SFU Children's Health Policy Centre, Simon Fraser University, Faculty of Health Sciences

BC Healthy Connections Project

PROCESS EVALUATION

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Perspectives of BCHCP Health Authority Managers – Wave 1 Interviews

One of the goals of the Process Evaluation (PE) is to identify factors that influence implementation of the Nurse-Family Partnership (NFP) in British Columbia from the perspective of Health Authority (HA) administrative decision makers responsible for BCHCP. The first wave of individual semi-structured interviews were conducted by the PE Research Coordinator either by phone or in-person between April and June 2015. The sample (n=14) included 2-3 participants (project/practice leads, managers, or directors) from each of the five participating HAs. The interviews focused on 5 areas of inquiry: 1) role of the HA manager responsible for the NFP program/BCHCP; 2) contextual factors influencing introduction of NFP into the community; 3) acceptability of the NFP; 4) NFP planning; and 5) implementation of NFP. The data from the first wave of interviews are themed using work based on diffusion of innovations in health service delivery organizations (Barnett et al. 2011; Greenhalgh et al. 2004). Four main themes were identified in the analysis of the data: 1) the role of research evidence; 2) communication process and structures; 3) the influence of individuals in facilitating/inhibiting adoption of the NFP; and 4) the impact of contextual factors.

Theme	BCHCP Health Authority Decision-Maker Perspectives
1. **The role of research evidence: a) intervention characteristics (NFP); and b) use of research to evaluate NFP in BC**	**Intervention Characteristics** • **Proven effectiveness:** NFP's reputation as an evidence-based intervention with high quality rigorous outcomes was the primarily rationale for the overall positive initial reaction most decision makers had to NFP coming to BC. • **Evidence-based approach is still relatively novel:** Using research evidence to guide decision-making can be seen as a challenge to existing public health culture/practice. Anticipate that this is "… really going to change Public Health service delivery." • **Identified need for targeted interventions:** Recognition that HAs need to be working further upstream and that over *"….the last fifteen years or so we, in Public Health, were getting even further away from support of the pregnant woman and the infant and toddlers."* Within public health culture there has been a shift in focus from a general population based approach to a greater understanding of the benefit of using targeted approaches to address current gaps in health inequity. • **Intervention adaptability:** As part of the negotiated contract, HA were to implement NFP with fidelity to the core model elements. During the first year of implementation, some decision-makers noted the requirement to implement with fidelity limited opportunities to adapt the intervention to the local context and populations. **Evaluation of NFP through a RCT (BCHCP)** • A high level of complexity associated with implementing NFP was attributed to identifying strategies to delivering a clinical program within the context of a RCT. • **Challenge of evaluating the NFP using an RCT design:** Some frustration with study inclusion/exclusion criteria and the sense that this restricted their decision making autonomy within their HA. Some senior decision-makers felt that offering NFP only through an RCT was not a "fit for [their] communities." • **Frustration with having do RCT:** Since strong evidence already exists regarding the effectiveness of NFP, some managers questioned why an RCT needed to be done at all. *"If we know that these are best practices, why can't we just implement?"*

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"So, we know that our target population for NFP are … the most vulnerable of the vulnerable, right?… If I have limited resources, I want to focus on the most vulnerable, because I think that's where I'll see the greatest return on my investment and the greatest impacts on health."	
2. Communication process and structures	• **Pre-existing collaborative relationships between HAs:** Structures were already in place that facilitated positive collaboration between Prevention Directors and perinatal public health leads. The majority of participants expressed the importance of already-built relationships, and an appreciation for how these networks have strengthened the overall implementation of NFP. • **Memorandum of Agreement between Ministry of Health (MoH) and each HA:** This mandate created a clear commitment to the NFP program/BCHCP that guided the participants in their decision making during challenging situations. • **Formal communication structures established:** Very helpful to have study protocols from SFU and other information from MoH so HAs could then begin planning and communicate to others as needed. Pre-existing relationships were further strengthened with the addition of NFP Committees, such as the Provincial Advisory Committee (PAC), the Regional Evaluation Advisory (REAC) and the Question & Answer (Q&A). *"I think that the collaborative approach has … given the program a lot of strength."* • **Early engagement of HAs:** Most participants expressed that the early face-to-face engagement of the external research team with the senior decision makers positively influenced the overall planning experience. • **Importance of effective communication strategies within HAs:** Some HAs were able to establish their own unique internal communications processes which facilitated sharing updates with staff at levels within the HA. "And that's held us in good stead. So, yeah we had a really good framework in place for how we did our work together." • **Perceived lack of decision-making autonomy:** Overall some participants perceived that they were told by Ministry of Health (MOH) they had to participate in the RCT. They also perceived that existing decision-making processes were disregarded and that the decision to go forward with the RCT *"… was a fait accompli when it was presented to us. SFU was the partner, and MOH and MCFD, they were the Steering Committee. They were making the decisions about it….It was odd compared to how we've done other projects."*
"I was told, this is what you need to do — so I did it… This is a program that has been, you know, given to us … There's no choice in the matter….so that's a challenge… to manage those expectations that everything will stay the same and we'll just add on this program."	
3. The influence of individuals in facilitating or inhibiting NFP adoption.	• **Role of champions**: Most of the participants see themselves, or were able to identify individuals within their organization, who are champions, advocates, communicators, and leaders of NFP. Also responsible for planning and implementing NFP. *"I'm also the liaison between the… front line of the NFP program, the actual operations of NFP and the senior leadership within our program. So, meaning the executive director, the vice president – those types of things. So, I communicate back and forth between them. But I also link with external stakeholder groups also. So, I have a big role in promoting and advocating and supporting the success of the program."* • **NFP Provincial Coordinator role seen as a provincial champion:** Appreciated that NFP Provincial Coordinator met on-site with HAs to help in developing timelines and other operational issues for the nurse education. • **Leadership role of MOH:** Formal communications to Chief Medical Health Officers, Vice-Presidents, and the Executive Directors of the different programs has positively impacted on renewed commitment to NFP. • **Positive perceived impact of NFP:** Some participants identified great satisfaction in seeing their NFP staff working at an advanced practice level, and seeing their professional growth. Senior decision makers also reflected on the multiple anecdotal stories of client success that NFP PHNs and supervisors regularly shared within the HA. • **Persistent lack of support:** In some cases lack of support for NFP at the senior

	management level has persisted, which is believed to be related to budget pressures and limited resources within the HAs, particularly public health nursing resources. • **Adding responsibility for BCHCP/NFP to existing work:** The opportunity cost of adding NFP to HA management portfolios influenced the overall attitude towards NFP within the HAs, dividing individuals between NFP supporters and NFP critics. Adding the NFP to the participants' portfolios has created challenges in balancing the available resources needed for NFP with the resources required for all the other public health interventions that they are responsible for. • **Impact of change in leadership on commitment to BCHCP/implementing NFP:** Although there might have been strong support initially for NFP, sometimes a change in senior leadership has resulted in a situation where *"all the people that were the knowledge holders of the planning and the support for NFP were gone… you have to go through the same argument from the beginning to the end about why, as they come in."* • **Lack of stability within senior management:** There were a large number of participants who described how the lack of stability within senior management led to challenges for themselves within their role because of the effect the turnover had on the clarity and continuity of communication and forward momentum, especially once implementation of NFP was underway. This leadership turnover reduced the stability of the NFP-focused teams at the senior level.
"It was a very supportive environment at that time [early planning for NFP] with our current leadership. But then it shifted. There was a shift all of a sudden. I think when the leadership left it shifted to all about the RCT."	
4. The impact of contextual factors • Political influences • Ideological influences	• **Commitment of MoH and HAs:** Participants expressed that they were *"… very impressed that… the province of BC, the Health Authorities were committed to investing in such a great program ... for our most vulnerable clients."* • **Potential systems impact:** See NFP as a "… great opportunity for public health nursing to really define what's unique and specific about that role within the nursing practice that sets them apart from other nurses within the system." • **Attributes that contribute to participants being successful in their role:** It is important to have a solid understanding of early childhood development principles, be familiar with the NFP scientific literature and to have broad-based, systems-based thinking. • **Building in critical incident stress debriefing support:** Several participants identified HAs need to build in critical incident stress debriefing support for the PHN nurses. *"This is a very intensive deep emotional work that they do. And they need more than your, just, normal workplace health kind of, you know, eat well, sleep well..."* • **Budget impacts of implementing NFP:** The most significant challenge to the participants was the expectation to incorporate NFP implementation within their existing budgets. This added program, that includes specialized PHNs, created challenges to staffing that ultimately affected other programs within their management portfolios. Decision-makers expressed having to balance the available resources needed for NFP with the resources required for all the other public health interventions that they are responsible for. There was a strong emphasis on how making these trade off decisions was very challenging for the senior decision makers. • ***Working with First Nations communities:*** Participants recognized that there was no process to seek ethics approval on-reserves however other aspects were difficult to understand and/or reconcile. *"Trying to explain to our First Nations partners why this is not open to … to community members at this time because it's an RCT and all of those kinds of things. That's been really hard… felt almost like a betrayal to not be able to offer the same opportunity to a group that is far more disparate than anyone else."* • **Expectations of research team:** Participants spoke about the complexity of seemingly simple tasks, such as the programming of the paper data collection forms into their Health Authorities' electronic medical record system. This challenge was a result of the differing perceptions of impact between the external research team's expectations and their own Health Authority capacity. • **Impacts of extending study recruitment:** HAs have been unable to achieve recruitment

numbers that were estimated by the MoH, resulting in extending recruitment phase of the RCT. *"But in all honesty, I don't think this is going to work in the long-term for us in this structure… I think there will be dwindling support for the program within the Health Authority if we don't start seeing some of this evidence and we don't start having some of our needs met."*

- **Inequity between NFP PHNs and other PHNs:** Perception is that NFP PHNs have the advantage of specialized education/training, program material and small caseloads, and early on seemed like they had nothing to do. *"And they're [both groups of PHNs] sitting side by side. And I know that that did create a moral dilemma for them. They were feeling bad that they weren't as busy as their colleagues… And I think it continues to be very hard in some of my offices where this goes on. In fact we have the haves and the have-nots."*
- **Impact of delay in obtaining ethics approval:** Most participants recognized that the delay in ethics approval was unexpected and a result of very complex processes that exists in BC. However, this *"… took way longer than anyone had ever anticipated. And the result of that was that…. I've gone out there and met with people and told them this is coming, and it keeps getting delayed…."* This delay has impacted on community engagement, interest in the research study, and recruitment.
- **Unusual to use a licensed program:** *Because the NFP program is protected by copyright there is a "… notion of secrecy around the program – the not being able to share tools or talk about those kinds of things - is weird."* HA managers not directly involved in NFP felt disconnected and excluded making it difficult to really understand the program and discuss it with community partners.

"I hear some great stories all the time. You know, I hear about people going back to school and women finishing their education. I recently attended a graduation ceremony, and I saw this young mother and her partner, and they were so together and so resourceful, and she's so mature for her age."

Summary:
Most of the participants identified that strong leadership skills, creatively solving problems, positive energy about the NFP, and information-sharing contributed to the success of NFP. The HA senior decision makers discussed many different perspectives about culture during their interviews, including the tension between a population versus targeted approach to providing public health services, combining scientific research norms with public health service delivery, and the value of public health's purpose being to reduce inequities amongst the most vulnerable. While these three challenges were discussed by the majority of participants independently, they are often interrelated and reflect a broader moral challenge between personal norms and values and large complex health system delivery.

Recommendations:
1. Revise eligibility criteria for women 20-24 years of age, in particular criteria for low-income
2. Have HA manager representative on BCHCP Steering Committee
3. Create structure for Operational Directors meeting to plan for implementation of NFP post-RCT recruitment
4. With limited resources, need to move to more proportionate-targeted interventions

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