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BC Healthy Connections Project

PROCESS EVALUATION

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BCHCP Process Evaluation Communique #1 | October 30, 2014

1. BCHCP Process Evaluation Project Update

The BCHCP process evaluation study objectives will be addressed through the collection and analysis of three types of data:

1. Qualitative interview data (1:1 interviews or focus groups) with Nurse-Family Partnership (NFP) public health nurses (PHNs), supervisors, the NFP Provincial Coordinator and managers. All NFP PHNs and supervisors will complete a minimum of 8 interviews over the course of the project; a sample of managers will complete a minimum of 5 interviews.
2. Fidelity report data submitted to the Ministry of Health from each Health Authority
3. Supervision and team meeting summary reports submitted by each supervisor.

As of September 30, 2014 –Wave 1 interviews have been completed with NFP PHNs from local health areas participating only in the process evaluation (n=11), all supervisors (n=10) and the NFP Provincial Coordinator (n=1). We anticipate scheduling and conducting the Wave 2 interviews with this group from October-December 2014.

A series of amendments have been submitted, or are in the process of being submitted, to the 10 research ethics boards (REB) responsible for reviewing this study, including the BC Ethics Harmonization Initiative, McMaster University and the Public Health Agency of Canada. Permission to invite all NFP PHNs who are part of the randomized controlled trial (RCT) and senior public health managers to participate in the process evaluation is being sought. We anticipate that our amendments will be approved by the end of October 2014.

Once we have full approvals of our amendments, Susan Jack (Process Evaluation Project Lead) and Natasha Van Borek (Process Evaluation Research Coordinator) will be contacting supervisors to negotiate a time and location to conduct focus groups with NFP PHNs with clients in the RCT. This will also be an opportunity to conduct a site visit within each of the five Health Authorities to meet as many members of the NFP team as possible. We anticipate conducting focus groups two times a year, for a total of 8-10 waves of focus groups throughout the project. Within each wave of focus groups, the interviews will be conducted physically in five locations: Vancouver, Victoria, Kelowna and two locations within Fraser Health (to be determined with supervisors). NFP PHNs who are not able to travel to a focus group, will have the option to complete a 1:1 telephone interview.

2. Project Findings: Fidelity to NFP Model Elements 1-5

In each BCHCP process evaluation Communiqué we will share a brief summary of findings emerging from our early analysis of the data. One of the overarching objectives of the process evaluation is to determine the extent to which the NFP is delivered with fidelity to the 18 required elements. In the first wave of interviews, supervisors have shared their perceptions about the successes and challenges their local health areas have experienced in meeting these elements. Below is a summary of the key findings, aggregated across all five health authorities, of what we learned from supervisors about site fidelity to Model Elements 1-5. As part of the BCHCP, the eligibility criteria for participation in the study included components related to NFP model elements # 1, 2, and 3. Therefore, it should be anticipated that if a woman has been deemed eligible to enroll in the BCHCP, then fidelity to these model elements should be assumed.

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Model Element 1: Client participates voluntarily in the program	
Implementation	• PHNs emphasize to pregnant women that it is her personal choice to participate in the program, and she can decide to leave at anytime. • Clear communication within team and to external agencies that NFP is a voluntary and not mandated program • Element components reviewed in core education and within team meetings. Concept of a voluntary program is familiar to PHNS. • Many PHNs also engage in a process of seeking continuous consent once a woman is enrolled in the NFP.
Challenges	• Community agencies and professionals continue to recommend, or would like to recommend, that some socially and economically disadvantaged pregnant women be mandated to participate in the NFP. • Perception that some NFP clients may volunteer to participate in the program but their motivation is based on another professional (social worker or probation officer) persuading them that enrollment in the NFP is helpful to fulfill probation hours or to have a "better chance of keeping her baby."
Solutions	• Local health areas have taken the initiative to communicate information about the NFP Model elements to other agencies. Discussions about the voluntary nature of the NFP occur at multiple levels: 1) between the PHN and the client where the PHN explains the importance of making a personal decision to enroll in the program; 2) between the PHN and the supervisor in reflective supervision where discussions about client engagement and retention occur; 3) at the front-line level, most commonly between PHNs and Ministry of Child and Family Development social workers about the voluntary nature of the program; and 4) at an inter-organizational level, with NFP supervisors communicating directly to other agencies.

"*I think that PHNs, public health nurses, are very comfortable with this concept of volunteer because they've been public health nurses for a long time and it's very common in public health to, to have informed consent and to understand that the clients are voluntary, that the whole service is voluntary, nothing is mandated in public health.*" (Supervisor)

Model Element 2: Client is a first-time mother	
Implementation	• General strategies implemented to ensure that women meet the eligibility criteria include: 1) screening for eligible women through the prenatal registration system (in some health authorities only); 2) administration of the BCHCP Referral and Eligibility form by NFP PHNs; 3) supervisors reviewing all BCHCP referrals to ensure that women meet the eligibility criteria and; 4) providing information about this model element in all internal (e.g. with NFP PHNS) and external discussions (e.g. with community partners).
Challenges	• Some NFP PHNs have ethical concerns about the limited definition of "first-time mother," in particular that a women will not be eligible for NFP if previous infant was apprehended, adopted or experienced early neonatal death. • At the time when eligibility is assessed, some women may choose to not disclose past pregnancy/birth; this information is later shared once enrolled in the program and trusting, therapeutic alliance has been established. • Some referral sources continue to express a desire to refer clients who do not meet this eligibility criteria
Solutions	• Supervisors identified four core strategies that are being implemented to address these challenges, including: 1) recognizing that the NFP is being evaluated within the context of the BCHCP, and so at team meetings and other education sessions, it is discussed that they are obligated to adhere to the study protocol; 2) supporting PHNs to openly discuss this issue with women who are considering enrolling in the NFP and providing PHNS with the skills and confidence to ask about the outcomes of past pregnancies; 3) discussing any ethical dilemmas that PHNs experience in their 1:1 reflective supervision sessions and; 4) continuing to have ongoing communication with community partners about the definition of "first-time mother" and encouraging them to make appropriate referrals.

"*One of the clients in our PE site had a death of a child at birth and the nurse felt really strongly that if that client was to become pregnant again it would be difficult for us not to accept her back into the program. They had had a good relationship during the pregnancy. The death of the child, it was quite an early premature labour situation… The nurses [think] it would be almost punitive not to allow her to come back into the program and it was difficult I think for the nurse. So ethically I, I do struggle with it. You know it feels a little bit like just because you didn't get an opportunity the first time you don't get that opportunity again. But I, you know I know that there may be good reasons because there doesn't seem to be anything in the NFP program that hasn't been done very thoughtfully. Like I really truly have the knowledge base to understand that.*" *(Supervisor)*

Model Element 3: Client meets low-income criteria at intake	
Implementation	• Across 5 health authorities, there was a high level of confidence that all women referred to BCHCP meet the low-income criteria at intake as set out in the BCHCP Referral and Eligibility form. Strategies to ensure meeting eligibility requirements include: 1) ongoing conversations with referral sources to ensure appropriate women are referred; 2) in health authorities where referrals are received through the prenatal registry, a preliminary screen is conducted; 3) in most sites, the PHNS who complete the referral and eligibility form are familiar with the criteria and experienced in completing the form; and 4) in some sites, the supervisor reviews the Referral and Eligibility form for accuracy before it is submitted to the BCHCP scientific team.
Challenges	• Concerns that existing criteria may be too limiting and that PHNs may be better able to ascertain "low-income" status through completion of an in-depth assessment. • Difficult at times to clarify if mother is lone parent (e.g. has boyfriend, live together "on and off), or has completed < grade 12 (clarification on type of diploma or leaving certificate that is required to meet this element). • Some women are not sure if they are receiving any type of financial assistance or not. • Many women may have access to food and shelter as they are living with a partner, parents or extended relatives; this is often a short-term solution and in essence the client has no independent financial resources.
Solutions	• To address some of these challenges, supervisors identified implementing a range of strategies, including: 1) encouraging PHNS to discuss any ethical concerns they experience within their reflective supervisory sessions; 2) to provide women with the provincial 1-800 # to call and see if they are receiving financial assistance- however, one supervisor commented that many of the women being screened do not wish to engage with more bureaucracy and that making this phone call is not a high priority for them; 3) to seek clarification around eligibility criteria through discussions with the NFP Provincial Coordinator; and 4) that when PHNs see that a client may be struggling to answer a question, some PHNS might step in and ask the client if she understands the question and what is her interpretation of the criteria.

"When the nurses are creating these relationships because that's part of what we do before we go into the R & E [Referral and Eligibility Form], they discover information that really … you know we know they're going to be a good fit [for the NFP]. You know they really don't have any money. They're washing dishes twice a night, you know two nights a week. And their boyfriend is hit and miss. But they're living with their moms and their dads and they, right now they do have an income because it's total[household] income. So there's these kind of ethical dilemmas where you know they're going to be a really good fit or they're with a boyfriend but you know he's not graduated or whatever. There's just so many areas. And I think the limitations are that nurses like to … we use a lot of our natural abilities too , our gut instinct, you know our assessments and when we feel that it would be a good fit for a client but they actually don't really fit the eligibility, it's frustrating sometimes." (Supervisor)

Model Element 4: Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of week 28 of pregnancy.	
Implementation	• The majority of women are referred to public health, screened for BCHCP eligibility and enrolled in the BCHCP and receive the first PHN contact prior to 28 weeks gestation. • Similar strategies have been established in each health authority to achieve this goal, most notably, active promotion or marketing about the importance of early referral of pregnant women through the prenatal registries, and communication with referral sources, generally physicians, encouraging them to refer potentially eligible women, early in pregnancy, to public health.
Challenges	• BCHCP (study requirements)- some women were "timing out" before a SFI could locate, contact & consent • Referral sources referring clients too late in pregnancy or close to 28 weeks gestation • Client related factors: 1) some high-risk pregnant women do not seek prenatal care until after 28th week; 2) some clients are difficult to locate and contact on a regular basis, and first visit can not be booked by end of week 28; and 3) some women are not aware of how many weeks they are into their pregnancy. • Challenging at times for NFP PHNS who work part-time in program to have the time and flexibility to schedule a visit prior to the end of client's 28th week. • In rural areas, two challenges emerged that impact this element: 1) in offices with 1 NFP PHN, if she is on vacation or on leave, potential new clients may not been contacted and visited in time; 2) there is a shortage of physicians in some communities which limits opportunities for women to seek early prenatal care and an early referral to NFP.
Solutions	• Challenges related to BCHCP study procedures have been shared and discussed at multiple levels. Supervisors appreciate responsiveness of SFU to address challenges; particularly "red flagging" referrals that need to be prioritized and contacted immediately. • At the community level, a majority of the supervisors indicated that they are continually engaged in communicating with their community partners and sources of referral about the importance of referring women early in pregnancy or encouraging women to register for the prenatal registry as soon as possible.

	Model Element 5: Client is visited one-to-one, one public health nurse to one first-time mother or family.
Implementation	• The supervisors all identified that the development of a one-to-one relationship between the NFP PHN and the client is a critical and essential element of the NFP program. All of the supervisors correctly interpreted the element, emphasizing that the core relationship is between the PHN and the client and her infant, and that the client may choose to invite her partner or other family members to be a part of the visit. • Participants in all sites confirmed that the NFP is not to be delivered within a group setting. Inherent in the discussions about the nature of a one-to-one home visit, several supervisors also commented on the importance of providing continuity of care, or one assigning one PHN per client, so as to support the development of a therapeutic relationship. At the same time, supervisors also identified that it is essential to communicate to clients that their NFP PHN is part of a team and there may be times when another PHN conducts the visit (e.g. during vacation periods) or that a supervisor may join the home visit.
Challenges	• Presence of other people during a home visit who were observing but not participating. • Two family members (sisters or cousins), sometimes living in same house, both enrolled in NFP. • Difficult for "one-nurse" offices or nurses who work part-time to conduct 1:1 home visits when on leave.
Solutions	• When others are present, PHNs may keep visit "social" and not discuss confidential content, or may choose to move the visit out of the home e.g. go for a walk or to the park. • When one PHN assigned to two family members, visits are kept separate; in some health authorities (where possible), a different PHN is assigned to each family member. • When a NFP PHN is on vacation, where possible, another NFP PHN may be asked to provide minimal coverage and make a few telephone contacts with a client.

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