroup (and additional site leads as appropriate). This manual was adapted using the US and UK implementation manuals. The final pilot version will be complete by the end of Dec, 2018. 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:**

For the pilot, the International version of the NFP Data collection forms was utilized to collect data. The forms were slightly modified and referred to as the Nursing Assessment & Data Collection Forms. The modifications included the addition of the draft Canadian NFP logo and RN signature spaces, minimal architecture changes, and removal of a few data fields that were already collected through our Provincial database (e.g. distance travelled). An Excel spreadsheet was developed for the pilot to input a large portion of data from these forms, and dashboards were developed to summarize the data into accessible visuals for program review. Our provincial database (ISCIS) was also utilized to collect data and provide monitoring reports related to program standards, expectations and CQI.

**Senior Nursing Leadership:**

MLHU is the license holder for the pilot and Heather Lokko (Director and the Chief Nursing Officer) is the project lead. Jennifer Proulx, the NFP manager at MLHU is also significantly involved. The Directors/Chief Nursing Officers for each site's department are all represented on the pilot Steering Committee and the Provincial Advisory Committee (PAC). The Provincial Clinical Lead has 6 years of NFP home visiting experience she brings to the role.

**License holder**:

There was representation from MLHU and each of the sites holding a Memorandum of Understanding (MOU) at each group/committee representation. See Table 1 for additional details.

**Other (please describe):**

- Dr. Susan Jack was the principle investigator for the pilot, and due to her NFP expertise, she provided significant guidance, leadership, and support to the overall pilot. Dr. Jack was also involved with the curriculum development as part of the team that decided on what the online platform architecture should be. In addition, she contracted staff and experts to design and maintain the technical components of the platform. She acted as both a consultant for curriculum development and authored the IPV content, in addition to facilitating the face-to-face IPV and TVIC education.
- Debbie Sheehan, the curriculum consultant and first NFP International Consultant to the pilot, took the lead on planning and developing the curriculum. She also provided leadership to the team that decided on the online platform architecture and then worked with the contracted experts to design the platform variables. She was central in developing the agenda for the first cohort of face-to-face education and facilitated some (25%) of the first cohort of education and all of the Supervisor-only face-to-face education. Debbie also mentored and supported the lead educator (the Clinical Provincial Lead) in delivering the face-to-face education.
- Lindsay Croswell, the Provincial Clinical Lead was part of the coordination team for troubleshooting and providing and maintaining access to users. She helped with the online orientation through the computer services unit; pilot tested the online education and worked with appropriate persons to troubleshoot any platform errors. Lindsay reviewed and contributed to the editing of all online content and coordinated the

 

uploading of any additional content during the pilot. She led most (75%) of the facilitation for the first cohort of education, developed the slide decks, and created the participant workbook, coordinated facilities, logistics, and catering, printing and teaching resources. Lindsay also conducted daily online evaluations and made changes to the agenda and activities based on feedback. In preparation for the second cohort of education, she reviewed interview feedback from nurses who participated in the first round of education and revised the agenda accordingly, adding activities to fill gaps in learning and removing what was considered less useful or redundant. Lindsay then facilitated 80% of the second cohort of education (including the same organizational/administrative tasks as the first cohort required). Finally, Lindsay coordinated additional education needs during the 3rd phase of education (e.g. TMEM support, planning IPV education which continued for a full day after initial face-to-face education).

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

The CaNE Project is funded by a $351,000 grant and significant in-kind and moderate funding contributions from participating health units. The Ministry of Children, Community and Social Services (formerly the Ministry of Children and Youth Services) approved allocation of NFP nurses, managers and administrative staff from the Healthy Babies Healthy Children (HBHC) Program to implement the NFP.

The investment of $351,000 was key in funding training and research. Health units contributed at least $4.3 million in primarily in-kind resources to provide NFP in their communities. They also leveraged in-kind contributions from many community partnerships.

Health units participating in the CaNE pilot as NFP implementation sites have committed to ensuring in-kind and fiscal resources are available to ensure the full duration of the NFP Program is provided to any client who enrols in the program during the CaNE pilot.

Over the three-year life of this project, education resources for Ontario were developed which allowed the three initial health units in phase 1 to deliver the NFP to over 300 low-income families.

The Province of British Columbia is in the midst of conducting 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.

**Description of our research team and capacity to conduct quantitative and qualitative evaluation:**

There is currently no single research team identified as part of a National or Provincial unit. For the CaNE pilot, Dr Susan Jack from McMaster University was the principle investigator and research lead. The data sources utilized for the pilot included both quantitative and qualitative data (focus groups with PHNs; 1:1 interviews with PHNs, Supervisors and Educators; evaluation forms; implementation data; and a demographic questionnaire) and these were analysed by the research team.

Since 2008, in Ontario and British Columbia, across a range of research projects, McMaster University has 1) led the adaption of the content used by public health nurses during home visits;

 

2) piloted the program for feasibility and acceptability; and 3) been involved in the RCT to evaluate NFP compared to usual services, along with a parallel process evaluation, in a program of research called the British Columbia Healthy Connections Project (BCHCP). Throughout these projects McMaster has continued to lead the process of adapting NFP materials developed in the US for use in Canada.

The purpose of the CaNE pilot was to develop, pilot, and formatively evaluate a Canadian model of NFP education for public health nurses and supervisors employed to deliver this targeted public health intervention in four Ontario public health units.

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

This project developed collaborations and foundational infrastructure in order to deliver the Nurse-Family Partnership (NFP) in 4 pilot sites in Ontario; these collaborations and infrastructure could be used in scaling-up the NFP program across the province. This included adapting/developing, and evaluating, NFP nursing education to prepare and support public health nurses (PHNs) and supervisors to deliver the NFP program. NFP complements the Healthy Babies Healthy Children (HBHC) program, which is funded by the Ministry of Children, Community and Social Services (formerly the Ministry of Children and Youth 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, health teaching and service coordination, and a Family Home Visitor (FHV or paraprofessional) 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, self-care, and other community services for children and families. PHNs generally visit once every 3-5 weeks and FHVs visit every 2 weeks. While HBHC connects many families with services, the program lacks an intensive component for young, low-income families, such as female lone parents.

In comparison to HBHC, NFP provides PHN-only home visits, is targeted towards a specific population of young, socially and economically disadvantaged first-time mothers, and offers more frequent home visits over a 2 ½ year period. 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 few years.

The $350,000 investment for the CaNE project leveraged over $4 million in existing resources from the main partner agencies.

Healthy Babies Healthy Children is a 100% provincially-funded program; however, some health units also draw on municipal sources to augment their provincial funding envelope for this program. 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 (4 of these are delivering NFP through the CaNE project). The introduction of NFP into this province has occurred at the grassroots level. The CaNE project lead, the McMaster-based NFP research team, and NFP champions from participating health units have ensured transparency and ongoing communication with the Ministry of Children, Community and Social Services about NFP research initiatives, practice implications of NFP, and opportunities for integration between NFP and the existing home visiting provincial program. Ministry staff have engaged with NFP to the extent that they have determined is appropriate, considering the ongoing status of the RCT in British Columbia.

**Description of our implementing agencies/sites:**

High level description of our implementing agencies/sites (Ontario Public Health Units):

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

4 implementation sites:

Middlesex-London Health Unit

Regional Municipality of York, Public Health Branch

City of Toronto (Public Health Division)

Niagara Region Public Health

**Current number of implementing agencies/sites delivering NFP**: 4

**How we selected and developed sites for the pilot:**

At the time of the initial proposal written there were six public health units forming the key delivery partnership. Middlesex-London Health Unit, Toronto Public Health, Peel Public Health, Ottawa Public Health, and Northwestern Health Unit provided letters of support to be implementation sites for the pilot. Hamilton Public Health had committed to partnering with McMaster University to facilitate the provision of nursing education. The 2015 proposal indicated that implementation would be phased, with three health units in the initial year and three additional health units added when feasible. The proposal also stated that 3 additional health units, York Region Public Health, Halton Public Health, and Wellington-Dufferin-Guelph Public Health had expressed interest in participating but were not able to formally commit at the time of the proposal submission. Due to timing, funding, and feasibility issues, the CaNE project was limited to three sites initially, with a fourth site joining as administrative support and internal funding were secured.

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

**Successes:**

- Emerging provincial infrastructure and increased shared capacity
- Experience of PHNs from having worked in other home visiting programs
- Initial results of piloted education (positive feedback on curriculum and delivery)
- Integration of home visiting programs within health units and growing support from Ministry
- Commitment of ongoing funding from all participating health units to ensure NFP continues post-pilot

**Challenges:**

 

- Lack of initial formal provincial governance/infrastructure
- Small team sizes
- Until recently, sustainability challenges post-pilot for clinical leadership and provincial education
- Documentation efficiency and consistency across sites
- Lack of central data collection system across sites

**Other relevant/important information regarding our NFP program:**

 

## PART TWO: NFP CORE MODEL ELEMENTS (CMEs)

Any analysis of data described below represent a total of 311 clients seen by a total of 16 PHNs from Toronto (n = 5), London (n=5), York (n=4) and Niagara (n=4) regions during the pilot ***(all data and analysis is from the pilot research team and included in the pending CaNE final report; data is not yet published and not to be shared beyond this report).***

| Core Model Element | Success and challenges in meeting each CME |
|---|---|
| 1. Client participates voluntarily in the Nurse-Family Partnership (NFP) program. | PHNs ensure that the client understands the program is voluntary and they are under no obligation or mandate to consent (from the program's perspective). The only real challenge with meeting this CME sometimes is for clients involved with child protective services (e.g. Children's Aid Society or Catholic Children's Aid Society). When clients are given expectations by a child protection worker that include enrollment in parenting classes or home visiting service (such as NFP) than the nature of what is truly voluntary is hard to decipher. To address this challenge, PHNs are clear and firm with child protection workers that the NFP program consent requires voluntary participation. Joint case management and consistent communication has helped with this challenge. |
| 2. Client is a first-time mother | Specific eligibility criteria related to CME:<br>First live birth. Women are eligible if a previous pregnancy ended in termination, miscarriage or stillbirth, or if previous parenting involved step-parenting only.<br><br>Data was missing on 5 participants. Of the remaining 306 participants, a total of 305 women were listed as first-time mother (first live birth); only one participant was listed as not a first-time mother.<br><br>There were challenges with consistent data input and this may have contributed to the missing data or data potentially being entered inaccurately (i.e. not a first-time mother). |
| 3. Client meets socioeconomic disadvantage criteria at intake | Our socioeconomic disadvantage criteria:<br>Using clinical judgment, it will be determined if the referred woman is experiencing social and economic disadvantage. Contextual factors that will be taken into consideration to reach the decision that the client is experiencing socioeconomic disadvantage will include any/all of the following factors: lone parent, completion of < grade 12, receipt of income assistance (disability assistance, Ontario Works) or no regular income, socially isolated with no financial support from partner or extended family, indication of financial stress (food insecurity, difficulties in paying rent, homeless), or expressed |

 

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| | plans to move towards independent living (e.g. Move out of parent's home).<br><br>The reported challenge with this CME is that the data source used to inform eligibility may not be accurate or there may not be a source at all (i.e. income unknown). In addition, there is often a dynamic nature of household income/support for some clients meaning that they may be financially supported at the time of referral but decide to leave the home they are living in, leaving them with no income. |
| 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. | Specific eligibility criteria related to CME:<br>Less than 28 weeks gestation. Women are recruited prior to 28 weeks gestation to ensure that participants receive their first home visit by the end of the 28th week of gestation.<br><br>Data was missing on 43 clients. Of the remaining 259 clients, the majority was enrolled prior to 25th week gestation: 35.1% (n = 94) were enrolled less than or equal to 16 weeks gestation; 36.2% (n = 97) were enrolled between 17- and 25-weeks' gestation; 20.5% (n = 55) were enrolled between 26 and 28 weeks and 8.2% (n =22) were enrolled past 28th week gestation. The mean gestation at time of enrollment was 19.79 weeks, ranging between 4 and 36 weeks.<br><br>At the time of the report, 1 client was booked for her first visit at 29 weeks, another client received her first visit at 29 weeks and was still active. 1 site accounted for 13 enrolments after 28 weeks: 5 clients at 29 weeks (4 still active), 4 clients at 30 weeks, 1 client at 32 weeks (still active) and 3 clients between 34-36 weeks. Feedback regarding these late enrollments was that there were challenges with connecting with clients and booking first visits. The decision to keep these clients enrolled in the program was made if the visit was completed within a reasonable time frame (from contact) and in consultation with manager (based on client issues) and if there was a risk of losing client to service by transferring them to the other visiting program.<br><br>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 pilot who provided individual NFP home visits.<br><br>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.<br><br>Moving forward, data on retention following transfers would be helpful in CQI for providing guidance on how best to transfer clients. |
| 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 3,338 visits were recorded. Of these, 2,820 were home visits (84.5%); 297 were alternate home visits (8.9%); 65 were attempted but not completed (1.9%) 138 were scheduled, but cancelled by the client (4.1%) and 18 were cancelled by the PHN (0.5%).<br><br>Of the 2,820 home visits, the majority took place in the client's home, 70.7% (n=1,996), followed by a family or friend's home 4.7% (n=137), a public health unit 3.3% (n = 95), school 2.3% (n =66), a doctor's office or clinic 1.6% (n=49), or 'other' 18.4% (n = 523).<br><br>Alternate home visits included, attending an appointment with the client (n=22), participating in a case conference (n=33), telephone calls/visits with client (n=144), texting with a client (n=59), other (n=29), or unknown (n = 10). |
| 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. | Data were available on 311 clients. At the time of analyses, 181 clients remained active (58.8%), 125 clients were discharged (40.6%) and 2 clients were reactivated (0.1%). Data was not available on three clients. Of the 125 clients who were listed as discharged, reasons for discharge include the following, 40 were client initiated (32%), 2 clients lost custody of their children (0.02%), 32 were lost to follow-up (25.6%), 30 clients moved (24%), 8 had a pregnancy loss/infant death (6.4%), 4 cases the PHN was unable to provide service, and no reason was provided in 9 cases.<br><br>Sites 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. Only one site reported a client being formally on an alternative schedule. Based on this feedback it appears that the standard schedule is being adjusted as needed instead of an alternative schedule being offered formally. This will have to be explored more fully with sites and emphasis |

 

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| | will be placed on the use of the STAR framework to support decision-making around the visit schedule. |
| 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. |
| 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 completed the piloted version of the core NFP education. Full details about the evaluation of the educational adaptations are included in the Final CaNE report (to be sent in Feb 2019). |
| 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. | Overall, PHNs met the benchmark across the five program domains and 3 program phases, pregnancy, infancy and toddlerhood. Please see table below. |
| 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.<br><br>It has been reported that PHNs often refer to the foundational theories during case discussion. |
| 12. Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular clinical and reflective supervision | Although the use of supervisor forms was not consistent and the data was not part of the Excel spreadsheet data collection for the pilot, all supervisors reported booking weekly 1:1 with all nurses. Completing 1:1 every week was challenging when schedules changed but the attempt to reschedule within the week or make use of phone check-ins were always considered. The greatest challenge reported with this CME was the frequency of observation visits. This challenge has been discussed and feedback provided to the NFP international team. There are also challenges with completing all the supervisor forms. Supervisors report that the forms do not support their role or the PHNs practice. A review of all supervisor forms is planned for the Ontario Community of Practice in 2019. The goal is to ensure the data around supervision is collected while only requiring the use of forms that are supportive to supervisors in their role.<br><br>See attached approved variance for additional details on this CME for the pilot. |
| 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. | See page 22, section "Information System and Analytical Capacity" for details, reflections and plans. |

 

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| 14. High quality NFP implementation is developed and sustained through national and local organized support | The establishment of the Ontario Community of Practice (ONCOP) and the Provincial Advisory Committee (PAC) during the pilot has provided great value to the implementation of NFP in Ontario. During the pilot, progress has been made provincially and nationally to support sustainability for the NFP program implementation in Ontario and Canada. The plan to move to one NFP license in Ontario post-pilot will help to improve the quality of implementation in the province and continue to build capacity for supporting the program in all implementation sites. |

CME 10 Table:

| | Distinct visits (n) | Personal Health (%) | Environmental Health (%) | Life Course Development (%) | Maternal Role (%) | Family & Friends (%) |
|---|---|---|---|---|---|---|
| **PREGNANCY** | | | | | | |
| **Benchmark** | | 35-40% | 5-7% | 10-15% | 23-25% | 10-15% |
| Total/Mean | 1,433 | 41% | 13% | 12% | 21% | 13% |
| **INFANCY** | | | | | | |
| **Benchmark** | | 14-20% | 7-10% | 10-15% | 45-50% | 10-15% |
| Total/Mean | 1,375 | 23% | 9% | 13% | 43% | 12% |
| **TODDLERHOOD** | | | | | | |
| **Benchmark** | | 10-15% | 7-10% | 18-20% | 45-50% | 10-15% |
| Total/Mean | 10 | 16% | 12% | 19% | 42% | 11% |

Any requested CME variance(s): ☐ No √ Yes (see approved variance request attached)

## PART THREE: PROGRAM IMPLEMENTATION

**Reflections on clients, family members, and the community**

Data were available on 311 clients. At the time of analyses (Sept 30, 2018), 181 clients remained active (58.8%), 125 clients were discharged (40.6%) and 2 clients were reactivated (0.1%). Data was not available on three clients. Of the 125 clients who were listed as discharged, reasons for discharge include the following, 40 were client initiated (32%), 2 clients lost custody of their children (0.02%), 32 were lost to follow-up (25.6%), 30 clients moved (24%), 8 had a pregnancy loss/infant death (6.4%), 4 cases the PHN was unable to provide service, and no reason was provided in 9 cases.

# of NFP clients (enrolled) participating in the program over the course of the pilot (*not just 2018): **311**

 

% of those eligible clients offered the program who have enrolled over the pilot period: **88%**
total eligible clients referred = 290, total who enrolled/consented = 256
per site: Niagara: 17/19 or 89%, Toronto: 116/141 or 82%, York: 37/38 or 97%, MLHU: 86/92 or 93%

Some initial reflections on the data above is that the enrolment rate is good but comparison to Hamilton, BC sites and other sites internationally may be helpful to gauge success. A focused look at the client initiated discharges would be beneficial for each site to reflect on ways to manage addressable attrition. Finally, as with other findings related to data collection, increased consistency in data inputting may help provide additional information (especially in the cases of the missing data or no reasons given).

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

Toronto:

- Age of youngest client is 14
- Client issues and challenges vary, based on history and stability of supports
- Surprised at how soon clients become pregnant again despite discussing spacing/prevention
- Many clients do not have English as their first language (newcomers with immigration challenges), Interpreters used for more visits than anticipated
- Have witnessed very positive support received from client's mother
- Many clients continue pursuing post-secondary education i.e. University and College
- Clients who are from a culture where it is more permissible to have children at a young age wanted less support or visits because they were receiving support from partner and family (i.e. if married at young age and considered natural part of life course); Some of these clients were transferred to other home visiting program

York:

- Concentrated occurrence of IPV in NFP client; with other home visiting program, experience was that clients did not disclose IPV nearly as much
- Greater collaboration with community partners to best support these clients
- More vulnerabilities than other home visiting program clients – sex trade workers, clients involved with child protection themselves as children
- More acuity
- One client was seen by other home visiting program and discharged due to lack of interest, but when referred to NFP, client followed through with services

MLHU:

- Multiple complex needs
- At intake – the majority of clients are <19; 70% no high school education; 25% precariously housed; 90% report <20,000 annual income; although data is difficult, a minimum of 20% report substance use (not including tobacco)

**Client engagement in the program (including client retention):**

- Clients like the intensity of the program, keeps them engaged
- PHN is the incentive (in sites where there is no policy to support the use of incentives)
- Intensity/frequency of visits allow clients to feel that they are supported/feel like they are being listened to

 

Reported challenges with retention:

- Young age of clients, often high risk pregnancies – clients have multiple medical appointments to attend and will often cancel visits to attend medical appointment; Need to determine with client when NFP service fits.
- If baby born with health challenges and is involved with NICU, difficult to book appointments with client as they have increased medical follow up; need to determine how we can best support client
- When client acknowledges that their NFP goals have been met (i.e. go back to full time school or work) and want to graduate early
- Unstable contact information, cell phone numbers, housing, challenge in remaining in contact with client

**Engagement of fathers:**

- PHNs engage with anyone the client identifies as a support and wants to include in visits, follow client's lead with respect to partner involvement
- Might be difficult initially to have a partner participate or attend visit but when they do they often want to continue to be a part of HVs
- Partners may not want to meet at home, but have had success with agreeing to meet in community i.e. coffee shop
- Challenge to complete IPV assessment if partner at all HVs
- Afterhours HVs have been provided to allow Fathers to participate on HVs, at client's request (on occasion)
- At times father involvement not ideal, related to IPV/controlling behaviours

**Engagement of other family members:**

- Again, PHNs follow client's lead regarding interest in family member involvement
- Often client's mom will tell client to call nurse for support and more info
- Client's moms supportive of client getting pregnancy info from nurse but may challenge parenting information shared from nurse
- May be challenge to complete IPV assessment if family member present at all HVs

**Engagement of community, in particular primary care providers and child welfare agencies:**

Referral Source data: Most clients were referred by other public health services (21.2%), followed by community partners (18.3%), self-referrals (12.5%), doctors' offices (10.6%) and CAS (7.1%). For approximately a third of the clients, no referral data was available (30.2%; n=94).

PHNs will refer clients for necessary services if needed during home visits or alternate home visits encounters. During the study period, 1,029 referrals were noted on the home visit or alternate home visit encounter forms. Of these, 241 were referrals for pregnancy and parenting programs, 232 were health care referrals, 194 were related to financial assistance, 54 for shelter and housing, 32 for substance use and harm reduction, 46 related to education and employment, 15 to children's services, 35 to CAS, 102 referrals were made to mental health/crisis intervention, and 78 referrals were to 'other' community programs and services. In most cases where a referral was recommended, the client was receptive (n =547; 53.2%), or the client or child were already receiving services (n = 313; 30.4%). In some cases, the service was recommended but declined by

 

the client, or the client was unable to follow through (n=103; 10.0%), the client no longer needed the service or the issue was resolved (n=12; 1.2%) or the referral was in process or the client was on a waitlist (n-54; 5.2%).

Notes on data:

- Many referrals to NFP were made from child protection agencies, shelters, Midwives, physicians, Social Workers, hospitals, schools
- Pregnancy and Aftercare workers at child protection agencies want PHN involvement and perceive NFP as more beneficial for clients then other home visiting programs and want to refer clients as early as possible
- Community Advisory Board in MLHU has representation from 17 community partners

**Success/challenges with receiving referrals:**

- Over time community agencies have learned the eligibility criteria for referral so initial challenges with ineligible referrals has decreased
- Some sites have experienced case distribution issues as caseloads increased (e.g., should there be a waitlist, triage of referrals, approval to hire additional PHN, etc,) requiring these multi layered considerations
- Large geographic areas mean that sometimes travel time is significant
- Data on 'active' clients for provincial ISCIS database not accurate because of competing indicators between NFP and other home visiting program
- Client phone numbers or address at time of referral may not be accurate
- Often, community partner agencies are making additional referrals because of success with previous NFP referrals
- Use of existing intake/referral process and screens in each site (for other home visiting program) has been mostly successful in completing referrals to NFP program; some challenges related to missed screens of clients that would have been eligible for NFP.
- Regular engagement with community partners promotes referrals,
- Presence of NFP PHN at community partner's sites allows opportunity to interact with potential NFP clients
- In 1 site, there has been an increase in the number of community referrals; partners see a need for the program

**Program Implementation**

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

The pilot used a slightly modified version of the International Data Collection forms. The pilot referred to this group of forms as the "Nursing Assessment + Data Collection Forms." The adaptations included the addition of the draft Canadian logo, changes to some of the form architecture (e.g. removing space for client name in order to use a printed label), and the addition of space for the PHN to sign and date at the end of the forms as per the College of Nurses of Ontario documentation standards. There have been no adaptations made to the Visit-to-Visit Guidelines for the pilot specifically. The Clinical Lead, the third-party researcher, and the project lead have been part of the Canadian group reviewing the program materials for compliance with Baby-Friendly Initiative (BFI) policy and updated nutrition guidelines and safety legislation/best practices in Canada. This group is also developing a formal process for reviewing program materials and has completed a draft document to date.

 

**Brief description of our nursing education program and enhancements made to the program:**

There was an identified need for a program of education that could be specific to the Canadian context; that is, to ensure that what is in the curriculum reflects what is needed and most relevant for public health nursing practice in Canada. CaNE educators shared that developing a Canadian-specific education would provide the opportunity to remove content from existing curriculum that was not relevant to Canada (e.g., a chapter on data collection based on format of US nursing assessment forms), as well as to add content where differences existed in Canadian community health and public health nursing practices (e.g., health teaching around nutrition and child safety).

Within this Canadian context, there was also the desire to develop an education program that could be practical and sustainable for individual provinces. In acknowledgment of the high costs being incurred to send nurses out of province or to the US to complete the education, one CaNE educator said, "developing a curriculum and an education program in Canada and more local to this project was the best-case scenario for cost savings and future sustainability." Further development and refinement of an education program also provided an opportunity to respond to previous feedback and nurse evaluations. One area specifically concerned the comprehensive workbook nurses complete in the first phase of education, where evaluations demonstrated experiences of information-overload and 'tuning out'. To a CaNE educator, this represented such a 'single way' of providing that information, and she shared that, "because it's a lot of information to take in it required a more evidence-based approach to the teaching methods used to introduce the concepts." Formalized research evaluations of the NFP nursing education among international sites appeared to be a gap in knowledge.

Finally, another reason to develop this novel curriculum was that it provided an opportunity to synthesize innovations. According to CaNE educators, the innovations and updates (e.g. the STAR framework and Mental Health Innovation Modules) made to the program over the last decade had not been integrated into an updated education program. There had also been previous discussion among international clinical advisory group members about the value of including a nursing theory as part of the education foundation.

The curriculum was developed to reflect the International NFP nurse core competencies as set out by the revised NFP Core Model Elements. The work plan had the following components related to curriculum development: 1) prepare version 2 of the Canadian Visit-to-Visit Guidelines; 2) develop CaNE Nurse Education Curriculum; 3) develop E-learning platform; 4) integrate with Canadian NFP; and 5) deliver CaNE curriculum.

The curriculum guidance document outlined the goals of the pilot education and the principles of the Canadian approach to NFP Education (see table below). These principles included imbedding the Transtheoretical Model of Behaviour Change throughout the curriculum to support PHNs in becoming skilled in using Motivational Interviewing for supporting behaviour change in clients. The principles also incorporated Blooms' Taxonomy, used to guide the matching of curriculum content with the most relevant teaching methods.

The curriculum was divided across 3 phases of education. The table below summarizes delivery methods, content addressed, and resources requited in each phase.

 

| Phase | Delivery | Content | Resources Required (in addition to pilot team) |
|---|---|---|---|
| 1. Introduction to NFP | Online<br><br>Self-study<br><br>40 – 50 hours | Moodle Platform Orientation<br><br>Introduction to NFP course (17 chapters): History Evidence and Fidelity; NFP International Program; Excellence in NFP; Human Ecology Theory; Attachment Theory; Self-Efficacy; Critical Caring Theory; Client-Centered Principles; Reflection in Practice; Therapeutic Relationships and Boundaries; Maternal Role; PIPE; Communication Skills; Content Domains; Structure of the Home Visits + Using the Visit-to-Visit Guidelines; Strategies for Recruiting & Engaging Clients; Nursing Assessment Forms and Information Gathering; 6 chapter review storyboards<br><br>STAR course<br><br>IPV course<br><br>MHI course | Instructional Design Expert<br><br>Learning Platform (e.g. Moodle)<br><br>Software to support use of Storyboards (e.g. Articulate)<br><br>Computer Services/IT Expert |
| 2. NFP Fundamentals | Face-to-face<br><br>6 days (42 hours)<br><br>*IPV education continued with one extra day added to original 5 days | ***Content reflects the first cohort of face-to-face education, as adaptations were made for the second cohort discussed later on.*<br><br>NFP Model<br><br>STAR<br><br>Communication Skills<br><br>TVIC<br><br>Visit-to-Visit Guidelines<br><br>Core Model Elements and Fidelity to the Model | Facility space with tables, WIFI and AV capabilities<br><br>Complete set of slides<br><br>Laptop<br><br>Large laminated version of NFP Model and CMEs<br><br>Dry erase paddles and markers (enough for each participant) |

 

| | | | |
|---|---|---|---|
| | | Using the four theories: Self-efficacy, human ecology, attachment, critical caring<br><br>Review and Application of Client-Centered Principles<br><br>Cultural Responsiveness: Four-Step Process<br><br>Reflection in Practice<br><br>Client Retention<br><br>PIPE<br><br>Maternal Role<br><br>IPV (full day) | Chart paper and markers<br><br>Video clips prepared for appropriate sessions (e.g. Motivational Interviewing)<br><br>PIPE curriculum (full set for educator and 1 set per 3 participants ideal)<br><br>Teaching doll (also required for each participant to bring)<br><br>General office supplies<br><br>Table supplies for participants: treats, fidget toys, craft supplies |
| 3. NFP Consolidation & Integration | Job Shadowing<br><br>Team-based<br><br>On-going | IPV system navigation<br><br>TMEM<br><br>PIPE (as needed)<br><br>*Before clients enter infancy stage:*<br><br>Keys to Caregiving<br><br>ASQ<br><br>Dyadic Assessment: NCAST | Maintenance of learning platform<br><br>Opportunities for job shadowing<br><br>Per site:<br><br>Keys to Caregiving (starter kit)<br><br>ASQ materials<br><br>NCAST materials |

**Novel Curriculum Elements:**

*I.Interactive Online Structure*

Canada is the first country to take a fully online approach to the first phase of education promoting an interactive, up-to-date, and user-friendly learning process. This first phase included the completion of the following modules: Introduction to NFP (known as "Unit 1" in the NSO curriculum), Intimate Partner Violence (IPV), and the Strengths and Risks Framework (STAR). As a strategy for organizing course content and interactivity (e.g., audio, video, quizzes, etc.), storyboards were developed that each covered key concepts of several chapters, and that could be completed in a short time period (e.g., no more than one hour).

 

*II.Content more deliberately integrated and embedded*

A few key innovations to the NFP program had occurred over the last 5-10 years and had not yet been integrated into core education. Instead it was previously provided as an addition to the education with the expectation that the nurses would consolidate the new knowledge with their core education independently. One of the CaNE educators shared that, "we've made concerted efforts to bring all the pieces of education and content together in a, in a cohesive way," specifically referencing the very deliberate embedding of both IPV and STAR within the curriculum. As another CaNE educator said, "this project allowed us to integrate it [STAR] as part of the core education for nurses. So the way in which we're doing it is brand new. No one's done it like this before. But it was needed…So having that embedded throughout education is new and necessary absolutely." More meaningful naming was also chosen for the different phases of the education, renaming from numbered units to: Introduction to NFP, NFP Fundamentals, and NFP Integration.

*III.Added Content*

New content in the Canadian curriculum include the following:

- Critical Caring Theory
    - Added to ground the work of public health nursing in the NFP program and to put language to the skills and often 'invisible' work of NFP PHNs
    - The addition of a nursing theory was discussed at the NFP International Clinical Advisory Group in 2017 and its inclusion was supported by Dr. David Olds
    - One CaNE educator said that the NFP education curriculum, "always felt incomplete from a theoretical perspective"; felt that this was a formal theory for integrating the nursing assessment and nursing knowledge pieces that was previously missing.
    - The same educator spoke about how Critical Caring Theory, "Resonates so completely with the work that, that public health nurses and specifically visiting public health nurses do"; Furthermore, she goes on to say that it, "strengthens the resolve and the commitment and the support of nursing leaders in Canada for NFP when they see that we're championing the work that's being done at a nursing practice level in Canada."
- Trauma- and violence-informed care (TVIC)
- NFP Canada program model (adapted from the US garden model)
- A final chapter or storyboard in the NFP Introduction called, 'Putting it all together' (intended to consolidate knowledge from all the modules)

*IV.Minimized Content*

The decision was made to spend less time on PIPE during online and face-to-face training given that nurses participating in the pilot had previous PIPE training through their individual health units as a requirement within the existing provincial home visiting program (Healthy Babies Healthy Children).

**Formative Evaluation and Curriculum Refinement:**

Through formative evaluation, refinements were made to the NFP Fundamentals curriculum before the second cohort of face-to-face education. The Clinical Lead (and educator) reviewed notes taken by the educators during the first cohort of education and the feedback provided through the daily evaluations completed by participants and made adjustments to the agenda, content and workbook for the second planned cohort of education. A summary of feedback (see below) from the research interviews was also provided by the research team to better inform the

 

refinements made. This information was valuable and timely, as the educator stated in her research interview, "...[the feedback] was so incredibly helpful, so I had already started making changes to the schedule of what sessions were going to be when, the length of them, and some of the content of them, and then even whether we were keeping a few of them or needing additional that weren't there. So I created an updated version of the workbook and the slides and the schedule based on the feedback I had and the feedback I received."
From the Summary of Feedback provided:

- Participants lauded the educators and their facilitation of the NFP education, the variety of teaching methods used, and the passion & experience they bring to this work.
- One NFP PHN said, "I know good teaching and it was really well done. Like very adult centered, beautifully facilitated. Like a nice combination of technology use and, and discussion and things like that, so. It was really good. It was really good education."
- What from the education has been most valuable/supportive to them in their roles as NFP PHNs: Interactive activities, IPV and TVIC content, NFP-specific information including client-centered principles and core model elements.
- What from the education was less valuable/supportive: Sessions on Visit-to-visit (V2V) guidelines, STAR, and PIPE; reviewing concepts in face-to-face training that were already covered in-depth online.
- What recommendations they had for the education: More practice and discussion with PIPE; less about theory; more hands-on/interactive activities; bring STAR sessions together; better examples/activities for Motivational Interviewing (MI); heavy/challenging sessions earlier in the agenda; continue to do IPV follow-up

**Summary of refinements that were made to the second cohort based on formative evaluation:**

- ***Maternal Role & Culture removed based on feedback from PHNs (had indicated that this was part of health unit education and felt repetitive)***
- ***STAR*** – scheduled earlier in the day & moved to the first day
- ***Visit-to-Visit Guidelines*** – ensured the opportunity to go online and access Website during session
- ***Motivational Interviewing*** – combine the two sessions; used new video content that was very well received and very engaging
- ***PIPE session was modified to include more time practicing using resources (hands-on) and less time on overall theory/concept learning***
- ***Boundaries & Therapeutic Relationships*** - combined these sessions and took out the majority of formal therapeutic relationship content that nurses already knew and spent additional time discussing boundaries and how to build healthy therapeutic relationships within boundaries
- ***Client Retention*** – improved content but added more background information and additional data
- ***Guest Panel*** – Hamilton nurses and supervisor invited to share about their experiences (5 attended), Q&A format used, questions recorded in advance

**Program Fidelity**

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

Of client data collected, 32% of clients discharged prior to graduation were listed as "client initiated" discharges. We were not able to collect length of visits through our Excel spreadsheet

 

and the provincial system was only able to provide an average length of visit per PHN. There was only 1 reported client on an alternative visit schedule.

**Our assessment of program content delivered to date (domains):**

Across all program stages during the pilot, PHN time spent in the Life Course Development and Family & Friends domains was within the benchmark range.

Across all program stages during the pilot, time spent in the following domains was outside of the benchmark range:

- Maternal role was 2-3% under benchmark range
- Personal health was 1-3% over benchmark range

For the Environmental health domain, PHN time spent during the infancy stage was within the benchmark range but time spent during the pregnancy stage and toddlerhood stage is 2-6% over the benchmark range.

**Our assessment of any other program fidelity benchmarks:**

*75% of eligible referrals who are intended to be recruited to NFP are enrolled in the program*
*60% of pregnant women are enrolled by 16 weeks gestation or earlier*
*100% of NFP clients receive their first home visit no later than the 28th week of pregnancy*

% of those eligible clients offered the program who have enrolled over the pilot period: **88%**

Enrolment data was missing on 43 clients. Of the remaining 259 clients, the majority was enrolled prior to 25th week gestation: 35.1% (n = 94) were enrolled less than or equal to 16 weeks gestation; 36.2% (n = 97) were enrolled between 17 and 25 weeks gestation; 20.5% (n = 55) were enrolled between 26 and 28 weeks and 8.2% (n =22) were enrolled past 28th week gestation. The mean gestation at time of enrollment was 19.79 weeks, ranging between 4 and 36 weeks.

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

- Improve data collection/information system to ensure data is not lost/missed or entered inaccurately (this may have contributed to the assessments above)
- Work with PHNs to increase formal enrolment in alternate visit schedule and utilize STAR to provide evidence for decision to support the client graduating and not initiating discharge
- Look at benchmark achievements across sites in Canada to learn from others, particularly in regards to enhancing early enrolment
- Explore the time spent in domains with PHNs to identify areas of support needed for practice considerations (e.g. reasons for increase time spent in personal health)

**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

 

- IPV

**We have made the following plans with regards to the following innovations:**

- MHI – will be uploading the modules to the current pilot education website (Dec 19, 2018)
- DANCE/NCAST – the pilot used NCAST and it is expected that discussions in January 2019 will confirm which tool will be used moving forward for all Ontario sites
- Shared model of supervision – Niagara Region public health (the most recent pilot site to implement) will be evaluating a shared model of supervision in 2019 through a descriptive case study analysis led by Dr Susan Jack

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

- MHI – there have been several challenges with the logistics related to the technology and support for reviewing and accessing the modules. Without an instructional designer or specific IT support and appropriate software we have had several delays in launching this innovation.
- DANCE/NCAST –with NCAST, there has been significant provincial investment over the last several years as part of the existing home visiting provincial program, and there is provincial support to continue (certification is paid by the 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, it is expected that cost-benefit will factor heavily in the consideration of which tool is used.
- Shared model of supervision – Niagara heath unit and McMaster University have been successful in securing funding and developing a protocol for evaluating the experiences of the health unit with a shared model of supervision. These results will add to the growing international knowledge and expertise on NFP supervision.

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

- NCAST (for the pilot) – This was a budget/resource decision for the pilot as all the PHNs had already been trained and were using NCAST in the other home visiting program. Due to the time limitations of the pilot and the internal health unit resources available to support the use of NCAST as a dyadic assessment the decision was made to use NCAST instead of DANCE.

**Our information system and analytical capacity:**

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

We currently have no ability to collect and analyse data at a national level (between BC and ON). We also have no consistent and efficient way to analyse data at a provincial level for NFP across the pilot sites or with Hamilton. 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 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.

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

The pilot project did have an adequate information system for collecting and analysing data for use at each site or across sites. The use of Excel to collect the data from the NFP forms provided a bare minimum needed to compile the annual report and complete the pilot report, it is not sustainable. Although the integration of dashboards provides an accessible way to view a summary of program data it is not comprehensive enough and lacks guidelines for use. Without a data dictionary, there isn't consistency in how data is entered into the current Excel document or how available information is pulled from the provincial database. Our plans below outline the initial stages of developing a plan for an information system and more standardized CQI process in Ontario.

**Our plans to develop a Continuous Quality Improvement process:**

Following the November PAC meeting, the decision was made for the participating sites to each have representation on a data collection working group beginning in January 2019. They are tasked first with the goal of creating a data dictionary, and then to produce a consistent data report from the different data systems at each site. Clinical Lead priorities for 2019 will include developing a plan for the utilization of this data report for CQI both internally at each site and across sites in Ontario. Should the RCT results be positive in BC and additional health units in Ontario implement NFP, it is expected that the development of a more robust data system will be prioritized. This is also an area that the National Governance Group is aware needs to be optimized.

The CaNE results (final report) dissemination plan is an agenda item of priority for PAC and the Steering Committee in Ontario. Both groups established during the pilot plan to continue meeting post-pilot. Post-pilot planning will look to this report in order to inform program planning decisions.

**Please provide:**

- A summary of your annual program data collected through your NFP information system or other data collection method (client referral data, NFP nursing assessment/data collection forms, etc.); or
- Attach a copy of your annual data report

All relevant and available data from the pilot has been included in this report. The final CaNE report (written for the funder) will follow in January 2019 and will include all data collected and analysed through the pilot. Our current state of multiple data systems across health units, with one excel spreadsheet used for the pilot specific data does not allow for a consistent "annual data report" as requested above.

 

**Nursing Workforce (as reported by the sites)**

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

During the course of the pilot, there were 2 PHNs lost to leaves (maternity and long-term disability/illness). In terms of addressable nurse retention factors there was only one PHN lost to another position. The Supervisor at that site provided the following insight: "possibly related to the following reasons – small team, team members located in 4 different offices to accommodate efficiencies for travel time/mileage related to home visiting. When clients outside of PHNs catchment required assignment, there was some difficulty in assigning, given some PHN preference to limit travel time to a confined area geographically. Such assignments were negotiated within the NFP team, amongst PHNs who had availability in caseload, as the Northern part of the area proved to be the busier and required the other PHNs to accept clients in the north."

Despite loss, the client transfers were accommodated easily, as the remaining NFP PHNs were able to accommodate the transferring clients, with room in caseload. Data to support exploration of how the loss impacted client retention is not yet available.

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

- Greater amount of flexibility required for NFP, to accommodate client's schedules, and although services typically provided during normal work hours (9-5), staff need to be aware that after hours visits can be required to meet client's needs, which may put off some from applying. Note: this flexibility must always comply with each health unit's Collective Agreement with the nursing union.
- Sites operate in large regions which can mean increased travel time
- Position requires passion
- Many health unit staff see NFP as hard work due to increased data collection and paperwork, intensity and following clients as they relocate
- MLHU had success with recruiting one new PHN during pilot, which was needed to prevent having a waitlist
- 3 new PHNs were recruited between York and Toronto in November 2018 adding to the nursing complement and they will complete education in 2019

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

- CaNE final report (to be sent in January 2019) will provide full details of the delivery of the core education (including successes and challenges)
    - Summary of greatest successes: establishment of online/self-study delivery of first phase of education with positive feedback, phase 2 face-to-face curriculum adaptations and delivery had very positive feedback
    - Summary of greatest challenges: timeline and multiple license holders in Canada (without an established decision-making body) lead to great difficulty in finding

 

consensus at times across the country, future decision-making regarding adaptations to education will require additional time and careful collaboration

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

- Early on during integration phase (before PHNs had large caseloads) teams were able to spend additional time meeting to review and look at facilitators and forms; considerable time was spent on integration and consolidation of knowledge; PHNs who started to pick up clients shared their approaches and learning with the rest of the team; when a new PHN started in 2018 (one year later) the process of integration was faster as PHNs on their team could mentor and provide support
- On-going challenge of finding balance between adhering to CMEs for program fidelity and using nursing judgment to remain client-centered
- Case conference sharing tends to override the (structured and planned) education component of the meetings
- The TMEM have had positive feedback, but can be a challenge for PHNs to fit in facilitation of this during meetings. Guest speakers, sharing updates/learnings from trainings are perceived as easier, sites have recommended adding them as a standing item at team meetings

**Successes/challenges with delivery of NFP nurse reflective supervision:**

- Supervisor making themselves available as needed in addition to scheduled meetings has enriched reflective practice. PHNs have commented that being able to 'unload' visit reflections at end of day, to review actions taken and feelings associated with the visit has been helpful to leave work 'at work,' have also utilized phones to connect as needed and avoid having to wait until scheduled 1:1
- Time is a challenge; Scheduled meetings or visits get rescheduled, which interferes with weekly frequency; competing priorities (e.g. required health unit training, mandated program training)
- NFP Supervisor forms feel cumbersome instead of supporting work of reflective practice; supervisors have expressed benefit in using the form as a guide for conversation and reflection instead of asking PHN to fill out in advance
- Having a manager with a good understanding of caseloads and the NFP program/work is important; this helps with trust and engagement in Reflective Practice and Case Consultation
- Have had great success in increasing group reflective practice at team meetings, during peer-to-peer interactions and self-reflection
- 1 site has utilized standing meeting days/times for reflective supervision; meetings are then prioritized and a high value is placed on meeting
- Have found it challenging for some very experienced PHNs who may not always see the benefit in the frequency of formal 1:1 meetings
- Have found it helpful for determining what needs to be documented and/or collected as data

**Challenges with supervisors having non-NFP staff as direct reports in addition to NFP PHNs:**

- Facilitating meaningful integration of programs, *where appropriate* (e.g. determining appropriate opportunities for joint education, ensuring clear referral/communication pathways between programs, etc)
- When supervising NFP and non-NFP staff, some report that on occasion the demands from the non-NFP staff affect the amount of time spent on on-going team-based NFP education

 

- 1 site reported that when a supervisor has non-NFP staff, it is ideal to have these staff engage in public health nursing work that is not home visiting to prevent blurring of programs.
- Scheduling weekly NFP meetings and reflective practice can be a challenge, but dedicating a consistent day of the week for NFP Team meetings has helped sites. 1 site reported that reflective practice meetings with NFP PHNs are better if done on a separate day from an NFP Team meeting as it is more useful to spread contact with NFP PHNs in week, to be more responsive with their caseload
- Meeting weekly is a challenge due to office locations and travel time for 1 team so they meet twice per month for a longer period (more meeting time overall, but not as often)
- Many 1:1 sessions (between PHN and supervisor) are over the phone due to travel time challenges for one site
- Can be challenging to meet organizational training requirements and NFP training requirements (in terms of dedicating the time required)

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

- There isn't a formal process in place; 1 supervisor shared that she had planned on having reflective supervision with her director – but only meets with her one on one monthly – and there is never time
- The Ontario NFP Community of Practice has been helpful to have a venue to connect, reflect, share challenges, etc.
- Having colleagues and clinical lead who understand the program and challenges of competing priorities is most beneficial.
- Supervisors report using their own management colleagues to provide support and reflect with
- 1 Supervisor also reported the use of regular self-reflection as helpful

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

- 1 site reported that there is not much interest from within health unit (other visiting program) to join NFP team – believe that the acuity of the clients is a factor and the need for flexible hours (after standard work hours) on occasion
- 1 site also reported that they have placed a second NFP PHN in same office as another, but challenges of such a small yet busy team tends to create feelings of isolation
- 1 site reported that NFP work is perceived by others as hard or unequal work compared to other programs provided by PHNs
- NFP delivery requires experienced nurse

**Summary**

**What have we achieved this year**:

Given the goals and objectives of the CaNE pilot, the overall achievements have been the development of a revised, Canadian curriculum, the successful provision of education, and the enhancement of provincial capacity and infrastructure growth. The CaNE final report (to be sent in January 2019) will provide full details on the results of the pilot (experience and perception of participants related to the education).

The tables below summarize the education completed during the pilot and the number of meetings completed provincially:

 

**Completed Education:**

**Summary of completed PHN and Supervisor education:**

| Cohort | Phase and Dates | Participants | Educators Involved |
|---|---|---|---|
| 1 | NFP Foundations Jan 2017 | 15 pilot participants (3 supervisors, 12 PHNs) | n/a |
| | NFP Fundamentals Feb 6-10, 2017 | 15 pilot participants (3 supervisors, 12 PHNs) | 3 |
| | NFP Fundamentals supervisor-only Mar 6-9, 2017 | 3 pilot participants, 1 Clinical Lead participant | 1 (1 session facilitator by Clinical Lead as second educator) |
| | NFP Consolidation & Integration activities: March 2017 – Dec 2018 | Additional IPV education day (attended by each pilot participant)<br><br>Job Shadowing completed by 8 pilot participants (2 supervisors, 6 PHNs) | 2 |
| 2 | NFP Foundations Feb 2018 | 7 pilot participants (3 supervisors including 1 director, 4 PHNs)<br>2 Hamilton PHNs<br>1 Hamilton Supervisor | n/a |
| | NFP Fundamentals April 9-11, 23, 24 2018 | 7 pilot participants (3 supervisors including 1 director, 4 PHNs)<br>2 Hamilton PHNs<br>1 Hamilton Supervisor (did not completed supervisor-only education) | 2 |
| | NFP Fundamentals supervisor-only Dec 10 and 13, 2018 | 1 pilot participant | 1 |
| | NFP Consolidation & Integration activities: May 2018 – Dec 2018 | Additional IPV education day (attended by each participant) | 2 |

**CaNE Governance (working groups, committees and sub-groups)**

| Name of group | Timeline | Number of completed meetings |
|---|---|---|
| CaNE Education Workgroup | Sept 2016 to Jan 2017<br><br>*amalgamated CaNE Education workgroup with implementation | 2016 – 3, 2 (Moodle specific)<br>2017 – 1<br>**Total – 6** |

 

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|---|---|---|
| | workgroup beginning in Feb 2017 | |
| CaNE Implementation Workgroup | Jul 2016 to Apr 2018<br><br>*transitioned to ONCOP to include Hamilton in May 2018 | 2016 – 2 (second meeting was 2 day long, in-person)<br>2017 – 10<br>2018 – 4<br>**Total – 16** |
| Ontario NFP Community of Practice (ONCOP) | Began May 2018 (ongoing) | **Total of 7** |
| CaNE Research Workgroup | Sept 2016 to Dec 2018 | Formally identified workgroup<br>Never met but members communicated by email CaNE research-related meetings (variety of attendees):<br>2018 – 2 |
| CaNE Steering Committee | Jul 2016 to Dec 2018<br><br>Will transition to the Ontario NFP Steering Committee in 2019 | 2016 – 3<br>2017 – 7<br>2018 – 6<br>**Total – 16** |
| CaNE Provincial Advisory Committee (PAC) | Sept 2016 to Dec 2018<br><br>Will transition to the Ontario Provincial Advisory Committee in 2019 | 2016 – 1<br>2017 – 1<br>2018 – 3<br>**Total – 5** |
| Canadian Clinical working group | Began Jul 2017 (ongoing) | 2017 – 5<br>2018 – 6<br>**Total – 11** |
| Canadian Governance Committee | Began Jun 2017 (ongoing) | 2017 – 6<br>2018 – 5<br>**Total – 11** |

**What challenges do we face?**

As discussed in other sections of the report the most current challenges and/or gaps include consistent and comprehensive data collection, sustainability planning, and provincial and national governance

- Anything else:

**Any other relevant information:**

 

## PART FOUR: ASSESSMENT OF PROGRAM TESTING AND EVALUATION

**Our feasibility & acceptability study: **full report and results for CaNE pilot to follow**

- Goals:
- Methods:
- Sample:
- Progress to-date:

**Data from feasibility & acceptability study:**

- Key findings from our data
- Reflections on our findings/results
- Any actions planned based on results

**Anything else that would be helpful for UCD to know?**

## PART FIVE: ACTION PLANNING FOR NEXT YEAR

Our planned program priorities for next year:

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
5. Establish fulltime Ontario NFP Nursing Practice 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

2017 Annual Report Success indicators for priority objectives (for reference):

- Positive feedback from PHNs using the NFP Canada website

 

- All NFP Visit-to-visit guidelines and NFP Nursing Education materials have been reviewed, adapted when necessary and are accessible online via the NFP Canada website or the NFP Nursing Education website via Moodle
- NFP Ontario Community of Practice has formed, ToR completed and meetings commenced
- Guidelines for Ontario NFP Community Advisory Boards have been developed by the Implementation workgroup with input from and reviewed by the Steering Committee, Provincial Advisory Committee and pilot HU community partners

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

Not at this time.

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:

1. Improve data collection consistency (see #2 in planned program priorities)
2. Improve "16 week" indicator by 10% closer to international benchmark
3. Improve % time spent per Domain indicators by 2% closer to international benchmarks
4. Develop process for Reflective Supervision for Supervisors (informed by results of International project)
5. Develop plan to address nurse recruitment/retention issues expressed by sites

Our research/program evaluation priorities for next year:

- Niagara site – Shared Model of Supervision descriptive case study (see final protocol – to be sent by Susan Jack)
- Determine how to evaluate process (to be developed, see above #4) for the provision of reflective supervision for supervisors

How we will know if we have been successful in meeting our objectives?
(*assuming this refers to the planned program priorities)

1. Final Guidelines for NFP CABs in Ontario 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
3. MLHU holds provincial license and MOUs with each participating site
4. Fulltime Provincial Clinical Lead is supporting sites and coordinating Ontario education (at least 1 cohort completed in 2019)
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
6. MHI modules are accessible to Canadian NFP teams (likely on current CaNE Moodle site)
7. Canadian Clinical working group using final process to review and revise program material as needed
8. Active participation in national NFP initiatives
9. Ongoing consultations completed with MCCSS, as requested

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 Ann Rowe as needed

 

- Continue National governance guidance and participation as determined by the needs of the committee

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

- Marketing and branding international support, informed by new branding from NSO (e.g. facilitate communication, templates etc.)
- Home Visit Encounter/Alternative Visit Encounter Form review following the revisions expected from the US (merging of forms)

 

## PART SIX: ANNUAL REPORT FROM UCD

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

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

- Support and guidance to Clinical Leads in clinical adaptation and implementation
- Participation in Canadian clinical advisory group and governance committee
- International Clinical Advisory Group and specialist clinical teleconference meetings re STAR revisions, program materials and international resources via the international NFP website and annual newsletter.
- Involvement in the international reflective supervision project

Identified strengths of program:

- Success of the educational curriculum – both as a sustainable model across Ontario and as an exemplar for other countries
- Strength of community leadership to support implementation and integration into Ontario healthcare system
- Strength of clinical leadership – to adapt program contents as necessary for context and develop educational content
- Quality of nursing workforce

Areas for further work:

- Development of data system to improve data quality and enable analysis to guide quality improvements
- Development of implementation manual to capture learning to date and for future growth
- Continued work on Canadian governance so that scale up can occur if BC RCT results are positive

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

- See part 5 agreed priorities

Any approved Core Model Element Variances:

CME # 12 – to be reviewed in 2019.

Agreed upon activities that UCD will provide through Support Services Agreement:

- Guidance for new Ontario Clinical Lead
- Continued input to Canadian clinical advisory group and governance committee
- Guidance re NFP data analysis
- Feedback and input into research findings and new initiatives

CaNE Variance.pdf

 

**Table 1: CaNE Governance Summary Notes**

| Group | Membership | Purpose/Objectives | Frequency/Format |
|---|---|---|---|
| CaNE Steering Committee | • Grant holder, MLHU (co-lead)<br>• Evaluation lead, McMaster (SC co-lead)<br>• Education lead, International NFP consultant (**no longer a member**)<br>• Implementation lead NFP CaNE Provincial Clinical Lead<br>• Participating Health Units:<br>  ○ MLHU Director or alternate<br>  ○ York Region Public Health (YRPH) Director or alternate<br>  ○ Toronto Public Health (TPH) Director or alternate<br>  ○ Niagara Region Public Health Director or alternate | Provides strategic oversight and ultimate decision-making for the CaNE Pilot Project, including: 1) delivery of the NFP pilot program within the designated Health Units; and 2) the development and evaluation of the piloted Canadian NFP nurse education model.<br><br>To support the objectives of each CaNE pilot project workgroups and provide consultation and ultimate decision-making for the CaNE pilot project. | • Teleconference<br>• Bi-Monthly meetings for 1 hour or at the discretion of the membership. |
| CaNE Provincial Advisory Committee | • NFP Supervisor and NFP Manager, City of Hamilton, Public Health Services<br>• Director, Family Health Division, City of Hamilton, Public Health Services<br>• AMOH, City of Hamilton, Public Health Services<br>• Associate Director, City of Toronto, Public Health Division<br>• NFP Manager, City of Toronto, Public Health Division<br>• NFP Manager, Regional Municipality of York, Public Health Branch<br>• Director, Regional Municipality of York, Public Health Branch | Works in an advisory capacity to facilitate collaboration, policy/practice consultation and ongoing communication amongst the various stakeholders, and the research/education/implementation workgroups on relevant aspects of CaNE.<br><br>• Provide guidance and consultation to the CaNE pilot project and advise the steering committee on decision making matters<br>• Share information about NFP as it relates to the CaNE pilot project throughout the province<br>• Provide long-term visioning and planning beyond the CaNE pilot project<br>• Consider systems planning for pilot project clients | • In-person<br>• Frequency of meetings – TBD (have been 2-3 times per year for 3-5 hr) |

 

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|---|---|---|---|
| | • Director, Ministry of Children and Youth Services<br>• NFP Provincial Coordinator, Ministry of Health, British Columbia<br>• Executive Director, Healthy Populations and Development, Ministry of Health, British Columbia<br>• Faculty, Offord Centre for Child Studies, McMaster University<br>• Chief, Health Promotion, Chronic Disease and Injury Prevention, Public Health Ontario<br>• President, RNAO<br>• CaNE lead researcher, School of Nursing, McMaster University<br>• CaNE research coordinator, School of Nursing, McMaster University<br>• CaNE co-investigator, School of Nursing, York University<br>• NFP International Consultant, Prevention Research Center, University of Colorado at Denver<br>• MOH, MLHU<br>• Director, Healthy Start Division, MLHU<br>• NFP Manager, MLHU<br>• Director, Niagara Region Public Health<br>• NFP Manager, Niagara Region Public Health<br>• NFP Supervisor, Niagara Region Public Health<br>*consider expanding membership to include representation from an organization with a poverty mandate, a provincial representative from | • Clarify fit/alignment/intersection of NFP with existing services and systems (framed as a continuum of services)<br>• Examine and promote the role of public health nursing in Ontario/health human resource capacity building as it relates to home visiting in pregnancy, postpartum and the early years. | |

 

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| | primary care/midwifery and a representative from child protection services. | | |
| Ontario NFP Community of Practice | NFP Leaders working in Ontario (ex. NFP Supervisors, Program Managers, Clinical Leads) | To provide a forum for discussion, collaboration, reflection and action related to the implementation and evaluation of the Nurse-Family Partnership Program in Ontario with fidelity to the Nurse-Family Partnership (NFP) program and excellence in nursing.<br>▪ To create a safe environment to ask questions, share ideas and refine skills as NFP leaders.<br>▪ To create a safe place for reflective practice and professional growth.<br>▪ To learn from one another's experience, expertise and to foster peer relationships.<br>▪ To be informed of and participate in provincial, national and international NFP progress and updates.<br>▪ Provide support and leadership to interested and emerging sites in Ontario<br>▪ To provide collaborative leadership and support to the health units (and NFP PHNs) to ensure all stakeholders feel valued, respected, competent, and cared for throughout NFP implementation and evaluation.<br>▪ To promote and strive for consistency in program implementation across the province.<br>▪ To contribute meaningfully to the development of tools and resources to strengthen the program in Ontario for clients and PHNs.<br>To explore ways the NFP program aligns, compliments and integrates Delivery within HBHC context (data etc.), | • teleconference<br>• will attempt to meet every month or as determined by the members. |
| Canadian NFP Clinical Workgroup | • Hamilton PHS license holder (Manager and Supervisor/Clinical Lead)<br>• CaNE license holder<br>• McMaster Researcher<br>• BC license holder | Increase communication, information sharing and cohesion between Hamilton, British Columbia, CaNE pilot and McMaster.<br>• Joint planning and decision making related to resources, innovations and clinical practice | • Teleconference<br>• every 2-3 months |

 

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| | • University of Colorado Denver (NFP International Consultant) | • Respond to requests from governance meeting on an ad hoc basis<br>• Address general clinical issues (not entity specific issues)<br>• This is an interim call/group until governance structure is in place | |
| Canadian NFP Governance Committee (*ToR Draft info*) | ▪ **Denver, Colorado**: University of Colorado Denver (3)<br>▪ **Ontario**: Hamilton Public Health (3); McMaster University (2); Middlesex-London Health Unit (3); Government of Ontario (TBD)<br>▪ **British Columbia**: Ministry of Mental Health and Addiction (1); Ministry of Children and Family Development (1); Ministry of Health (2); Simon Fraser University (3)<br>▪ **Other Provinces/Territories**: to be welcomed by membership with voting privileges. TBA<br>▪ **Other Agencies/Affiliations**: As invited by membership. Voting privileges to be decided<br>▪ **Ex-officio:** As invited by membership<br>▪ **Guests:** As invited by membership | The Canadian Nurse-Family Partnership Governance Committee is responsible to?? the license holders and will achieve the following[1]:<br>• Provide strategic direction for NFP in Canada working with International/National/ Provincial/ Territorial/ Regional/ Community partners.<br>• Explore the benefits of and complete the necessary articles to incorporate an NFP entity for the purposes of promoting and guiding NFP in Canada under the Canada Not-for-Profit Corporation Act governed by a Board of Directors.<br>• Apply for funding opportunities and oversee ongoing evaluation, research and program development.<br>• Ensure a high quality nursing education program is available for supervisors and nurses for Provincial/Regional adaptation and delivery.<br>• Advise on program expansion and support setup in other Provinces/Territories/jurisdictions.<br>• Develop a NFP-specific continuous quality improvement program and support regional, provincial and national program quality improvement with emphasis on fidelity to the NFP model. | • Teleconference or in-person<br>• Meet at minimum 3 times per year |

 

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| | | • Adapt program to the National, Provincial, Territorial social context so it remains relevant and reflects developing knowledge and evidence.<br>• Mobilize program change based on new research.<br><br>• Develop and maintain program resources that help improve outcomes for women, children, families, and communities.<br>• Maintain a Canadian NFP web-site for program resources/communication tools.<br>• Facilitate shared learning across all Canadian and International NFP sites/societies.<br>• Provide opportunities for sites to meet (in person and/or virtually) together.<br>• Contribute to the NFP international networks.<br>• Undertake projects with Provinces to develop and adapt NFP within the country's context and in line with learning from the NFP evaluations undertaken.<br>• Seek out continued and new partnerships, collaborations, and funding sources to ensure the sustainability, adaptation and modernization of NFP across Canada.<br>• Develop and disseminate reports, evaluations, and research evidence pertaining to NFP.<br>• Develop a National Unit responsible for the Canadian license.<br><br>Core Functions (more details emerging)<br>• Communication<br>• Science<br>• Policy<br>• Implementation | |

 

# DRAFT Ontario Nurse-Family Partnership Governance

## Effective March 2019

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

 

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| | To enhance alignment of NFP with existing services and systems<br><br>To ensure ongoing learning from and connection with NFP in British Columbia | • Executive Director, Healthy Populations and Development, Ministry of Health, British Columbia<br>• Faculty, Offord Centre for Child Studies, McMaster University<br>• Chief, Health Promotion, Chronic Disease and Injury Prevention, Public Health Ontario<br>• Researcher, School of Nursing, York University<br>• Provincial poverty-reduction representative<br>• Provincial representative from primary care/midwifery<br>• Provincial representative from child protection services<br>• NFP International Consultant, Prevention Research Center, University of Colorado at Denver (ad hoc) | | |
| Ontario NFP Community of Practice | To ensure fidelity to the NFP program, excellence in nursing practice, and consistency in program implementation across the province.<br><br>To create a safe environment for exploring, sharing, learning, and engaging in reflective practice and professional growth.<br><br>To keep informed of and provide perspective on provincial, national and international NFP initiatives.<br><br>To build and maintain positive relationships between and to provide mutual support for all Health Units implementing NFP. | • All NFP supervisors working in Ontario<br>  ○ Program Managers<br>  ○ Supervisors<br>• Ontario Provincial Clinical Lead<br>• Research representative (2x/year) | • teleconference<br>• will attempt to meet every month or as determined by the members. | Ontario Nursing Practice Lead to chair<br><br>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.<br><br>To clarify and enhance how NFP aligns, complements, and integrates with HBHC.<br><br>To ensure connectivity between NFP research and practice. | | | |
| Canadian NFP Clinical Workgroup (interim group until formal Canadian governance structures in place after completion of the BC trial) | To increase communication, information sharing and cohesion between Hamilton, British Columbia, CaNE pilot and McMaster.<br><br>To engage in joint planning and decision-making related to resources, innovations and clinical practice<br><br>To respond to requests from the Canadian NFP Governance Committee on an ad hoc basis<br><br>To bring forward and address general clinical issues | • BC license holder<br>• Ontario license holder<br>• Ontario Provincial Clinical Lead<br>• BC Provincial Clinical Lead<br>• McMaster Researcher<br>• University of Colorado Denver (NFP International Consultant) (ad hoc)<br>• Research representative from BC | • Teleconference<br>• every 2-3 months | • |
| Canadian NFP Governance Committee (*ToR Draft info*)<br><br>(interim group until formal Canadian | The Terms of Reference for this committee are still under development.<br><br>Draft core areas of focus include communication, science, policy, and implementation. | • **Denver, Colorado**: University of Colorado Denver (3)<br>• **Ontario**: Hamilton Public Health (3); McMaster University (2); Middlesex-London Health Unit (3); Government of Ontario (TBD)<br>▪ **British Columbia**: Ministry of Mental Health and Addiction (1); Ministry of Children and | • Teleconference or in-person<br>• Meet at minimum 3 times per year | • |

 

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| governance structures in place after completion of the BC trial) | | Family Development (1); Ministry of Health (2); Simon Fraser University (3)<br>▪ **Other Provinces/Territories**: to be welcomed by membership with voting privileges. TBA<br>▪ **Other Agencies/Affiliations**: As invited by membership. Voting privileges to be decided<br>▪ **Ex-0fficio:** As invited by membership<br>▪ **Guests:** As invited by membership | | |

 