



Nurse-Family Partnership: Is It a Fit for First Nations Communities in BC?

A Report from the BC First Nations and Aboriginal
Maternal and Child Health Promising Practices Working Group

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This report was prepared by Deborah Schwartz, Flourish Consulting, on behalf of the BC First Nations and Aboriginal Maternal and Child Health Promising Practices Working Group.

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Overview

This report was commissioned by the Tripartite First Nations and Aboriginal Maternal and Child Health Strategy Table (Strategy Table) in British Columbia in August 2012¹ and has been funded through the Health Services Integration Fund (HSIF).

The Strategy Table established a working group to guide the development of this report. The working group included representatives from the First Nations Health Authority, the regional health authorities, the Ministry of Health, Simon Fraser University's Children's Health Policy Centre, and health directors and maternal and child health coordinators from First Nations communities. Participants in the working group were drawn from each of the five health authority regions and represented both urban and rural/remote communities.² Each had extensive experience delivering and managing maternal child health programs. The Healthy Women, Children and Youth Secretariat of the BC Ministry of Health acted as the administrative lead for the project.

The working group has met eight times during the past 2.5 years—three teleconferences and five in-person all-day meetings. During these meetings, the members shared their ideas, experiences and recommendations, reviewed the material coming from the interviews and literature search, and provided guidance to the consultant about this report.

Purpose of This Report

The purpose of this report is to provide feedback and advice to the Strategy Table about the suitability of the US home visiting program developed by Dr. David Olds, called Nurse-Family Partnership (NFP), for BC First Nations communities—to respond to the question, “Is NFP a good fit for First Nations communities?”

“NFP is an intensive maternal and child health home visiting program that provides first-time moms with valuable knowledge and support throughout the pregnancy, continuing until children reach 2 years of age. According to the US studies, partnering first-time moms with public health nurses empowers mothers to confidently create a better life for their children and for themselves. The goals of NFP are to (1) improve pregnancy outcomes, (2) improve child health and development, and (3) improve economic self-sufficiency.”³

In 2011, the BC Ministry of Health (MoH) launched a project called the BC Healthy Connections Project (BCHCP) to study NFP. The BCHCP is to determine whether this program works in BC communities compared with existing services. Prior to the BCHCP, this program had never been tested in Canada before.

¹ At the time, the Strategy Table comprised representatives from the interim First Nations Health Authority, First Nations and Inuit Health – BC Region, regional health authorities and the BC Ministry of Health. Additional proposal partners were the Provincial Health Services Authority, the BC Association of Aboriginal Friendship Centres, the First Nations Health Directors Association and Simon Fraser University's Children's Health Policy Centre.

² See Appendix A for the working group membership.

³ Information on NFP and the BCHCP was taken from the BC Healthy Connections Project website: <https://www.healthyfamiliesbc.ca/home/bc-healthy-connections-project>.

The Children’s Health Policy Centre at Simon Fraser University is conducting the scientific evaluation of NFP through the BCHCP over the next 5 years—in partnership with McMaster University, as well as the BC Ministry of Children and Family Development (MCFD) and five participating regional BC health authorities (Fraser Health, Interior Health, Island Health, Northern Health and Vancouver Coastal Health).⁴

The BCHCP study is expected to be completed in 2020. Depending on the outcomes of the study, the MoH, the MCFD and the regional health authorities will determine whether or not to implement NFP province wide.

The feedback and advice contained in this report is intended to help the Strategy Table gain a better sense of the strengths and weaknesses of NFP for First Nations communities, from the perspective of health directors and maternal and child health coordinators who were interviewed for this report. These health directors and maternal and child health coordinators have years of experience implementing programs (with similar goals to those of NFP) in First Nations communities, and can therefore provide critical insights on the suitability of new programs and services, and implementation challenges in First Nations communities.

The advice shared in this report is also intended to help prepare the Strategy Table to support First Nations communities to determine whether or not NFP is a good fit for them, should it become available for provincial implementation in 2020.

Who Contributed to This Report?

More than 50 people contributed their ideas to this report—either as a member of a group discussion or in a one-to-one interview.⁵ They included:

Working group members	~23
MCH coordinators, health directors and government partners	~24
US: Dr. Olds, NFP National Service Office staff, White Earth Nation representatives	9
Number of participants	~56

We asked the BC participants one main question about the BCHCP and the NFP program: “Based on the brief overview of the NFP goals and program components, do you think the study should be expanded to First Nations communities? For example, do you think it is a program your community would be interested in exploring?”

We asked the US interview participants about their experience implementing NFP in American Indian and Alaskan Native communities, adaptations they have made to the program, lessons they have learned so far and early outcomes, and also asked them to share any advice they might have for BC.

⁴ Ibid.

⁵ Attention has been paid to not counting participants twice, as some people participated in an individual interview as well as in the working group discussions or at the MCH meetings.

Challenges

A central challenge for the working group members (as well as the other interview participants) was that the NFP program was new to BC and therefore First Nations communities were not familiar with it. The information available to the public about the program focused on a general description, not specific details about curriculum or content, owing to copyright issues. Also, because clients were just starting to be enrolled in the BC study in 2012, there was very little information about whether or not the clients liked the program. Without knowing the specifics of the NFP curriculum, the working group wondered how it could compare and contrast NFP with other programs and make an informed recommendation.

But it was precisely because the program was new that it made sense to explore whether the NFP program might be an acceptable and feasible home visitation program in First Nations communities. The HSIF provided an opportunity to do just that.

More questions followed. If funding was available to study or implement NFP, could it be used to expand the federal First Nations Maternal and Child Health (MCH) programs? What about existing Indigenous home visiting programs such as the Nuuchahnulth First Nation's program, Mother's Story.⁶ Why weren't we studying these programs instead of an American "mainstream" program?

Some understandable concerns were expressed from members who had spent many years working with their community to develop excellent services that worked well. They wondered,

"What is the problem with the program we are delivering? Why would we want to replace it? Why are we always getting distracted by the next new shiny thing that might not be as good as what we have now?"

The working group members grappled with these questions during their initial teleconference meeting in August 2012, and raised excellent points about exploring Indigenous programs and building on existing successes. As one working group member said,

"Let's not re-invent the wheel—and let's not ignore current excellent programs that have been underfunded or have not had the opportunity to be evaluated."

The message was clear that in addition to responding to the question about NFP, the working group wanted to also explore existing promising practices in BC for First Nations and Aboriginal MCH programs. They believed strongly that the HSIF project provided an opportunity to highlight and learn lessons from these programs.

In support of these suggestions, the working group asked the Nuuchahnulth working group members to present on Mother's Story and a First Nations and Inuit Health (FNIH)⁷ representative to present on the federally funded Maternal and Child Health (MCH) program at the first face-to-face meeting of the working group held in October 2012.

⁶ More on the Mother's Story program is found in the second report from the working group which is titled *Promising Practices in First Nations and Aboriginal Maternal and Child Health Programs*.

⁷ This request was made prior to the transfer of the FNIH Branch to the First Nations Health Authority.

Group members were deeply moved by the presentation of Mother’s Story by the Nuu-Chah-Nulth team, and it reaffirmed for them the importance of honouring existing programs that were being implemented in BC

The October 2012 meeting was a turning point meeting in many ways, as it solidified the working group’s support to truly engage in an exploration of existing promising practices, and to expand its scope beyond just commenting on the NFP program. The terms of reference were revised and the group renamed itself the “First Nations and Aboriginal Maternal and Child Health Promising Practices Working Group.”⁸

A revised work plan was developed and the consultant was directed to include additional questions in her interviews that would reveal information on existing promising practices. The decision was later made to separate the findings from the interviews into two separate reports, one report that dealt with the question of NFP, and a second report that captured the findings on promising practices in First Nations and Aboriginal maternal and child health programs. This report addresses whether or not NFP is a fit for BC First Nations.

Key Messages from the Interviews

The interviews with BC participants occurred in two rounds over a 2-year period. This is an important point, as the advice altered between the rounds, with participants becoming more interested in exploring NFP by the second series of interviews. The key messages from both rounds of interviews are presented in the following sections:

BC interviews

Keep the door open for NFP. Communities will decide for themselves if it is a good fit.

- NFP may or may not be a fit for First Nations communities. It is up to the community to decide whether or not to explore the program. NFP might augment existing services and/or offer an option for communities that are currently without any maternal and child health services. Communities and health authorities want to work together at the local level to determine if NFP is appropriate for them, and if so, how implementation should happen.

Any programs or initiatives offered by the health authority or the Ministry of Health to residents of BC should also be offered to First Nations communities.

- Interview participants sent a clear message that governments and health authorities have a shared responsibility to provide services to First Nations communities. If NFP becomes available for province-wide implementation in 2020, health authorities should offer the choice to First Nations communities to participate in NFP.

⁸ See Appendix B for the working group’s terms of reference.

Address funding and service inequities before introducing new programs.

- Interview participants raised the issue of inequities in funding and service levels between communities. They noted that sometimes introducing new programs can inadvertently increase these disparities. They recommended conducting an analysis of current programs and services, and prioritizing funding to communities that do not have maternal and child health programs.

Support adaptations and enhancements to the NFP curriculum.

- NFP may be appropriate for some communities with adaptations and enhancements. Some of the possible adaptations that were identified are making cultural additions to the curriculum, expanding the program to all pregnant women of any age, offering support for children up until age 6 and not making the hiring of Bachelor of Science in Nursing (BScN) nurses a requirement.

US interviews

Although the US implementation of NFP in American Indian and Alaskan Native communities is still in the early stages, the US interview participants were able to share the following early lessons:

Community choice and community leadership are key.

- Interview participants stressed the importance of being invited into the community and ensuring the leadership in the community (both political and health administration leadership) understands and wants NFP and is able to champion the program.

Be patient and take the time to build trust and strong relationships.

- The interview participants reminded us that introducing health promotion programs such as NFP takes time and can only work if government and the community take the time to build strong partnerships with each other, and in turn with community members.

Build the right data system that is owned by the community and has value beyond NFP.

- Building the right data system takes enormous time and energy but is critical in order to monitor and evaluate NFP. The data system has to serve the community beyond NFP and provide a venue for the community to tell its own story.

Adapt and enhance the curriculum to align with community values.

- The US communities have made several enhancements to NFP including opening the program to women at any stage of pregnancy and with more than one child, and providing support to children up until age 6. They have also integrated the language of the tribe into the curriculum and incorporated cultural teachings.

Background: What are Nurse-Family Partnership and the BC Healthy Connections Project?⁹

Nurse-Family Partnership (NFP) is a landmark primary prevention program developed over 35 years ago in the United States by Dr. David Olds. The program is aimed at improving the lives of young, low-income, first-time mothers and their children, starting prenatally.

NFP has three main goals:

- To improve pregnancy outcomes.
- To improve child health and development.
- To improve parents' economic self-sufficiency.

The implementation of NFP by the health authorities and the scientific evaluation of this implementation by Simon Fraser University are together referred to as the BC Healthy Connections Project (BCHCP).

Why the BCHCP and NFP?

The focus on home visiting programs, and specifically the NFP program, emerged from the joint work of the MoH and the MCFD. Research has shown that home visiting programs help parents improve their parenting skills and enhance the mental health of children. NFP was selected for the study, as the program had been evaluated in the US and has demonstrated many positive outcomes.

In November 2010, the MoH and the MCFD launched *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use*.¹⁰ The Introduction to the plan makes its purpose clear:

*The plan places a strong emphasis on children and families. For the majority, mental health problems originate in childhood, pointing to the need for early intervention to mitigate risk of future illness. Mental health and substance use problems can often be prevented. In other cases, their onset can be delayed and/or their impact lessened.*¹¹

Key NFP Program Elements

NFP offers the following:

- Serves young, low-income, first-time mothers.
- Provides an average of 64 home visits by public health nurses (PHNs). PHNs and mothers work together on topics such as how to have a healthy pregnancy,

⁹ The information in this section is taken with permission from a presentation in 2014 by Dr. Charlotte Waddell, Simon Fraser University, Children's Health Policy Centre.

¹⁰ Ministry of Health Services & Ministry of Children and Family Development. (2010, November 1). *Healthy minds, healthy people: A ten-year plan to address mental health and substance use in British Columbia* [Electronic resource]. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf.

¹¹ Ibid, p. 3.

preparation for childbirth, nutrition, exercise, parenting, child development, future life planning and accessing community resources.

- Builds in flexibility to meet individual and cultural needs.
- Begins early—the first visit is before the 28th week of pregnancy.
- Provides long-term supports until the child’s second birthday.
- Permits PHNs to develop strong and trusting relationships with each mother participating in NFP. This intensive level of support helps women manage the emotional, social and physical challenges they face to gain the confidence to create a better life for their children and themselves.
- Encourages community engagement.

US Scientific Evaluations

Three randomized controlled trial (RCT) evaluations have been conducted in the US: in Elmira, New York (semi-rural, 89% White), in Memphis, Tennessee (urban, 92% African-American) and in Denver, Colorado (urban, 45% Hispanic).

At completion of the RCT evaluations and also during follow-up for 10–17 years following the RCTs, multiple significant positive outcomes were found when children had reached 2 years of age. These positive outcomes include:

Mothers

- Decreased tobacco use (prenatally)
- Increased maternal economic self-sufficiency (over the life course).

Children

- Decreased child maltreatment (early childhood–adolescence)
- Increased cognitive development (early–middle childhood)
- Decreased child behaviour problems (early–middle childhood)
- Decreased youth crime (adolescence).

Service usage

- Decreased use of child protection services
- Decreased use of health care services
- Decreased use of social assistance programs
- Decreased use of youth and adult criminal justice systems.

Finances

- Net returns—US\$2.88 to US\$5.70 for every dollar invested
- Savings accrued across multiple sectors over 10–15 years
- The program “pays for itself.”

Why Evaluate NFP in BC?

NFP may not be more effective than our existing services; we don’t know yet. Many outcomes—for example, the prevention of prenatal alcohol use, of child anxiety,

depression and substance abuse, or of intimate-partner violence—have not yet been fully evaluated.

McMaster’s Offord Centre and Hamilton Public Health Services conducted the first Canadian pilot study. But NFP is untested in Canada beyond the Ontario pilot, and it is important to further test the program in Canada, as there are differences between Canada and the US. For example, there are greater socioeconomic inequalities and fewer universally available health and social services in the US than in Canada.

A few steps are required before implementing NFP in a new jurisdiction; they include the following:

Adaptation

- Modify the program for the local context.

Feasibility and acceptability

- Conduct a pilot study in a small sample RCT.
- Evaluate effectiveness in a large sample at multiple sites.

Expansion

- Disseminate and maintain, with ongoing evaluation.

BCHCP Goals

Conduct a randomized control trial study:

- Evaluate effectiveness in a large sample at multiple sites with 1,000 mothers and children.
- Compare NFP with existing services.
- Conduct a process evaluation.
- Assess feasibility and acceptability of NFP.
- Review the experiences of 75 NFP public health nurses (PHNs) and supervisors in delivering NFP.

Eligibility Criteria

INCLUSION: Women are eligible to participate if they meet *all* inclusion criteria at referral

1. Age 24 years and under

2. First birthⁱ

3. Less than 27 weeks gestationⁱⁱ

4. Competent to provide informed consent, including conversational competence in Englishⁱⁱⁱ

5. Socioeconomically disadvantaged^{iv}

EXCLUSION: Women are ineligible to participate if they meet *any* exclusion criteria at referral

1. Planning to have the child adopted

2. Planning to leave BCHCP catchment area for 3 weeks or longer^v

ⁱ Client is eligible if a previous pregnancy ended in termination, miscarriage or stillbirth, and if previous parenting involved step-parenting only.

ⁱⁱ Mothers must receive their first home visit by the 28th week of gestation, according to NFP fidelity requirements.

ⁱⁱⁱ Must be able to participate without requiring an interpreter.

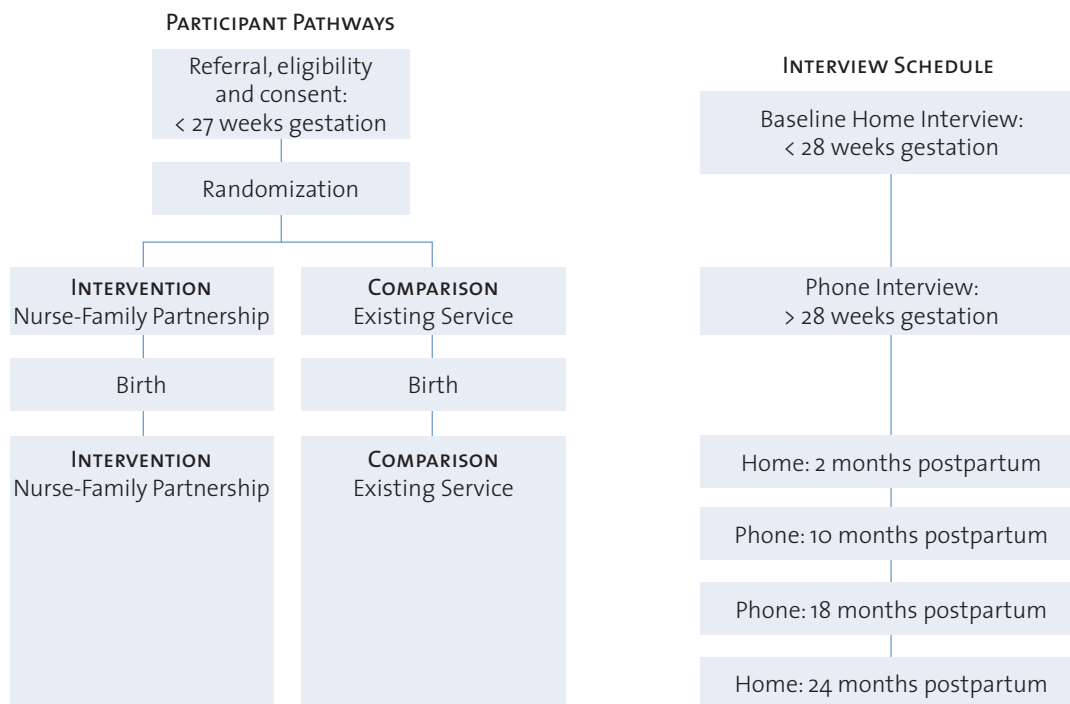
^{iv} Based on indicators associated with increased risk of child injuries.

^v The catchment area comprises designated Local Health Areas within BC All Aboriginal women living off-reserve are welcomed into the program.

Outcome Indicators

Domain	Primary Indicator	Secondary Indicator
Pregnancy		Prenatal alcohol and tobacco use <i>Maternal Self-Report</i>
Child health	Childhood injuries (birth → 24 months) <i>Ministry of Health data on outpatient, emergency, and health care encounters</i>	Child cognitive development (24 months) <i>Bayley Scales of Development</i> Child behaviour (24 months) <i>Child Behaviour Check List</i>
Maternal health		Subsequent pregnancies (24 months) <i>Maternal Self-Report</i>

BCHCP RCT Process



BCHCP Timelines

The BCHCP was planned to happen in two phases: phase one: 2012–2014 (completed) and phase two: 2013–2018 (in progress).

Phase one: 2012–2014 (completed)

- NFP PHN and supervisor education initiated.
- New Canadian NFP curriculum finalized.
- New content added on preventing intimate-partner violence.
- NFP PHN and supervisor basic education completed.
- Practice period of 6–12 months required to hone PHN knowledge and skills with “guiding clients.”
- The “guiding client” mothers and infants are continuing to receive NFP services across BC. These clients will continue until children reach their second birthday.
- Ethics approval provided by Simon Fraser University and five health authorities.

Phase two: 2013–2018 (in progress)

- RCT launched in late 2013.
- Process evaluation launched in 2014.
- Scientific staff recruited.
- Protocols, measures, instruments and databases developed.
- Ethics approval obtained from Simon Fraser University, University of British Columbia, University of Victoria, McMaster University, five BC health authorities and the Public Health Agency of Canada.
- Referral, recruitment and retention procedures piloted.
- Government data-sharing agreements finalized.

A Note about Funding for the BCHCP

No new funding was made available to implement the BCHCP. The funding for the project comes from existing health authority and MoH budgets, which were re-profiled to implement the project.

Next Steps for the BCHCP

- All eligible (and consenting) First Nations and Aboriginal women living off-reserve are welcomed into the BCHCP.
- The BCHCP is seeking ongoing funding for evaluating child and maternal outcomes and cost-effectiveness over the long term in BC—i.e., 10–15 years.
- The BCHCP study will be completed in 2020, at which time the MoH and the health authorities will determine whether or not to offer the program throughout BC.



Feedback on NFP from MCH Coordinators, Health Directors and Working Group Members

How We Asked the Question about the Suitability of NFP for First Nations

At the start of each phone interview and at the start of the group discussions at the MCH coordinator meetings, the consultant provided the following preamble:

“The BC Ministry of Health, the regional health authorities and Simon Fraser University are collaborating on an initiative called the BC Healthy Connections Project. They are studying whether or not the Nurse-Family Partnership program is a good fit for BC families. Our working group is very interested in your ideas so that we can provide advice to the BCHCP. Are you familiar with NFP?”

As anticipated, none of the MCH coordinators or health directors were familiar with the BCHCP, and they knew very little about NFP. At this point, the consultant would provide a brief description of the BCHCP and NFP. She would then ask:

“Based on this brief overview of the NFP goals and program components, do you think the study should be expanded to First Nations communities? For example, do you think it is a program your community would be interested in exploring?”

Limitations of the Feedback

The following feedback is based on two rounds of interviews and discussions. This is an important point, as the advice altered between the rounds, with participants becoming more interested in exploring NFP by the second series of interviews.

The first round of feedback was gathered over a 20-month period from August 2012 through March 2014. For much of this time, the BCHCP was still being established and clients were just being enrolled. Because the BCHCP was in its early stages, the interview participants had very little information on NFP. This lack of available information likely contributed to their reluctance to support the idea that NFP be expanded to on-reserve communities.

An additional limitation is that the individual interviews were conducted with MCH coordinators who worked in communities that were already funded to deliver MCH programs—although this was not true for the working group. Six working members represented communities that did not receive MCH funding.

Did the selection of the interview participants from the funded MCH programs bias the feedback? Would the advice about NFP be different from communities that do not receive MCH funding or do not have well-established programs? These questions led to the decision to engage in a small, focused second round of interviews with health managers from communities not receiving MCH funding, as well as from communities with years of experience working with multiple (and ever-changing) MCH programs and government partners/funders. The second round of feedback was gathered over a much shorter period—7 months—from May 2014 to November 2014.

Round 1 Feedback (August 2012–March 2014)

There were about 50 participants in the initial round of interviews:

- a. Working group members: Three teleconference discussions and three all-day in-person meetings in Vancouver. Approximately 10 working group members participated in the teleconferences and 20 working group members attended each of the three in-person meetings.
- b. MCH coordinators: One 2.5-hour in-person MCH meeting in Vancouver. The meeting had 15 participants. Also, 90-minute telephone interviews with 10 communities. The interviews encompassed 15 participants. (In a few of the communities, the coordinator invited the family visitors to participate in the interview.)

Overall, the feedback from the first round of interviews and discussions sent a very conflicted message. Some participants said, “No thanks. We’re not interested in NFP or the BCHCP study.” Other participants, who represented communities in need of more resources, were hesitant to comment on NFP at all. These participants were nervous to decline any opportunity to explore potential funding sources, even though they knew very little about NFP and whether or not it would be a fit for their community.

The core messages from the first round of discussions can be broadly summarized as:

“I don’t think we need NFP—but maybe some communities might want it. We’re already implementing excellent, culturally appropriate programs. How about putting resources toward adequately funding existing programs?”

“Let’s address the inequity issues before we look at new programs. There are big discrepancies in funding amounts between communities. And there are communities right now who don’t have any MCH funding. Let’s fund them before we start new and different programs.”

“We don’t really know anything about NFP. We’re not sure if it would work for First Nations communities. But if NFP is the only funding source available, well maybe we need to be open to it. But why must we continually reinvent the wheel? We would prefer, and appreciate, MCH funding if it is available.”

Additional concerns and reluctance focused on the following five themes:

Requirement to conduct a study and the study design

Participants were concerned about the requirement to first test the program before they could implement it. Where would they find the funding to do this? And if there was funding to evaluate, shouldn’t resources be put to studying existing programs first?

Concerns were also expressed about the RCT study design. This did not seem feasible or desirable in small communities, nor did it align with community-based qualitative research approaches.

What would be the ethics approval process? Some of the working group had heard about the protracted ethics approval process that the BCHCP had gone through and they wondered if this would be a problem for First Nations.

Important Update: Subsequent to this concern being raised in the first round of interviews, members of the BCHCP Scientific Team met with Dr. Olds in March

2015 to clarify whether or not it would be necessary to conduct an additional study in First Nations communities before expanding NFP to on-reserve communities, should the current RCT show NFP's success, and should the program be offered when the BCHCP is fully completed in 2020. Dr. Olds confirmed that an additional study would *not* be required, particularly because the BCHCP currently includes First Nations women and children who are living off-reserve. He did stress that he would want NFP to be adapted for First Nations communities prior to widespread delivery, however. He also said he hoped that First Nations would commit to doing their own evaluations, as they would with any new public health program. The BCHCP Scientific Team is also committed to assisting with any adaptations and evaluations, should First Nations wish to pursue this.

Community and cultural fit

Participants wondered if the NFP curriculum is culturally appropriate for their community. Does it have an American bias or reflect American Indian, rather than Indigenous/Canadian values? And if it is not a fit, is it possible to adapt it? Participants had heard that program facilitators must adhere to all 18 of the fidelity requirements.

Participant eligibility criteria

Existing MCH community programs are more inclusive and provide a broader range of services than does NFP. For example, current MCH programs are open to women of all ages, at any stage of pregnancy, and provide support until a child is 6 years of age. Participants saw NFP as providing a restricted and more limited service to women and children. They were concerned this would be a serious setback, not an improvement to current services.

Program staffing

Participants expressed concern that NFP requires BScN-trained nurses to deliver the program and do the home visits. This did not seem necessary, sustainable or financially feasible, and was a significant point of concern.

Communities are delivering effective home visiting services through lay professionals, sometimes in addition to social workers and nurses. These home visitors are trained and have built trust in the community. Research on home visiting programs is starting to show that lay helpers can be just as effective as nurses in affecting program outcomes.

Rural and remote communities already find it challenging to recruit nurses, and several communities have long-standing vacancies. They have experienced a high turnover in staff as nurses leave to be closer to their own families elsewhere. This situation has made continuity of care a challenge.

Communities are committed to developing their own community capacity and see the value in training their own members, who are likely to stay in the community, to deliver these programs.

Funding and partnerships with funders

Given that there is no “new” money or special budget to expand NFP to First Nations communities, where would the funds come from? Participants wondered if the MoH had plans to make funding available in the future—and if funding was made available to expand the program to First Nations communities, who would control the funds?

Who would lead the project? Would communities receive the money directly? Would they have the freedom to implement in their own way, or would they be required to adhere to health authority or MoH policies and procedures?

Several participants have excellent working relationships with their regional health authority; however, some do not, and these communities are cautious about entering into partnerships.

Round 2 Feedback (May 2014–November 2014)

There were seven participants in the second round of interviews:

- a. Three health managers from communities not receiving MCH funding
- b. Two health managers from two large First Nations communities receiving funding, plus two home visitors who attended one manager's interview.

In this second round, the consultant gave a fuller description of the BCHCP and was able to say more confidently that NFP could be adapted, as it had been in the US. She spent more time asking follow-up questions and generally drawing out the participants' opinions and ideas about expanding the study to First Nations communities.

As well, the working group further discussed the NFP question at its May 2014 in-person meeting. By this time, the working group had been meeting for almost 2 years, and the group members knew more about the BCHCP and NFP. There had been reports from the BCHCP team, and the consultant shared lessons learned and insights from the meetings with Dr. Olds and White Earth Nation.

The additional information helped the working group to better understand how NFP could be adapted, and provided some reassurance that it wasn't an "either this or either that" situation. It introduced the possibility that maybe there was a way to work with different models and different funders to bring more services to communities in need. The working group still had important questions—and many of these questions remain unanswered—but overall, there seemed to be more openness to the BCHCP and NFP.

Keep the door open for offering NFP in the future

Feedback from the second round of interviews and discussion validated and echoed the five themes from the first round—BUT with a couple of key differences. This time participants expressed more openness and raised a critical point that was not so clearly raised in the first wave of interviews. This time, the core message was:

"We should keep the door open for working with the health authorities on delivering programs such as NFP. It might work for some communities. Some communities might embrace the opportunity. And if it can be adapted, it might enhance current services and give communities another source of funding. Each health authority needs to connect with the First Nations in their region and have their own discussion. The relationships need to be built at the local community level, and the decisions need to be made in collaboration between the health authority and the First Nations community or Aboriginal organization."

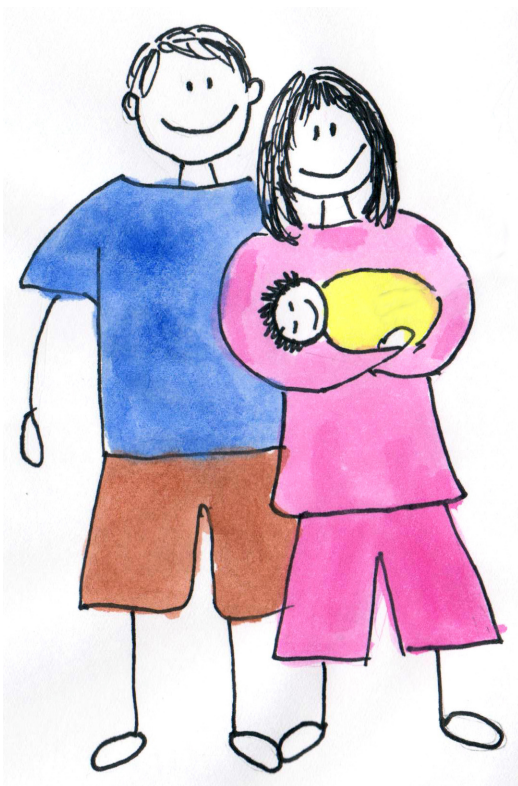
A second core message that had not come across as clearly during the first set of interviews focused on government's responsibility to provide services and funding to First Nations communities on-reserve:

"Health authorities and the Ministry of Health need to understand that ANY program that is offered by the health authorities to the residents in their region needs to also be offered to First Nations communities. It should not be an afterthought, and health authorities should not 'wonder if....' It needs to be part of the health authority's regular and normal business practice to include First Nations and First Nations on-reserve communities in their service planning and budgets."

"The Ministry of Health and the health authorities have a shared responsibility to provide services. It can't just be about the federal government, or the FNHA. All governments have a role to play and need to collaborate and share resources."

The participants had this to say on the topic of the working group providing advice to government and the health authorities:

"Together, the First Nations communities and health authorities can determine the best way to implement NFP, or not. The Ministry of Health, the FNHA or working groups should not make decisions for communities. Communities have the right to and want to work directly with the health authority in their region and build their own local relationships and networks."



Summary of Feedback: Four Key Points

In summary, the following key messages were gathered:

Keep the door open to work with the BCHCP and NFP. Communities will decide for themselves if NFP is the right fit for them.

Some communities may embrace this opportunity when and if it becomes available in 2020. NFP might be useful for some communities to augment and enhance existing services. It is up to the First Nations communities to decide whether or not they want to implement NFP—or any other initiative. Health authorities and First Nations need and want to build relationships at the local level and make these decisions together. The FNHA, the MoH and working groups should not make decisions on behalf of communities.

Ensure that any programs or initiatives offered by the health authority or the Ministry of Health to residents of BC are also be offered to First Nations communities.

Interview participants sent a clear message that governments and health authorities have a shared responsibility to provide services to First Nations communities.

Address funding and service inequities before introducing new programs.

Interview participants raised the issue of inequities in funding and service levels between communities. They noted that sometimes introducing new programs can inadvertently increase these disparities. They recommended conducting an analysis of current programs and services and prioritizing funding to communities that do not have maternal and child health programs.

Support adaptations and enhancements to the NFP curriculum.

NFP may be appropriate for some communities with adaptations and enhancements. Some of the possible adaptations that were identified are making cultural additions to the curriculum, expanding the program to all pregnant women of any age, offering support for children up until age 6 and not making the hiring of BScN nurses a requirement.

Advice from Dr. David Olds

In April 2013, the consultant, the BC Ministry of Health staff and BCHCP team members met with Dr. David Olds (developer of NFP) by teleconference to seek his advice and guidance based on his experience working with Alaskan Native and American Indian communities. Dr. Olds' responses to four main questions are described below.

How Have You Approached Implementation of NFP in American Indian Communities?

The US experience has been to take it slowly and to understand people's natural skepticism toward NFP. They want people to take their time and not feel any pressure to adopt a particular model.

This process has been very much supported and facilitated by the Patient Protection and Affordable Care Act HR3590 (PPACA)¹²—most commonly referred to as Obama's Affordable Care Act, or Obamacare. In May 2010, this legislation set aside funding and provided mechanisms for Alaskan Native and American Indian communities to explore various home visiting programs before choosing which programs might work best for them. **Note: This is a critical point. The PPACA legislation enabled the federal government to offer community grants. The grants provided the resources for communities to dedicate up to one year to explore models and plan their services, as well as provided funding to implement 5-year pilots.**

People have grown to understand NFP and embrace it. Positive experiences have been communicated from one community to the next. Over time, communities have approached the National Service Office and asked to pilot the program.

Five communities are piloting the program:

- The Southcentral Foundation serving Alaskan Natives and American Indian families in the greater Anchorage, Alaska area
- The White Earth Band of Chippewa in Minnesota
- The Fond du Lac Band of Lake Superior Chippewa in Minnesota
- The South Dakota Health Department serving the Oglala Lakota Native Americans on the Pine Ridge Reservation
- The Port Gamble S'Klallam Tribe in partnership with the Jefferson County NFP program in Washington State.

What Adaptations Have Communities Made to the Model?

Dr. Olds reported that the National Service Office did not require a cookie cutter approach—and that openness has led to genuine collaboration. The program was designed to be respectful, and it resonates well with Indigenous populations. They believe adaptations are necessary but need to be done collaboratively, to ensure that the adaptations are not at variance with the core principles of the program.

¹² See the "Subtitle L—Maternal and Child Health Services" section starting on page 245 of the act. Retrieved from <http://obamacarefacts.com/wp-content/uploads/2014/10/obamacarebill.pdf>.

The number of requested modifications has been small. A key modification has been to open the program to *multips*, a term referring to multiparous women, or women who have given birth more than once. They have also made enhancements to their facilitator tools and materials, to ensure they are culturally respectful and aligned with the community's values and needs. For example, the language and approach to reducing tobacco use needs to be modified in communities where tobacco is used culturally and in ceremony. Another issue is the program prohibition on keeping firearms in the home. This prohibition needs to be adapted in rural and remote communities. Some people must keep a firearm in their homes to hunt or to protect themselves from bears, for example.

They use the term “formative evaluation” to describe the process of implementing, learning about and adapting the program. “Formative evaluations stress engagement with stakeholders when the intervention is being developed and as it is being implemented, to identify when it is not being delivered as planned or not having the intended effects, and to modify the intervention accordingly.”¹³

In addition to conducting their formative evaluation, they have received funding from the Hearst Foundation to create communities of practice and thereby support one another in serving Indigenous populations.

What Lessons Have You Learned So Far?

According to Dr. Olds, the communities are still in the early stages of collecting data and therefore it's too soon to say what impact the program is having. But one critical lesson so far is to put sincere efforts into building relationships and to collaborate right from the start. It takes time and patience to build trust.

When it comes to working with Indigenous populations, they do not have a “tightly buttoned-down” time frame for developing and evaluating the program. They want it to evolve thoughtfully and inclusively. They understand they are learning as they implement. The main lesson has been to take it slowly, and to allow communities to explore in their own time and at their own pace. It's quality, and not quantity, that counts.

They are curious about how the outcomes might differ between Indigenous communities and other populations—for example, in smoking rates, the decision to have other children and the timing of pregnancies. Dr. Olds said,

“I want to use good science and good practice to help children and families.”

What Advice Do You Have for Us in British Columbia?

Dr. Olds and his team have offered themselves as a resource to the working group and to the Strategy Table in BC. They are very interested in how NFP might work in Canadian Indigenous communities.

¹³ From page 1 of Geonnotti, K., Pelkes, D., Wang, W., & Smith, J. (2013, March). *Formative evaluation: Fostering real-time adaptation and refinements to improve the effectiveness of patient-centered medical home interventions*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from http://pcmh.ahrq.gov/sites/default/files/attachments/FormativeEvaluation_032513comp.pdf.

Guidance from the US NFP National Service Office

In June 2013, the consultant and Ministry of Health staff met with Jeanne Anderson, Nurse Consultant, and Connie Frederick, Nurse Educator for the Nurse-Family Partnership National Service Office¹⁴ by teleconference to learn about their experience working with Alaskan Native and American Indian communities.

What Lessons Have You Learned So Far?

Jeanne and Connie stated that at least six lessons or approaches are critical:

- You need to be invited into the community. There are good reasons why there is mistrust. This program (or any other program) should never be thrust on a community. For example, in one case NFP was introduced by the state, and not at the invitation of the community, and it was not successful.
- In another case, the state did not take the time to build relationships with the Elders and the tribal leaders, and as a result, the community ended up withdrawing from the study. They are now at a stage of re-engaging and starting over with relationship building. You cannot skip relationship building and expect to be successful.
- The tribes expect the state (or partner) to understand and respect Indigenous sovereignty.
- The government partner needs to understand the impact of historical trauma on Indigenous people, and realize this trauma is still current and ongoing. A trauma-informed approach is critical.
- You need to respect the differences between “collective cultures” versus “individualistic cultures” and adapt your practices and approaches accordingly.
- Any program must be rooted in the community’s values.

What Adaptations Have Been Helpful?

First of all, the communities offer the program to multip women and there is no age restriction. In addition, places are left open in the binder where communities include their own curriculum on Traditional and cultural ways of dealing with trauma and grief, for example.

Jeanne and Connie also recommended some other adaptations:

- Include Traditional and cultural people in the delivery of the program. Offer options for women who want to connect with Traditional people and cultural advisors.
- Continually reflect on your practice and base your adaptations on these questions: “How can we ask our clients questions in the most culturally respectful way? How can we use the language? What images and words can we use that would better resonate with the women?”
- Use the language of the specific tribe. Several of the community pilots are translating the headings in the NFP binder into the language of their tribe.

¹⁴ For more information about the National Service Office please see <http://www.nursefamilypartnership.org/Communities/National-Service-Office>

Experience of the White Earth Nation, Minnesota

In August 2013, the consultant met in person with six nurses from the community nursing team who are responsible for implementing NFP at White Earth Nation in Minnesota. The Nation's NFP program evaluator also participated in the meeting.

White Earth Nation is a large Chippewa American Indian reservation in north-western Minnesota, with a population of about 9,800 people. It is estimated that about 4,500 people live in the community. About 20–30 babies are born each year, and approximately 135 women are enrolled in NFP.

White Earth Nation was the first American Indian community to pilot NFP and the first to become certified to deliver NFP services. Interestingly, the White Earth Nation had already explored NFP as a potential model before Obama's Affordable Care Act became legislation in 2010. Their health team reviewed several models available at the time and decided NFP best met their needs. They had already completed one year of their own pilot when the 5-year grants became available through Obamacare.

At the time of this interview, the community was just completing its third year of a 5-year federally funded project to pilot and evaluate NFP. They had started their pilot in 2011.

What Has Been Your Experience Piloting NFP So Far?

NFP is not the first maternal and child health program for White Earth Nation. The community has implemented several good programs over the years—and more importantly—the nurses, health staff and community workers have been establishing trust and building relationships for many years. NFP has been able to leverage these networks and relationships—it wouldn't have been possible to implement NFP services if these relationships weren't already in place, and if the nurses themselves had not already established rapport and trust with the families.

NFP provides a comprehensive curriculum and tool kit for nurses. The training provides consistency—a “universal” style of nursing—and gives nurses a common language. It has been helpful to work from the same model, as it makes it easier to collaborate and it supports effective case consultation.

White Earth Nation recognizes the intense emotional and physical demands of this work and the high rates of nurse burnout. In an effort to better support their health care staff, they have “institutionalized” regular self-care for nurses into their practice. Every 2 weeks, nurses are allowed 4 hours of paid work time to engage in some rejuvenating activity, which might include, for example, attending a meditation or yoga class, undertaking self-directed study through journaling and reflection, participating in a training workshop or attending a ceremony.

But self-care alone is not enough—they have implemented two other key strategies to help mitigate the effects of “vicarious trauma” in working closely with families in crisis where abuse, addictions and despair run high:

- They work in pairs—two nurses per family. This has been a particularly helpful strategy to support continuity of care for clients, to mitigate burnout, to cover

sick days and holidays, and to provide better support to deal with potentially dangerous or charged encounters.

- They hold weekly meetings and case conferences.

So far, it has been a positive experience, but it has not been without its challenges.

What Are Some of the Challenges?

Reporting and data collection issues: Because this pilot is part of a very large national study to determine the effectiveness of the NFP approach, the reporting requirements are complex and intensive. Sometimes the nurses find these requirements onerous and don't always agree with the indicators. Nor do they feel confident that clients feel free to answer honestly—for example, when they are asked questions about drug and alcohol use or smoking. The nurses believe that women may understate their substance use or not report it accurately for fear of child welfare agencies getting involved and apprehending their children.

The nurses wonder if it might be more useful to ask some of these questions again, later in the woman's journey, perhaps after the baby is born. They suggest asking a woman to reflect on an earlier time—asking something like, “When you were first pregnant, did you use?” and “What helped you to make better choices in the early stages of your pregnancy?” The nurses also wonder if allowing the woman to tell her story later in her journey—from a perspective of “looking back on it”—if this reflection could add another dimension to the picture and perhaps provide more accurate data.

The visiting schedule: The nurses think the strict visiting schedule outlined in NFP doesn't work well for clients in crisis, or with chaotic lives. They flex the visits to accommodate clients' needs.

Recruitment of nurses with a 4-year BScN degree: White Earth Nation's health team has found it challenging to hire only BScN nurses to fill the positions. They wonder whether this requirement is in fact necessary—especially in areas where recruitment of health care providers is already a challenge, as the requirement becomes an additional barrier. They have hired registered nurses (RNs) and have found these nurses to be very effective in their roles. In their experience, it is more important to focus recruitment on attracting nurses whose values are aligned with the community's values, who are emotionally and socially intelligent, and who practise in a culturally safe and respectful manner. They want their nurses to have the personal skills to connect with clients in a kind and non-judgmental way. In their experience, RNs who meet the above criteria can be trained in the NFP model and are just as effective as the nurses with the BScN credential.

What Are Some of the Adaptations You Have Made?

White Earth Nation's health team refers to the changes in NFP as enhancements rather than adaptations. They are concerned that if they use the term adaptation, people might think they have watered down the program or weakened it in some way. They use the term enhancement because not only does their program meet all of the NFP's 18 fidelity requirements, but also it is even more robust because they have added cultural components into the curriculum, opened the program to multiples and included pregnant women of any age.

Two examples of curriculum enhancements are:

- Using a circle model (such as a medicine wheel) rather than the “coat of arms” model that is suggested in NFP binder, to explore the women’s values and goals
- Holding a woman’s baby or child to model parenting behaviour. The nurses do not use a doll when they are teaching or modelling baby care. They find that using a doll feels awkward and contrived to their moms. Culturally, it is quite appropriate to hold a baby or child and model the parenting behaviour. In fact, in the Anishinaabe culture, it is considered a very good thing to show love and affection and form a direct relationship with a woman’s child.

The nurses make use of incentives to encourage the women to participate. Women earn “points,” which can be exchanged for items and services.

What Advice Do You Have for Us in British Columbia?

The nurses had three main points to make concerning how to proceed in BC:

- Be patient—it can take up to 3 years before you build a relationship with a woman and her family. The best way for a woman to hear about your program is word of mouth from her friends and family. If the program/the nurse has been helpful to the woman, she will tell others, and that’s how the program becomes part of the community. You cannot rush this stage.
- When you do connect with a woman, do not rush to get through the “planned activities in the binder” during a visit. This isn’t about following your agenda and checking off the boxes. Women will disconnect if you do that. Nurses have been trained to be very task-oriented, but they need to slow down and follow the woman’s lead. A successful visit is a visit where the woman feels heard and supported.
- A supportive team leader and a supportive team are critical. You cannot do this work in isolation. Your team leader needs to allow you to do your job in your own way, yet at the same time be there for you and support you to be effective.

Lessons Learned from White Earth Nation’s Evaluator

The consultant met again with White Earth Nation’s NFP program evaluator Cyndi Anderson by teleconference in December 2014 for a progress report on the NFP pilot projects and on any further lessons learned since the August 2013 meeting.

White Earth Nation has completed 4.5 years of the 5-year project; however, the federal government has extended all of the American Indian and Alaskan Native pilot projects by an additional 2 years. In keeping with the principles of formative evaluation, it was clear that implementation challenges needed to be addressed along the way and valuable community feedback incorporated. The 5-year schedule simply did not allow adequate time to work through start-up and implementation issues. Extending the projects for an additional 2 years gives communities a better chance to gather valuable data and more accurately gauge the program’s impact.

It is important to pause here and to remember that the experience of these pilots will determine whether or not targeted funding for NFP in American Indian and Alaskan

Native communities will be included as part of the federal budget. The White Earth Nation pilot, as well as the other four pilots, need to demonstrate how this program has been effective. To that end, the data collection framework includes 35 constructs and six benchmarks.¹⁵ The six benchmarks are:

- Maternal and Newborn Health
- Child Injuries, Child Abuse, Neglect or Maltreatment, and Reduction of Emergency Department Visits
- School Readiness and Achievement
- Crime or Domestic Violence
- Family Economic Self-Sufficiency
- Coordination and Referral for Other Community Resources and Supports.

This is a highly complex and detailed evaluation. Some of the implementation challenges have resulted from database/data system conflicts.

Since We Met in August 2013, Do You Have Further Insights or Lessons to Share?

White Earth Nation is not conducting an RCT, as the RCT study design would require some of the women seeking services to be assigned to a control group that would not be offered the same full range of services. Although the RCT would provide comparison data, it would also create an ethical dilemma for White Earth Nation, as it conflicts with the cultural and community value of never denying service to any woman or family. Instead, the community is conducting a qualitative study, which will also provide excellent data and is more aligned with the community's values.

About 135 mothers are enrolled in the study. They include women of all ages, as well as first-time mothers and multips.

White Earth Nation works with two data systems to collect information. It has created its own data system, which it owns and controls. All data about participating families are entered into White Earth's data system, which maintains information on all moms and their children of all ages. The Nation also works with the NFP federal data system, which is designed to only accept data that meet the NFP criteria for the national study—for example, data on first-time moms under the age of 25 and data on children from 0–2 years. White Earth extracts the pertinent data from its data system and uploads the appropriate data file to the federal system for inclusion in the national study.

One of the big lessons has concerned responding to the database/data system challenges—and determining the best, most relevant information to collect. Creating and learning to use the data collection system was a huge and complex undertaking—the work of this cannot be underestimated. It was critical to involve the organizational and community leaders, as well as the front-line staff, in learning about the system and understanding why it is important to collect information and monitor progress. **Staff engagement or lack of it will “make or break the data.”**

Many communities have had negative experiences with research, data collection and evaluation. There are good reasons for communities to mistrust universities and

¹⁵ See Appendix C for the complete list of benchmarks and constructs.

governments; therefore, it is essential to spend quality time with people, ensuring everyone has been involved in the process and understands how to collect good data and why this information is critical to delivering effective services.

Communities want the data to “tell a meaningful and respectful story.” The data story needs to validate the services, and show the staff that the work they do makes a difference—the data collected at the “street level” need to make it to the “policy level” and improve funding and services for the people.

How Have You Responded to the Challenges?

The evaluator sits down with staff to show them how to use the data system and why their input is critical. She explains why the charting needs to be done well and how it can make or break the data. The health team are integrating iPad and iPhone applications to assist the nurses in their charting and data collection. These devices make it easier to input the information during or very soon after a visit with a family.

The White Earth Nation has created a case management system called “WE CARE.” “WE” stands for White Earth, while “CARE” is an acronym for coordination, assessment, resources and education. This case management system has been implemented across all social and health departments. It puts clients at the centre, providing a mechanism to improve staff performance and service quality, and revealing duplications and gaps in services. For example, they discovered that sometimes three or four helpers from different programs were seeing the same family. These service providers were often unaware of each other and were not collaborating or coordinating services.

Another example of duplication occurred with the way the Ages and Stages Questionnaire (ASQ) assessments were administered. Again, families were sometimes asked to complete the same questionnaire multiple times because different helpers were not coordinating their services. The case management system also helps prevent families from falling between the cracks and reveals gaps in services. For example, it can show if a family has missed visits or not received a referral.

What Are Some of Your Early Findings About the Impact of the Program?

It is too soon to say with certainty; however, the following changes are indicated:

- An increase in breastfeeding
- An improvement in infant and child health
- An increase in referrals to other programs
- The potential for a decrease in harsh parenting
- Decrease in smoking and in drug and alcohol use in some cases—although it is too soon to say with certainty, as the community is also seeing an increase in heroin and meth use in some families.

In addition, there has been a decrease in staff turnover in the maternal and child health programs, perhaps because of the improvements in training, coordination and support.

There is definitely an increase in the tribal understanding of the importance of data collection and good evaluation, and an increase in tribal capacity to create and manage

data systems and case management systems. A big win is that the tribe understands, owns and manages its own data. White Earth Nation can now tell its own story!

What Additional Advice Do You Have for Us in British Columbia?

Cyndi made four suggestions of particular value for BC:

- Build the right data system—this is critical.
- Ensure the data system is useful beyond the life of the pilot project.
- Involve the community leadership. These programs need to be part of the community’s vision.
- Be patient—this work takes time.

Summary of Early Lessons from the US Experience

Community choice: Communities must choose the program, not have it thrust upon them. Overall, yes, NFP can work well in Indigenous communities if the communities themselves choose it and if they can make the modifications and enhancements to align it with their community values and ways of working.

Trust and relationships: Time is needed to build trust and relationships. It is critical to take a community development approach and to take the time to build truly collaborative relationships.

Staff: White Earth Nation found that RNs are just as effective as BScN nurses in their roles. The focus needs to be on recruiting and training staff who are culturally competent and emotionally intelligent and who know how to build trust with families.

Client eligibility: NFP appears to work best if it is open to women of all ages, first-time moms as well as multips, and if the program supports families until their children reach at least the age of 6 years.

Curriculum: Communities can enhance the program by using their own language and integrating cultural components.

Data systems: Creating the right data system is time consuming but is essential for success. Communities have the right to own their own data and tell their own story.

Community leadership and vision: Community leaders must be involved, and this work needs to be part of the community vision. Informed and supportive leaders are essential to the success of the program. The program needs to be part of the community’s overall vision of health and healing if it is to be fully embraced and supported.

Where to from Here? Six Recommendations

The discussions over the past 2.5 years provide a response to the main question the working group set out to answer: “Is Nurse-Family Partnership a fit for First Nations communities in BC?” The response is,

“Maybe yes and maybe no. Keep the door open and support First Nations Communities to decide for themselves.”

The following six recommendations offer potential next steps:

For the Strategy Table:

1. Stay connected with the BCHCP team until the project’s completion in 2020.
2. Request that the MoH refresh the December 2011 Ministry of Health briefing document on birth estimates and possible NFP sites.

For the FNHA:

3. Work with First Nations communities and health authorities at the regional and community level to identify communities who might be interested in implementing the program if it becomes available in 2020.

For all partners:

4. Conduct an analysis of current MCH and ECD programs and services to identify inequities and needs.
5. Explore possible funding options for the NFP after the BCHCP is completed in 2020.
6. Collaborate with all partners who deliver MCH and ECD programs, such as the MCFD and non-governmental organizations, to better coordinate services.

Appendix A: The First Nations and Aboriginal Maternal and Child Health Promising Practices Working Group Members¹⁵

	Name	Organization
1.	Alma Zukanovic	FNIH, Health Canada
2.	Avery Kelly	BC Ministry of Health
3.	Charlotte Waddell	Simon Fraser University
4.	Cheryl Sauve	Seabird Island
5.	Dena Carroll	BC Ministry of Children and Family Development
6.	Denelle Bonneau	Penticton Indian Band
7.	Donna Jepsen	BC Ministry of Health
8.	Donna Moore	Nisga'a Health
9.	Eden Foreman	Heiltsuk Health
10.	Eileen Ruth	Kwadacha First Nation
11.	Ellen Newman	BC Aboriginal Association of Friendship Centres
12.	Jan Tatlock	Island Health
13.	Jeanette Callahan	Nuu-chah-nulth Tribal Council
14.	Joan Geber	BC Ministry of Health
15.	Joanne Woodridge	Vancouver Coastal Health
16.	Kayla Serrato	First Nations Health Authority
17.	Lerinda Wright	Sto:lo Nation
18.	Leslie Fournier	Lower Similkameen
19.	Liz McKay	Nuu-chah-nulth Tribal Council
20.	Nicole Gibbons	First Nations Health Authority
21.	Patricia Hoard	West Moberly First Nations
22.	Rick Kuzyk	FNIH, Health Canada
23.	Tara Nault	BC Ministry of Health
24.	Lucy Barney	Aboriginal Health, Perinatal Services, PHSA

¹⁵ Please note that not all members were able to attend all the meetings. As well, there were staff changes over the 2-year period—for example, BC Ministry of Health and FNIH staff changes, as well as new members joining from the First Nations Health Authority after the transfer in October 2013.

Appendix B: First Nations and Aboriginal Maternal and Child Health Promising Practices Working Group Revised Terms of Reference (April 2013)

PURPOSE	<ul style="list-style-type: none"> • To identify existing MCH programs in BC aimed at Aboriginal and First Nations women. • To explore the need for, and viability and acceptability of providing the Nurse-Family Partnership (NFP) program to Aboriginal and First Nations first-time expectant women living on-reserve in BC. • To produce a document that highlights promising practices in MCH programs and provides recommendations on programs that should be evaluated and/or considered for broader implementation.
REPORTS TO	The Aboriginal Perinatal Planning Committee
FUNCTIONS	<ul style="list-style-type: none"> • Review information on existing services and programs for Aboriginal and First Nations expectant women in BC, (and their accessibility by First Nations people—geographically, culturally, economically). • Review culturally safe and respectful approaches. • Guide the development of a report with findings and recommendations. • Provide advice and guidance to the BC Healthy Connections Project.
FREQUENCY OF MEETINGS	<ul style="list-style-type: none"> • Teleconferences every 6 weeks (1.5 hour teleconferences). • Two face-to-face meetings (all day). • Meeting frequency will be evaluated on an ongoing basis.
MEMBERSHIP	<ul style="list-style-type: none"> • At least five First Nations and Aboriginal representatives who have experience delivering maternal child health programs in their communities and/or organization. • Membership will consist of personnel from the federal and provincial systems who have responsibility and work within the Aboriginal maternal and child health subject area, and must align with the “Tripartite Way of Working” model (see the Tripartite Management Team’s document, <i>Health Actions Implementation Approach</i>, published February 2010).
TIMELINE	September 2012 to March 2015

Appendix C: White Earth Nation Benchmarks, Constructs, and Performance Measures

Benchmark 1: Maternal and Newborn Health

CONSTRUCTS

Prenatal care

Performance Measure: Percent of women who receive prenatal care by the end of the first trimester. (Outcome)

Parental use of alcohol, tobacco or other illicit drugs

Performance Measure: Percent of women who remain alcohol, tobacco- or otherwise drug-free from time of enrollment to 12 months post-partum. (Outcome)

Inter-conception care

Performance Measure: Number of mothers receiving information on inter-conception care between birth of first child and conception of second. (Outcome)

Inter-birth intervals

Performance Measure: Number of maternal subsequent pregnancies while in the program. (Outcome)

Screening for maternal depressive symptoms

Performance Measure: Number of mothers screened for depression. (Process)

Breastfeeding

Performance Measure: Number of mothers breastfeeding at birth. (Outcome)

Well-child visits

Performance Measure: Number of children receiving well-child visits at age appropriate intervals. (Outcome)

Regular visits to a primary health care provider or medical home (this could include traditional medicine) for both mothers and children

Performance Measure: The number of mothers and children who routinely visit their primary health care provider or medical home, including traditional medicine. (Outcome)

Maternal and child health insurance status

Performance Measure: The number of mothers and children who have health insurance coverage or who receive medical care through Indian Health Service (IHS). (Outcome)

NOTE: The White Earth Nation sees a distinct difference between mothers and children who have health insurance coverage and those who utilize IHS, which is not an insurance program; rather, it is an entitlement program. We will list each of these separately, as to only list those with health insurance coverage would provide a skewed perspective, since IHS is not a health insurance program.

Benchmark 2: Child Injuries, Child Abuse, Neglect or
Maltreatment, and Reduction of Emergency Department Visits

CONSTRUCTS

Visits for children to the emergency department from all causes

Performance Measure: Number of ER/urgent care visits and number of hospitalizations requiring overnight stays. (Outcome)

Visits of mothers to the emergency department from all causes

Performance Measure: Number of maternal ER/urgent care visits. (Outcome)

Information provided or training of participants on prevention of child injuries

Performance Measure: Number of participants receiving information or training on injury prevention. (Process)

Incidences of child injuries requiring medical treatment

Performance Measure: Number of child injuries requiring medical treatment. (Outcome)

Reported suspected maltreatment for children in the program

Performance Measure: Number of children referred for suspected maltreatment. (Outcome)

Reported substantiated maltreatment for children in the program

Performance Measure: Number of substantiated maltreatment cases as compared with number of non-program participants. (Outcome)

First-time victims of maltreatment for children in the program

Performance Measure: Number of children in program who are first-time victims. (Outcome)

Benchmark 3: School Readiness and Achievement

CONSTRUCTS

Parent support for children's learning and development

Performance Measure: Percent of parents supporting children's learning and development. (Outcome)

Parent knowledge of child development and their child's developmental progress

Performance Measure: Percent of parents demonstrating knowledge of their child's developmental progress. (Outcome)

Parenting behaviors and parent-child relationship

Performance Measure: Percent of parents demonstrating increased positive interactions in parent-child relationships. (Outcome)

Parent emotional well-being or parenting stress

Performance Measure: Percent of parents screened for depression. (Process)

Child communication, language and emergent literacy

Performance Measure: Percentage of children being screened for communication skills. (Process)

Child's general cognitive skills

Performance Measure: Percent of children screened for cognitive skills using the "Problem Solving" subscale. (Process)

Child's positive approaches to learning including attention

Performance Measure: Percent of children screened in "Personal-Social" subscale and total ASQ score. (Process)

Child's social behavior, emotion regulation and emotional well-being

Performance Measure: Percent of children screened for social behavior, emotional regulation and emotional well-being. (Process)

Child's physical health and development

Performance Measure: Percent of children screened for physical growth standards for age. (Process)

Benchmark 4: Crime or Domestic Violence

CONSTRUCTS

Domestic violence: Screening for domestic violence

Performance Measure: Percent of women receiving screening. (Process)

Domestic violence: Of families identified for domestic violence, number of referrals made to relevant violence services

Performance Measure: Number of referrals made to domestic violence or victim services. (Process)

Domestic violence: Of families identified for the presence of domestic violence, number of families for which a safety plan was completed

Performance Measure: Of families identified for domestic violence, number of safety plans made. (Process)

Benchmark 5: Family Economic Self-Sufficiency

CONSTRUCTS

Household income and benefits

Performance Measure: Increase in total household income and benefits over time. (Outcome)

Employment or education of adult members of the household

Performance Measure: (1) Increase in the educational attainment of adults participating in households over time. Educational attainment shall be defined by the completion not only of academic degrees, but also of training and certification programs. (2) Increase in the number of paid hours worked plus unpaid hours devoted to care of an infant by all adults in participating households over time. (Outcome)

Health insurance status

Performance Measure: The number of mothers and children who have health insurance coverage or who receive medical care through IHS. (Outcome)

Benchmark 6: Coordination and Referral for Other Community Resources and Supports

CONSTRUCTS

Number of families identified for necessary services

Performance Measure: Percent of families screened for maternal depression and related needs. (Process)

Number of families that required services and received a referral to available community resources

Performance Measure: Percent of families requiring services that receive a referral. (Process)

Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies

Performance Measure: Number of agencies with a partnering relationship with home visiting program. (Process)

Number of completed referrals

Performance Measure: Number of completed referrals documented in client's chart. (Process)

MOUs: Number of Memoranda of Understanding or other formal agreements with other health or human service agencies in the community

Performance Measure: Number of MOUs maintained as part of program implementation. (Process)

