BC Healthy Connections Project

PROCESS EVALUATION

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BCHCP Process Evaluation Communiqué #2 | Public Health Nurse Nurse-Family Partnership Education
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"Knowing that everything we get [in NFP education] is gold standard was one of the most professionally satisfying things I've experienced in nursing. It was really cool. And I'll never forget the last day of our training, there was 65 of us, and I remember feeling how excited we all were and that feeling that the whole group was as excited as I was, and I could've been mistaken of course but that was my feeling of the day that we were all poised on the threshold of something really exciting. That was really, really amazing" [NFP Public Health Nurse].

Nurse-Family Partnership (NFP) Education Core Model Element 9 (Canadian Version):
Public health nurse (PHNS) and nurse supervisors complete core educational sessions required by the US Nurse-Family Partnership National Service Office and deliver the intervention with fidelity to the NFP Model.

It is a requirement that all PHNs and supervisors providing NFP services through the BC Healthy Connections Project (BCHCP) will participate in all core NFP education sessions in a timely manner as per the signed Nurse-Family Partnership Implementation Agreement with the University Of Colorado at Denver Prevention Research Center (PRC). Fidelity is the extent to which Health Authorities (HAs) adhere to the 18 model elements when implementing the program.

The goals of the NFP nurse education program are to:

1. Prepare PHNs and supervisors to deliver the NFP program with the required level of competence to achieve positive client outcomes comparable to the three US trials.
2. Develop and sustain an effective workforce that achieves a high level of client outcomes through delivery of the NFP with fidelity to NFP principles and model elements.
3. Promote self-efficacy in NFP nurses in relation to their own continuing education and professional development.
4. Build strong nursing teams able to support their members to build and maintain expertise, skills and confidence in delivery of the program.

The NFP education uses a mix of face-to-face sessions, self-study, team-based learning, teleconferences, webinars, and on-line modules. Key components include: Nursing Practice Units 1-4 (focus on the NFP model), Partners in Parenting Education (PIPE), Keys to Caregiving, use of Edinburgh and ASQ-3 & ASQ-SE. In addition, British Columbia is implementing two new innovations developed by the Prevention Research Centre: Dyadic Assessment of Naturalistic Caregiver-child Experiences (DANCE), and the Intimate Partner Violence (IPV) intervention. PHNs and Supervisors receive approximately 20 days of core NFP education and Supervisors receive an additional 5.5 days. Core NFP education in BC is currently provided by the US NFP National Service Office (NSO), PRC (DANCE), and Dr. Susan Jack (IPV). All on-line modules/webinars are accessed through the NSO secure website. Additional details are found in the Appendix - British Columbia Nurse-Family Partnership Education Components. The NFP education program is tailored to the development of clinical competence for delivery of NFP and it is expected that HAs will also offer PHNs local education and learning opportunities in relation to their individual needs, team needs, and their local context such as breastfeeding, fetal/infant/child development, child welfare, immunizations etc. As part of Unit 2, each PHN completes a Skills/Experience Assessment Form, which is reviewed with her NFP Supervisor.

BC Healthy Connections Project
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Additional funding to support the ***Process Evaluation*** *provided by the Public Health Agency of Canada; Principal Investigator: Susan Jack*

Process Evaluation (PE) Interviews:
Through the individual interviews/focus groups conducted as part of the BCHCP PE, questions were asked to explore Core Model Element 9 - NFP education. The PHNs and Supervisors had a great deal to share with the interviewers regarding their experiences with the NFP education. This communiqué summarizes the key findings regarding PHN Core Education and Integration of Learning. Additional communiqués are being prepared specific to supervisor education, DANCE, PIPE and IPV.

	PUBLIC HEALTH NURSE CORE EDUCATION
Strengths	***NFP Education Content*** • **Relevancy**: Curriculum content is relevant to their nursing practice and up-to-date. Content was "thought-provoking." • **Most important components of education:** While a range of topics are reviewed in NFP education – the following were identified as highly valued sessions**:** goal setting, NFP program model, the client-centered principles, reflective practice, therapeutic relationship, professional boundaries, NFP theories, effective communication techniques/motivational interviewing (MI), DANCE, strength-based approach, PIPE, content domains, IPV, and infant cues and development. • **Cultural competency:** A focus on providing culturally competent care is a requirement for PHN practice in BC; so the inclusion of the material was redundant to some PHNs – whereas others appreciated examining cultural competency through a NFP lens. • **PIPE**: "probably the most important component of the NFP program because it really builds on attachment" ***Learning Environment*** • **Educator expertise**: The content and clinical expertise of all educators was recognized and appreciated, as was their ability to tailor content specific to the NFP model. Educators' skills in being able to "role model" NFP nurse competencies (strength-based approach, learner-centered education) was highly valued. • **Learning environment:** At all times the educators demonstrated: a deep respect for participants, recognized that individuals learn in different ways, provided safe space for learning, and were able to answer learners' questions quickly and efficiently. These factors contributed to a very strong adult learning environment. ***Teaching and Learning Modalities*** • **Teaching methods:** Learners like the mix of face-to-face sessions, self-study/team based learning, teleconferences/webinars (mixed reviews), on-line modules. Specific tools that were particularly liked included the use of videos (although quality of some was poor) and the visual of NFP garden (attached). • **Unit 1 (self-study)**: Was excellent to do that ahead of time to lay the foundation for what they learned in Unit 2 (face-to-face); mixed reviews on helpfulness of teleconferences provided to reinforce this learning. • **Unit 2 face-to-face:** Almost everyone enjoyed the face-to-face interactive learning; provided an opportunity to put things into practice; promoted discussion with other colleagues and learners; appreciated getting a chance to go away as it fully freed them up to focus on learning; sense of shared passion, pride in their work, felt appreciated, felt really inspired, and motivated to do the work. • **Time commitment for learning:** Overall PHNs indicated that sufficient time was allocated within their assignments to attend required education sessions and do self-study. • **NSO webinars:** Mixed reviews - some PHNs felt modules were a good reminder of previous learning i.e., looking at core model elements again, reviewing underlying NFP program principles and philosophies; others found the content too US-centric and too basic.

	PUBLIC HEALTH NURSE CORE EDUCATION
	• **Academic credit:** PHNs felt like they were "doing another complete associate degree with the amount and quality of the learning that was happening" and expressed some desire to explore potential for academic credit.
Challenges	***Challenges Specific to Wave 1 (original cohort) NFP PHNS*** • **Learning as they were going with Wave 1:** At the beginning of the BCHCP there was a sense that everyone (including scientific team) was learning as they were going; felt that they were getting things in pieces rather than having everything given as a cohesive plan/structure. • **Information on conducting NFP home visits:** Educators spent a lot of time providing information on what should be in visits but Wave 1 PHNs had never "seen NFP" done therefore were left just "imagining how we were supposed to go in and provide this program material that we'd been given." • **Delay in being able to use/apply NFP knowledge for Wave 1 PHNs:** Almost six months until PHNs starting picking up clients; disappointing and "horrible" because they couldn't use the NFP materials with clients until ethics approval received for Guiding Clients; would have been better to schedule education closer to when BCHCP study started (non-issue for Wave 2 and beyond). • **Data entry for Wave 1 PHNs:** NFP components of Panorama/Paris databases were not complete at the time of the Core Education. Learners thus left Unit 2 Core Education not having a clear idea how to document NFP nursing practice in BC or what documentation would look like based on the systems that we were being developed for their use. • **Client Documentation**: NFP nursing assessments forms were designed with the assumption that there is one NFP client record- however BC has separate charts for infant + mother; PHNs still struggling with this; ***NFP Education Content*** • **Education manuals:** The core education was delivered by US-based educators and using US-based education manuals – this created some "trouble using our manuals [during education] and that was difficult" due to differences between NSO and Canadian visit-to-visit guidelines. • **Unit 2 (Face-to-Face) - Too much content/too superficial**: It was expressed that in the time allotted that there were so many different topics that they didn't explore any one topic to a great extent. For some nurses, this then became just a topic overview. Given the expertise and practice experience in home visiting and maternal-child health that many NFP PHNs possess, it was identified that some core content was "too basic" including content related to home visiting procedures; felt some of the content was too basic due to previous experience/skills of PHNs e.g. home visiting, cultural awareness, and therapeutic relationships. • **Content level of education:** Mixed views on this; some PHNs felt education was below their level of experience and/or knowledge - it was superficial or it was very beginner/introductory level. • **Unmet learning needs:** some PHNs left Unit 2 feeling unsure about what a NFP home visit would actually look like. • **Motivational interviewing (MI):** Mixed feedback; many PHNs already had some level of knowledge and expertise with MI; some PHNs identified that the NFP MI education "brought that skill level to … a higher place than what we were using it at;" others expressed that "unless you're using [MI] all the time you'll never get as good. I mean you're not as competent." • **Imbalance of education time for MI (< 1 day) versus DANCE (~ 5 days):** Only use DANCE four times whereas MI is used on every single visit; not enough emphasis on MI given it is such an integral part of the program.

PUBLIC HEALTH NURSE CORE EDUCATION

- **PIPE:** Wave 1 PHNs hadn't received their PIPE materials – this delay was very disruptive to the learning and raised everybody's anxieties; set some individuals on the track of not liking PIPE because of the way it was introduced. In the PIPE education, some PHNs were not comfortable using dolls; at end of Unit 2 did not feel confident in own skills or that they knew what they are "supposed to be doing." For the novice NFP PHN, PIPE was identified as one of the hardest concepts to understand; PIPE pre-assignment wasn't helpful. Note: Wave 2 nurses spent one day reviewing PIPE materials in advance of Unit 2 and therefore were able to integrate PIPE with more ease.
- **Content Specific to new innovations not seamlessly integrated into existing NFP education:** Some PHNs expressed that the PIPE and DANCE education sessions had no relevance to anything. Examples of opinions included: "once I had gone through it all then it started to, to fit together;" it felt "chaotic as a learner"; too many new concepts mixed together; concepts seemed to bounce in and out a bit too quickly; not a great flow.
- **Boundary setting:** Only brief discussion provided; didn't touch on some of the boundaries that PHNs may have to address i.e. a client who "thought the nurse was her best friend."
- **Session on cultural awareness:** It was more about cultural sensitivity and knowing your different groups versus really exploring where you come from and your own assumptions and perceptions and how that can interfere with working relationships with clients; felt uncomfortable with how it was presented; mixed recommendations with some PHNs feeling cultural safety isn't needed while others feel it needs to be enhanced.

Learning Environment

- **Unit 2 Face-to-Face-length of sessions:** Some learners expressed that attending Unit 2 was: a) overwhelming given the amount of content covered and b) exhausting given the length of the learning sessions (scheduled for 07:45-17:00 but some educators went overtime or into breaks and lunches). One participant expressed that this was a "blatant disregard for our time."
- **Unit 2 Face-to-Face-location**: This unit was conducted in a centralized, urban BC setting, which required some nurses to travel and stay in hotels during the week whereas others were required to commute each day as cost of hotel would not be reimbursed. As it was explained, some PHNS "had to drive 2.5 hours to get there, then a train, and then 2.5 hours back. No hotel… It was stressful… We felt like our needs kind of weren't met a little bit."

Teaching and Learning Modalities

- **Role playing:** It was mandatory that everyone demonstrate a PIPE lesson in front of the whole group; this caused great anxiety in some individuals knowing they had to do it; "because it's so difficult to overcome the fear or the apprehension around role playing you don't actually learn from the exercise because you're so busy fearing it and fearing role playing in front of your peers that you actually don't learn from doing the activity."
- **Issues with accessing NSO webinars***:* Technology issues at the beginning related to HA firewalls was frustrating and wasted valuable PHN time; the overall impression was that the webinars are used to present a lot of content in a very didactic manner.
- **Teleconferences:** Given the geography of BC, many educational sessions were held via teleconference. For some PHNs this was a new way of learning and for some it was hard to listen sometimes and learn that way.

PUBLIC HEALTH NURSE CORE EDUCATION

Integration of NFP Education into Public Health Role

- **Unit 1:** Some PHNs who were not released from their other PHN work found finding time to do this self-study difficult; many distractions with regular public health work; overwhelming to be on their own doing it.
- **Time commitment:** It was a bit of a struggle at the beginning when other HA staff were getting used to not having NFP PHNs available for them to do "regular" public health work; felt disjointed sometimes with competing priorities; some PHNs found estimate of time for Unit 1 was too short.

Ongoing Education/Professional Development Needs

- **Working with clients who have complex mental health issues:** PHNs recognize that they are not counsellors but "feel very at a loss quite often" working with these "very, very challenging clients" e.g. clients who are bipolar.
- **Working with Ministry of Children and Family Development (MCFD):** Scenarios were brought forward from the NFP teams with the understanding that they were going to have a Q & A with MCFD about how to work with them more collaboratively – this has never happened and it really needs to happen.
- **Job stress:** PHNs requesting sessions for themselves such as compassion fatigue or burnout, trauma-informed practice – explore how PHNs might feel working with families that are disclosing lots of "really heavy" issues.
- **Aboriginal competency course:** (or something similar) offered in each HA - self-directed and online – recommend all the NFP PHNS/Supervisors take it?
- **Additional topics to add/enhance:** Mental health issues and addictions; fetal, infant, and toddler development; prenatal care; adolescent development; brain development; sexual abuse + child abuse and neglect.

Solutions and Recommendations

NFP Education Content & Format

- **Modifications to Unit 1:** Make formatting to make it more "readable" i.e., increased use of bullets, key messages versus narrative style; some content could be provided later when it makes senses i.e. reflective practice when PHNs have a caseload.
- **Unit 1 Orientation- Application of content to practice:** As part of new NFP PHN orientation designate a PHN and/or Supervisor to share a typical NFP day before doing Unit 1 "Just so we know how play fits in and how the guidelines fit in and how the home visits fit in and how the facilitators fit it."
- **Modifications to Unit 2 Face-to-Face:** Consider adding in more days to Unit 2 however several PHNs noted that one week away from home was enough due to personal commitments; more practice with visit-to-visit facilitators; strengthen sections on reflective practice and professional boundaries; switch "practice partners" each day to enrich learning experience; address issues regarding long days, lack of breaks, and inequity amongst local PHNs who may have long driving times versus PHNs from other HAs who have opportunity to stay in hotel.
- **Observe NFP home visits prior to attending Unit 2:** All PHNs should observe NFP home visits – this has been incorporated for Wave 2 PHNs; develop videos of NFP home visits to provide more context.
- **Reduce focus on the nursing assessment forms during Unit 2:** Preference is to spend less time on documentation in Unit 2; Note: many questions related to the nursing assessment forms have recently emerged at the BCHCP Q&A Committee so this would need to be addressed in an alternate way.
- **Modifications to MI:** Provide more practice with increased emphasis on working with clients who don't appear motivated to change; assess effectiveness of PHNs with using MI and provide ongoing support with it i.e., more webinars.

	PUBLIC HEALTH NURSE CORE EDUCATION
	• **Modifications to PIPE:** Explore alternatives to role playing PIPE lessons in front of the whole group; provide more informational re theoretical underpinnings "so that we understand a bit more about exactly what it is…"; consider adding another half day at the end of DANCE to take the PIPE skills to another level; revisit use/timing of PIPE assignment. • **Documentation:** Need to adapt documentation sessions to be BC specific; review what goes on which chart (infant + mother) and how to do that; review how facilitators can be used with more emphasis on how it all comes together; this session needs to be tailored to the context/platform in each country. • **Emphasize usefulness of Keys to Caregiving:** Content excellent and the clients really like knowing about newborn characteristics and arousal states etc.; consider providing this before Unit 1. ***Teaching and Learning Modalities*** • **Webinars:** Need to incorporate principles of adult learning, drawing on people's experience and their stories. Would be valuable to make them more interactive. • **Provide session(s) re working with MCFD:** What expectations PHNs could have if they did call, clarify response time, role of MCFD staff, more information on the legal system, knowing what happens with apprehensions and the father's rights to visit the child, law around custody and protection orders etc. • **Develop/provide access to more NFP videos:** Would like the opportunity to watch videos of NFP nurse home visitors using PIPE, conducting NFP home visits; seeking new video to replace one currently used for baby cues • Explore options for academic credit for NFP education

"So it's a lot of content in a very short period of time and it is overwhelming but over time it all makes sense when you have time to process it and kind of digest it a bit more."

"It [NFP education] kind of brought together a lot of the different things that I've done in the past and that's what made it very satisfying for me as well."

"I finally for the first time ever felt really validated that I had the skills and knowledge and an aptitude for the material, and it wasn't dummied down. I felt, wow! Like I don't have to pretend I'm slow to figure out this program."

Integration of Learning:
As per core model element #14, two NFP team meetings per month should be devoted to education and two are scheduled for case conferences. Each NFP Supervisor has access to a Team Meeting Education Handbook which is a resource for professional development in the NFP model. It consists of modules on a variety of topics, and each module is designed to expand the team's knowledge and understanding of topics related to NFP nursing practice. Teams select the modules that are most essential and/or of the most interest to them to use. The modules are designed for either a NFP supervisor or PHN to facilitate. Learning is focused on discussion and hands-on activities. The facilitator of the topic is not expected to be an expert on the subject, as the learning comes from each other. Recognizing the time constraints many NFP teams experience, any preparatory reading has been kept brief.

	INTEGRATION OF LEARNING
Helpful Strategies	• **NFP Supervisors identify learning needs of their teams/individual PHNs:** Through reflective supervision, team meetings, case conferences, and clinical consultation; will organize a guest speaker, a site visit, a follow-up meeting, a phone call etc. to ensure that PHN(s) have access to the information/support. • **Team meetings:** Review topic from team meeting handbook, compassion fatigue, ethics, boundaries, MI/communication skills, safety planning, breastfeeding, attachment, therapeutic relationships, boundaries, personal values -- how that impacts your care, DANCE, review of specific facilitators, review education resources provided in Unit 2&3 individually and as team, review IPV clinical pathway, trauma-informed practice, mandate/services provided by MCFD etc. • **Case conferences:** Offer a really good opportunity for individual skill development and learning from peers; opportunity to revisit a lot of the components of the NFP model as far as the clients – what is the client's desire and always coming back to what they really want; provides a safe environment for open and honest discussion; If PHN/team is "stuck" and not sure where the next step is, helpful to pull out NFP model visual (garden). • **PIPE:** Still learning big things about PIPE - it's still "quite a steep learning curve." • **Provincial level:** Bring forward some of those issues provincially that they feel might be common to others and then through the Supervisors Community of Practice, they have tried to identify a plan to address the learning needs. • **Teleconferences from the NSO:** Have been very helpful e.g. on PIPE understanding concept of "fun, fast, furious." • **PHNs develop individual learning plans:** Little mention of how they are used • **Access other learning resources/experts within the HA:** Ethics, boundaries, emergency contraception, compassion fatigue, prenatal pathway, MI; Some professional development funding from HA (this is limited) for individual learning needs • **Access to the American NFP community website**: NFP PHNs/Supervisors can access educational resources directly; can participate in any new NSO webinars e.g. MI. • **Documentation:** Supervisors did some work post Wave 1 Unit 2 to identify what NFP documentation goes on which chart (maternal + infant) and how PHNs should separate content domains; also addressed questions regarding what assessments for infants would look like and how documentation needed to be done on an infant chart on an ongoing basis. • **HA specific:** One HA has a clinical nurse educator department where they go around from health unit to health unit and they'll do things like updates for our Best Beginnings Program, harm reduction, nutrition etc.
Challenges	• **Time commitment:** Hard to fit in formal/planned integration sessions for IPV and DANCE + other teleconferences because of the caseload/needs of clients. • **Isolation of some NFP PHNs:** PHNs working in small offices don't get to work with other NFP nurses to do hands-on practice together; team meeting education modules don't lend themselves well to teleconferences – designed to be used in-person; one team had only met twice in-person.

	INTEGRATION OF LEARNING
	• **Part time issues:** Teams with a lot of part time nurses haven't had a lot of time to do team education; between a team meeting and a one-on-one reflective supervision session every week, only leaves 1.5-2.5 days of client time; Hard to juggle competing demands of NFP work and regular public health work for those who only do NFP part time. • **Scheduling conflicts:** HA updates are delivered in health unit-based team education meetings and NFP PHNs are often attending NFP meetings on those same days and so they miss out on the HA education days. • **Inconsistent continuation of support:** "Sometimes we go to in-services or we go to workshops but things don't always maybe have the follow-through." • **PIPE:** "It still feels when I prep for visits and I have to do PIPE lessons I still feel like I'm not 100% sure I'm doing it in the way that they want it done."
Solutions and Recommendations	• **Time commitment:** Recommendations(s) will be made in a future communiqués about addressing issues specific to the integration sessions for IPV and DANCE. • **Continuation of support:** Ensure strategies in place to ensure follow-through and a review of information. • **PIPE:** Develop strategies for further integration/refinement of skills • **Isolation of some NFP PHNs:** Pursue opportunities/strategies for PHNs working in small offices to come together more often i.e. use of videoconferencing. • **Part time issues:** A future communiqué will more deeply explore issues related to part time nurses versus fulltime. • **Motivational interviewing:** Provide "… regular opportunities to practice it or to talk about it … to keep it fresh in your mind."

"I feel like I'm doing better then I was 2 years ago. I'm more confident in my skills … I think, for me, honestly I think it's just practice. That's what makes this, with this program I think you just have to keep having clients and then keep practicing … ."

Appendix – British Columbia Nurse-Family Partnership Education Components

Component	Method	Description	Time Commitment
Nursing Practice Unit 1	Self-study + tele meetings	To assist new NFP PHNs/ Supervisors to develop foundational knowledge of the NFP Program, theories, home visiting intervention, and Partners in Parenting Education (PIPE) before attending Unit 2.	~ 34 hours self-study + 4 telemetering's x 1.5 hrs.
Using the NFP Visit-to-Visit Guidelines	Online module	Review of purpose, components, structure, ways to use the guidelines to prepare and conduct a home visit	1 hour
Partners in Parenting Education (PIPE)	Self-study, teleconference, team-based	The PIPE educational program is designed to strengthen relationships by increasing the emotional availability of parents/primary caregivers.	2 hours self-study 1 hr teleconference 2 hrs for assignment
Edinburgh Postnatal Depression Scale	Self-study	Review policy document Addressing Perinatal Depression a Framework for BC's Health Authorities (2008)	1 hour
Nursing Practice Unit 2	Face-to-face	To prepare new PHNs/Supervisors to implement the NFP intervention with fidelity to the model. Delivered to reinforce and deepen knowledge, understanding and skill development of information introduced in Unit 1.	3.5 days
ASQ-3 and ASQ-SE	Self-study + Teleconference	The ASQ-3 (screens general development) and ASQ:SE (screens social-emotional development) tools actively involve parents in the screening process. Note: PHNs already knowledgeable re ASQ-3/ASQ-SE need not attend	4 hours
Introduction to IPV	Teleconference	Orientation session to Intimate Partner Violence (IPV) Intervention	1 hour
IPV Nurse Education Modules	Team-based, on-line + self-study	The IVP intervention education is designed to: review and discuss NFP IPV clinical pathway; apply the NFP IPV clinical pathway to client scenarios; and review IPV documentation and assessment procedures.	20-25 hours
IPV Consolidation Workshop	Face-to-face or teleconference	Reviews the NFP IPV Clinical Pathway + discusses NFP PHN response to identify and respond to IPV among NFP clients	1 day
IPV Introduction for Supervisors	Face-to-face or teleconference	To provide an overview and orientation to the Supervisor's role in IPV as it relates to NFP.	3 hours
Nursing Practice (Unit 3)	On-line	Self-directed distance learning course, comprised of individual lessons: • Early Emotional Development: Temperament • Fidelity & Model Elements • Motivational Interviewing	4.5 hours
Supervisor Unit 3	Interactive webinars	Supervisors are required to participate in 5/6 topics which include: 1. Building, Assigning and Managing Caseloads 2. Supervisor Role 3. Recruiting and Hiring Staff 4. Building Community Advisory Boards 5. Motivational Interviewing Refresher	~ 7.5 hours
Supervisor Unit 4	Face-to-face	To support the supervisory role and continued development of competencies	3 Days
Keys to Caregiving	Self-study/team	Content focuses on: infant states and state modulation, infant behaviour, infant cues and the importance of the feeding interaction.	~ 2.5 days
DANCE	Self-study and team-based	Provides background information in preparation for the DANCE Fundamentals.	4 hours

Component	Method	Description	Time Commitment
DANCE Fundamentals	Face-to-face	Support learning of the DANCE behaviours, practice DANCE coding, across all dimensions, conducting DANCE observations during home visits, and translating DANCE observations in to intervention strategies using the DANCE STEPS	3 Days
Supervisor DANCE Integration	Teleconference	Opportunity to provide feedback to the DANCE Trainer on site's experiences, successes, and challenges in order to further support learning and integration into practice.	6 hrs. (1 hour x 6 months)
DANCE Integration	Teleconference	DANCE Integration is a six-month, individual and team-based learning and support program designed to advance mastery of the DANCE and integration into practice.	~ 9-12 hours (1.5-2 hrs. per month x 6)

Note: green shaded rows are supervisor-specific education

- Core NFP education is provided by the US NFP National Service Office (NSO)
- All on-line modules/webinars are accessed through the NSO secure website
- DANCE is provided by Prevention Research Centre (University of Colorado at Denver)
- IPV provided by Dr. Susan Jack (McMaster University)

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