Bringing in Care:
Evaluation of the Middlesex-London Health Unit Neighbourhood Health Care Program

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Abbreviations Used in This Report

EYRC	Early Years Resource Coordinator
LIHC	London Intercommunity Health Centre
MLHU	Middlesex-London Health Unit
NP	Nurse Practitioner
OEYC	Ontario Early Years Centre
PHCTF	Primary Health Care Transition Fund
PHN	Public Health Nurse
WBC Clinics	Well Baby/Child and Breastfeeding Clinics (also referred to simply as Well Baby Clinics)

Executive Summary

Introduction

This report is a summative evaluation of the Middlesex-London Health Unit *Neighbourhood Health Care Program*. The primary purpose of the program was to increase access to primary health care services, especially among under-serviced, high-risk, vulnerable populations. Two key characteristics of the model were the use of a multidisciplinary team, and operating clinics in several high-risk areas every week on a rotational basis. This demonstration project was funded from April 2004 through the end of July 2006. The clinics operated from October 2004 to the end of July 2006.

Purpose of the Evaluation

- To describe and document what was done in order to be accountable to the Ministry of Health & Long-Term Care.
- To draw conclusions about the effectiveness/viability of the multidisciplinary model for possible future implementation.
- To draw out lessons learned and make recommendations in terms of implications for practice.

Section 1: Description of Program Start Up

Various processes undertaken to get the NHC clinics ready to open on schedule, including building community partnerships, hiring staff, team building and developing an operational plan proceeded smoothly. A good deal of deliberate and careful attention was devoted to the hiring process, with the intention of recruiting individuals who would be able to function as a cohesive group in delivering service as in integrated, multidisciplinary team. It proved extremely difficult to identify a suitable and qualified candidate to fill the role of Nurse Practitioner. In the end it took more than 17 months to fill the role. In the interim, a NP was temporarily seconded by one of the community partners, the London Intercommunity Health Centre. The NHC team developed an operational plan and data gathering system, in preparation for opening the clinics in October 2004.

Section 2: Early Implementation and Formative Evaluation

A formative evaluation conducted after about two months of operation resulted in some significant changes to the program. These included:

- A *Site Lead Committee* made up of designated representatives from each of the clinic host organizations and the NHC team was instituted to more reliably elicit and process feedback from the host organizations. The Site Lead Committee was to meet three times a year. Between meetings, NHC team members were to actively maintain open channels of communication with each site through the Site Lead.
- A Health Promoter was hired on a part-time basis to help develop stronger links among the target population, using some of the funds that had been earmarked for a Nurse Practitioner.
- It was recognized how social determinants of health affected the ability of the NHC team to increase accessibility of primary health care among members of the target population. The team affirmed that they should keep a social determinants of health perspective in mind, and to the extent possible, employ community development as well as clinical and health education strategies.
- A number of factors prompted the NHC team to reconsidered eligibility criteria for clients to receive services. It was decided to open up all but NP services to anyone presenting for service, even if they have a family physician, if they otherwise met the eligibility criteria.
- The difficulty in recruiting a Nurse Practitioner had the unintended positive consequence of broadening the NHC service concept beyond a primarily clinical focus, to a more determinants of health perspective and approach.
- The role of Registered Dietitian was changed from a part-time to full-time role. The remaining NHC team members began developing into a highly cohesive team.

Section 3: Statistical Overview of NHC Services Provided

- Based on intake data collected by NHC team members between October 4, 2004 and May 25, 2006, a total of 2,410 visits were made to NHC clinics by 712 families which were comprised of a total of 1,055 individuals.
- Clinics held at the two Ontario Early Years Centres were the most highly utilized, accounting for more than half of all client visits. Clinics held at the public housing complexes also accounted for substantial numbers of visits at between 13% and 19%. Clinics held at the public elementary schools and Families First in White Oaks attracted relatively few clients.

- It took about nine months for clinic utilization to build to a fairly steady level. Increase in clinic utilization coincided with the decision hold two of the NHC clinics in conjunction with Well Baby/Child and Breastfeeding Clinics at the OEYC sites.
- The average number of visits to NHC clinics per family was 3.4. Forty percent of families visited a NHC clinic only once. Almost 75% of families visited clinics 1 to 3 times. About 10% of families visited a NHC clinic 8 or more times.
- Child visits accounted for 56% of all visits, while adult visits accounted for 44% of all visits. Fifty eight percent of visits were first time visits, while 42% were return visits. New problems were presented at 65% of clinic visits, while 35% of visits were follow-up visits dealing with previously presented concerns.
- Monitoring growth and weight was the focus of about 75% of all initial children's visits. This service is very similar to services provided at Well Baby Clinics, and the prevalence of its provision would appear to reflect the conjoint offering of the two types of clinics.
- Next in order of frequency at 30% of initial child visits, was service related to physical well-being. This category would generally include (but not be restricted to) services that deal with "medical" concerns.
- Similar to what was found with children, most of the documented services provided at initial adult visits had to do with either breastfeeding (at 26%) or physical well-being (at 22%).
- While breastfeeding was often the initial presenting concern for many adult clients, intake data indicates that when all adult visits are taken into consideration, the NHC team provided a more comprehensive service than is available at the Well Baby Clinics alone.

Section 4: Characteristics of Clinic Users

In terms of a gender profile of adults and number of children per household, the characteristics of NHC families can be summarized as follows:

- Almost 78% of the families recorded in the NHC intake database had one female adult as the only adult member of the household presenting for service. Sixteen percent (16%) had an adult female and adult male registered. About 5% had a one male adult registered as the only adult member of the household presenting for service.
- Almost 60% of NHC families lived in households with one child. About 19% lived in households with 2 children. About 7% lived in households with 3 children. Less than 4% of household had 4 or more children residing there.

The stated target population for the NHC program included persons without access to a family physician, young families (with children ages 0 to 6 years) and "vulnerable populations", defined in terms of recent immigrant status and living in "high-risk areas". In terms of these characteristics, the profile of NHC clinic users is as follows:

- Clients were recorded as having no family physician at about 23% of all client visits.
- Clients were recorded as being part of a young family at 92% of all client visits.
- People seeking service at NHC clinics were eligible to receive the services of the Nurse Practitioner only if they met all three eligibility criteria. Based on a strict definition of eligibility, clients were eligible for NP services at about 26% of all client visits.
- About 8.4% of NHC clients had immigrated to Canada within the last *5 years*. When comparing this to the 5.5% of the general population of London that immigrated to Canada within the last *10 years*, one may conclude that the proportion of recent immigrants served by the NHC program was *moderately high*er than the relative proportion of recent immigrants in the general population.
- We used postal code data to determine the incidence of low income in the neighbourhoods NHC families lived in compared to the general population, as an indicator of the extent to which the program served persons residing in "high-risk areas". The NHC program drew clients from a range of income levels. Almost half of the clients could be said to live in reasonably well off neighbourhoods. However, compared to the general population, a substantial proportion (18.4% compared to 3.2%) lived in low-income neighbourhoods (areas with more than 50% of incidence of low-income household.)

Section 5: How the Clinics Operated

Services Provided, Schedule and Description of Settings

- The NHC team members collectively provided a wide array of health services. Some examples include: physical and mental health assessments, well baby checks and breastfeeding feeding support, reproductive health counselling and support; nutrition consultations and education for adults, pregnant and lactating women, and children, introducing solids to infants, dealing with fussy eaters, and diabetes education; parenting support including monitoring and stimulating child development, positive discipline, child safety and speech and language checks; treatment of common illnesses, immunizations, monitoring and screening for chronic diseases, annual health exams and health promotion.
- Clinics were scheduled to operate for 2 hours every morning and afternoon except Tuesday and Friday

mornings. Team members were known to stay for 3 hours or more in order serve clients needing service.

- Clinics were held in three different types of settings. Each offered advantages and disadvantages. They all had in common the advantage of being located close to members of the target population. They all had the disadvantage of operating in "borrowed space" which meant setting up and taking down the clinics eight times a week, hauling equipment and files, and having to deal with less than optimal space for conducting services that required privacy such as clinical examinations.
- The two Ontario Early Years Centres were very congenial locations in which to operate, in terms of being ready made for a key segment of the NHC target population; i.e., young families. The sites were family-centred and child friendly. The fact that Well Baby Clinics had been operating in these locations for some time facilitated the use of the NHC program by that client base.
- The public housing complexes (as well as the co-op townhouse complex in which Families First in White Oaks operated) lent the advantage of exclusive use of an entire townhouse unit during clinics hours. They also had the advantage of being highly accessible to a different key segment of the target population; i.e., "high-risk areas". Being located within a housing complex was a facilitator of access for complex residents, but also a barrier to access for those residing nearby but outside the boundaries of the complex.
- The public elementary schools were perceived to be a potentially very good site by program planners, but despite great effort expended to promote the clinics to their respective communities, they never became well utilized. There appeared to be problems with visibility and accessibility. NHC team members speculated that many members of the target population might have negative associations with a school setting.

Impressions Gleaned from Direct Observation of Four Clinics

- Childreach (OEYC London North Central) was the first site recommended by the NHC team for observation because it gets very busy. Many people who are at first unaware of the NHC program come to the site expressly for the Well Baby/Child and Breastfeeding Clinics. I observed a young mother with an infant going through an intake interview and being very pleased to have the Nippissing developmental screen administered to her by the EYRC. I then observed a consultation by the Dietitian with the teenaged mother, while the young father hovered nearby keeping an eye on the couple's toddler. The PHN consulted with a mother who was anxious about her child's weight gain and a rash on the child's face; she reassured the mother about the weight gain suggested she go to the physician to check the rash.
- There was little action at CC Carrothers Public School during the hour and a half I was there. I experienced some difficulty finding parking and locating the clinic site in the basement of the school. I had an opportunity to talk with the team about their experiences with and perceptions of the NHC program. A young couple with baby presented for services about 40 minutes after the scheduled opening of the clinic. They were first time parents who were known by the team to travel to whatever site the clinic may have been operating at on any given day to obtain well baby checks.
- The Limberlost clinic located in the centre of the public housing complex, would seem to be a little challenging for an outsider to find. It is however well known to and utilized by residents of the complex. During a brief tour of the clinic site the NP pointed out that it is the one location where she had a real examination table for conducting clinical examinations. I observed a young woman (who was a recent immigrant from Eastern Europe) with her toddler and infant. I learned that a friend had brought her to the clinic before her baby had been born, and that she had initially hung back, not asking for any service. NHC team members had established a relationship with her over time to the point she now comes every Monday. Her toddler was very energetic and comfortable in the setting. I observed team members advocating by phone with government health officials regarding access to health care, on behalf of a recent immigrant who spoke little or no English. An ESL teacher from the community who had brought the woman to the clinic was also assisting.
- Like the clinic at Childreach, the clinic at OEYC London Fanshawe operated in conjunction with a Well Baby Clinic. As in other sites I observed a number of consultations, including a joint consultation between the Dietitian and the NP about a baby who had had pneumonia, had lost weight and appeared dehydrated. They recommended to the mother to go to a walk-in clinic right away. I also observed the PHN consulting with a young mother with infant, and the infant's grandmother. The women had concerns about some symptoms that the baby was showing and wondered if they should go to a walk-in clinic. The PHN reassured the women, suggesting they wait for the time being, and gave them signs to watch for that would indicate a need for a physician visit. A couple with an infant and two other children were receiving well baby checks. They related the difficulty they were having getting a family physician, having to be on a waiting list even to pick up an application. Team members took their time with each client.

Section 6: Clients' Experience of the Clinics

Three focus groups were conducted with 20 NHC clients. Findings from these focus groups together with findings based on analysis of clinic intake data are presented below.

When we asked clients about the specific reasons why they came to a NHC clinic, we found the following. The most common experience was for clients to initially access the NHC clinics though a Well Baby Clinic. A number of those who accessed the program through the Well Baby Clinic were not fully aware of a distinction between the two types of clinics, and were somewhat unaware of the full range of services available to them through the NHC program. About a quarter of the focus group participants came to a NHC clinic seeking some sort of non-urgent medical services. Others mentioned coming specifically for some health information related to a specific concern, such their child's food allergies. The reasons offered by focus group participants for coming to a NHC clinic were generally consistent with reasons for the group of NHC clients as a whole, based on analysis of intake data.

We asked clients at intake what they would have done if the NHC program had not been available. The most common response was that they would have sought out a Well Baby Clinic. This reinforces our finding of how important these well baby and breastfeeding supports are to the population of NHC clinic users. A substantial proportion indicated they would have done "nothing" (23.4%), or gone to a walk-in clinic or emergency room (15.4%). Taken together with client and NHC team member accounts of the experience of receiving and providing service, these findings suggest that the NHC program does play a significant role in facilitating access to health care before problems escalate, as well as deflecting unnecessary use of walk-in clinics and emergency rooms.

Clients provided vivid accounts of what it was like to receive NHC services from the NHC team in a coordinated, multidisciplinary manner. They expressed appreciation for being able to get so many services in one place at one time. They described how the NCH team helped them access physicians and other resources. Thirty four percent of individual clients received at least one referral to an outside resource. Clients recounted examples of NHC team members consulting and advocating with physicians on their behalf. They described receiving a wide variety of up-to-date health education information, and having team members carefully go over the information to make sure they understood it. One minor complaint that was heard from a few clients was some lack of privacy when clinics were very busy.

We asked NHC clients to discuss the difference between the NHC program and other primary health care services they have received. This question generated a very rich discussion in all three focus groups on the distinction between the approach taken at the NHC clinics and the traditional medical model. A number of related themes emerged in these discussions including: how the NHC program treats them and their health concerns holistically, appreciation for team members taking time, being able to access the clinics regularly on an as needed basis, the comfortable and friendly atmosphere in the clinics, and the importance of the supportive and relationship-oriented nature of service.

Section 7: NHC Team Members' Assessment of the Program

Findings based on a focus group held with NHC team members to elicit their perceptions of the impact of the program are presented below.

NHC team members described important differences and distinct advantages to the NHC model as compared with the Well Baby Clinics and other similar clinical models. It is important to note that two PHNs who worked Well Baby Clinics in conjunction with NHC clinics contributed to this discussion and concurred with the overall assessment.

The most obvious and significant distinction is the multidisciplinary team. The multidisciplinary team made possible the provision of more complete early assessments for individuals and families. The NHC team worked together as an integrated team, focusing on and addressing the interconnections among various determinants of health. Team members reported learning from each other through consultations and observing one another's practice, thereby expanding their understanding of the determinants of health and enriching their own practice. They noted a difference in the breadth and thoroughness of the assessments they were able to do. As one team member said, "We tend to do the whole family assessment, the social assessment, the head-to-toe assessment…"

Other key differences included a focus on the whole family and the specific targeting of vulnerable populations. The team felt that the consistency of the personnel from clinic to clinic was an important factor in building trust with members of vulnerable populations. They felt the community development component, even though it was underdeveloped, was an important and distinguishing component of the NHC program.

In terms of the experience of running the program both with and without a Nurse Practitioner the following observations were made. The experience of having to run the clinics without a Nurse Practitioner had the unintended benefit of opening up the service to a wider segment of the population. It was recognized that on a population or community level, it pays dividends to not have to restrict the program to only those who do not have a family physician. Many clients who had a family physician experience various barriers at any given time that restricted their access to their physician, such as transportation, child care issues, waiting times, time constraints on visits, and a narrowly focused medical perspective. Moreover, the constraints on physicians' practices (e.g., funding mechanism, physician shortages) as well as the nature of the medical model often means that physicians are only able to address patients' most

pressing needs. Little can be done in terms of prevention and health promotion. In the context of the NHC model, the NP, in cooperation with her colleagues, addresses and promotes health on many other levels.

In terms of the objective of increasing access to medical services, the NHC program adapted to the unavailability of a NP, by thinking more in terms of all team members facilitating clients' access to medical services through referral and advocacy. Even though the team was able to link clients with medical services, there was perceived to be a great advantage in having the NP service available right in the neighbourhoods, in terms of overcoming the kinds of barriers referred to above. It was mentioned in particular that the NHC target population benefited especially from preconception, pregnancy, mental health and immunization related services.

The NHC team had recommendations as to how the multidisciplinary team could be strengthened if the model was ever to be implemented again. They strongly endorsed the value of each of the original four roles. In addition, they strongly recommended that the team include a full-time Health Promoter to undertake program promotion and community development work. They also recommended incorporating a role to address mental health and woman abuse issues, such as a Social Worker or Community Mental Health Worker.

Finally, in reflecting on the importance of collaboration to the success of the program, and in recognizing that working collaboratively requires skill, it was recommended that any future program invest resources in deliberate training for collaboration.

Conclusion: Lessons Learned from Community Partners

Community partners were involved in the development and implementation at two levels. An Advisory Committee made up of MLHU administrators and mostly management level representatives from partner agencies provided "higher level" guidance and advice as the program was implemented. A Site Lead Committee made up of NHC team members was created after program start up to deal with any concerns that developed "on the ground." Both of these groups met as the program was winding down to reflect on lessons learned and offer recommendations.

There were a number of fairly specific operational suggestions offered. Some of the more global lessons learned and recommendations around which there seemed to be a high degree of agreement are presented below.

- Strong community partnerships were critical to the success of this program.
- Administrative structures were strengthened by clear terms of reference and a joint accountability agreement between partners.
- Administrative structures were flexible and adaptable, as exhibited in the adaptability of the original vision, the creation of a Site Lead Committee, and the management of the challenges surrounding the recruitment and support for the Nurse Practitioner.
- It was very valuable to build partnerships and to link with organizations well established with the target population.
- More attention and resources should be devoted to a community development if such a model were to be implemented again.
- The community partners very strongly endorsed the model as a viable alternative approach to primary health care. They articulated a number of developments that suggest the time is right for such a model.
- There was recognition that the model is not sustainable without some kind of permanent funding.
- The partners strongly believe this model deserves ongoing, permanent funding.

Introduction

Purpose of the Evaluation

This report is a summative evaluation of the Middlesex-London Health Unit *Neighbourhood Health Care Program*. This demonstration project was funded from April 2004 through the end of July 2006. The clinics operated from October 2004 to the end of July 2006.

Purpose Of Evaluation:

- To describe and document what was done in order to be accountable to Ministry.
- To draw conclusions about the effectiveness/viability of the multidisciplinary model for possible future implementation.
- To draw out lessons learned and make recommendations in terms of implications for practice.

Background on the Neighbhourhood Health Care (NHC) Program

The Middlesex-London Health Unit's *Neighbourhood Health Care Program* (NHC) was a demonstration project funded under the federally funded and provincially administered Primary Health Care Transition Fund.

The Primary Health Care Transition Fund (PHCTF)

According to description of the PHCTF program on Health Canada's website,[1] its purpose was to provide "support for the transitional costs associated with introducing new approaches to primary health care delivery." It was further stated that "although the PHCTF itself is time-limited, the changes which it is supporting are intended to have a lasting and sustainable impact on the health care system."

The stated objectives of the PHCTF were:

1. To increase the proportion of the population with access to primary health care organizations which are accountable for the planned provision of comprehensive services to a defined population;
2. To increase the emphasis on health promotion, disease and injury prevention, and chronic disease management;
3. To expand 24/7 access to essential services;
4. To establish multidisciplinary teams, so that the most appropriate care is provided by the most appropriate provider; and
5. To facilitate coordination with other health services (such as specialists and hospitals).

Problem/Need Statement

Under this program, the Middlesex-London Health Unit submitted a funding proposal for an innovative, interdisciplinary primary health care model under the title *Community Health Early Assessment, Resource and Treatment (CHEART) Demonstration Project in Under-serviced High-risk Areas of London, Ontario* (April 2004).

The problem that the model was primarily intended to address was limited access to primary health care. The proposal writers cited a shortage of approximately 350 family physicians, leaving an estimated 20,000 Londoners without access to family doctors. Further it was argued that a number of other barriers impede members of certain sub-populations from accessing primary health care services that are available. This sub-population includes members of "vulnerable populations," including young families and recent immigrants living in under-serviced, high-risk neighbourhoods. Identified barriers include transportation, culture and language barriers. Because of such barriers, members of vulnerable populations often do not obtain needed health care services in a timely fashion, resulting in:

- Unnecessary escalation of easily managed illnesses resulting in more costly care.
- Overuse of costly walk-in and emergency room services.

Although the original funding proposal did not emphasize the point, as the model began to be implemented, program staff became increasingly cognizant of how various determinants of health including housing, income, employment, social support and social exclusion impacted on and were relevant to the implementation of the model.

Target Population

The specification of the target population was somewhat ambiguous in the funding proposal. Formally and explicitly the target population was defined as:

> Young families and caregivers of children 0-6 years of age who seek service at any of the five project sites with a focus on vulnerable families who have difficulties accessing other primary health care alternatives (p. 3).

[1] Retrieved June 13, 2006 from http://www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index_e.html#1

Elsewhere in the proposal reference is made to providing service "in under-serviced, high-risk areas" (p. 1). This phrase also appears in the project's mission statement (p.2).

Although it is not specified in the proposal, the presence of the Nurse Practitioner on the team was taken as imposing a restriction on service. Initially, only those persons who were not enrolled with a family physician, or had some legitimate barrier to accessing their family physician, were to be considered eligible for the service. (This particular eligibility criterion became problematic for a variety of reasons, and was later adjusted as discussed on page 18.)

In addition to not having access to a family physician, the proposal mentions other "barriers" to access the program is intended to address including: transportation issues (e.g., "people in under-serviced areas…must go great distances to seek care") language and culture. Specific reference is made to access to health care as "the number one issue affecting the immigrant population of North East London" (p. 1).

In practical terms then, the target population for the NHC as the program began was:

- Persons with no access to a family physician
- Young families (parents, children, caregivers) with children 0-6 years of age
- "Vulnerable families" understood as persons residing in "under-serviced, high-risk neighbourhoods" including recent immigrants.

Eligibility Criteria

This target population was translated into the following eligibility criteria. As the program began, persons were provided service if:

- They had no access to a family physician, *or*
- There was some legitimate barrier to accessing their family physician (such as transportation), *and*
- They were pregnant or resided in a household that included children up to age 6 years old.

Service Concept

The core concept of the NHC Program was to rotate a multidisciplinary health team around the city to a number of neighbourhood-based sites on a weekly basis. The multidisciplinary team (hereafter referred to as the NHC team) was to be composed of a Nurse Practitioner (NP), a Public Health Nurse (PHN), a Registered Dietitian and an Early Years Resource Consultant (ERYC) or parenting expert. The NHC team was supposed to work together in providing a holistic service as a cohesive, integrated unit. The team was to be supported at the health unit by a part-time Administrative Assistant and Program Manager.

As expressed in the funding proposal,

> The Nurse Practitioner is vital to the success of the program. With the extended class designation the NP can diagnose and treat 50-80% of the problems seen in an emergency department in addition to health promotion counselling. Working in collaboration with the PHN, most of the health care needs can be met. The Dietitian and Early Years Resource Consultant round out the staff complement with nutrition assessment and counselling as well as parent-child assessment and education respectively.[2]

The idea of multidisciplinary team explicitly addressed one of the objectives of the PHCTF program. Such a team would be able to provide a range of primary health care services. What was seen as a particularly innovative aspect of the NHC program was the idea of taking the services right into "high-risk neighbourhoods" in order to overcome a variety of barriers to service.

In order to do this it was envisaged that the clinics would be set up at existing community service organizations including Ontario Early Years Centres (OEYCs), public housing complexes and public elementary schools. Further, it was anticipated that in doing so, the program would be able to build on established relationships that existing community service organizations already had with members of the target population.

Program Governance

The proposal was submitted by Middlesex-London Health Unit, on behalf of several community partners, with the health unit identified as the administering agency. Initially, the community partners included London Fanshawe OEYC, London Children's Connection (London West OEYC), Childreach (London North Centre OEYC), and Smart Start. An Advisory Committee, chaired by the Director, Family Health Services, MLHU and made up of representatives from community partner agencies was formed to provide guidance to the project as it was implemented. One of the strengths of the project was that as it unfolded and certain needs presented themselves, additional community partners were sought out and brought on board. By the time the project was being fully implemented, the Advisory Committee also included representatives from the London Intercommunity Health Centre and Merrymount Children's Centre.

As a result of a formative evaluation process that was held two months after the first two clinic sites were opened, a *Site Lead Committee* was formed. It was made up of one representative from each of the NHC community sites and the NHC team members. The purpose of this committee was to handle any particular

[2] Community Health Early Assessment, Resource and Treatment (CHEART) Demonstration Project in Under-serviced High-risk Areas of London, Ontario (April 2004). p. 2.

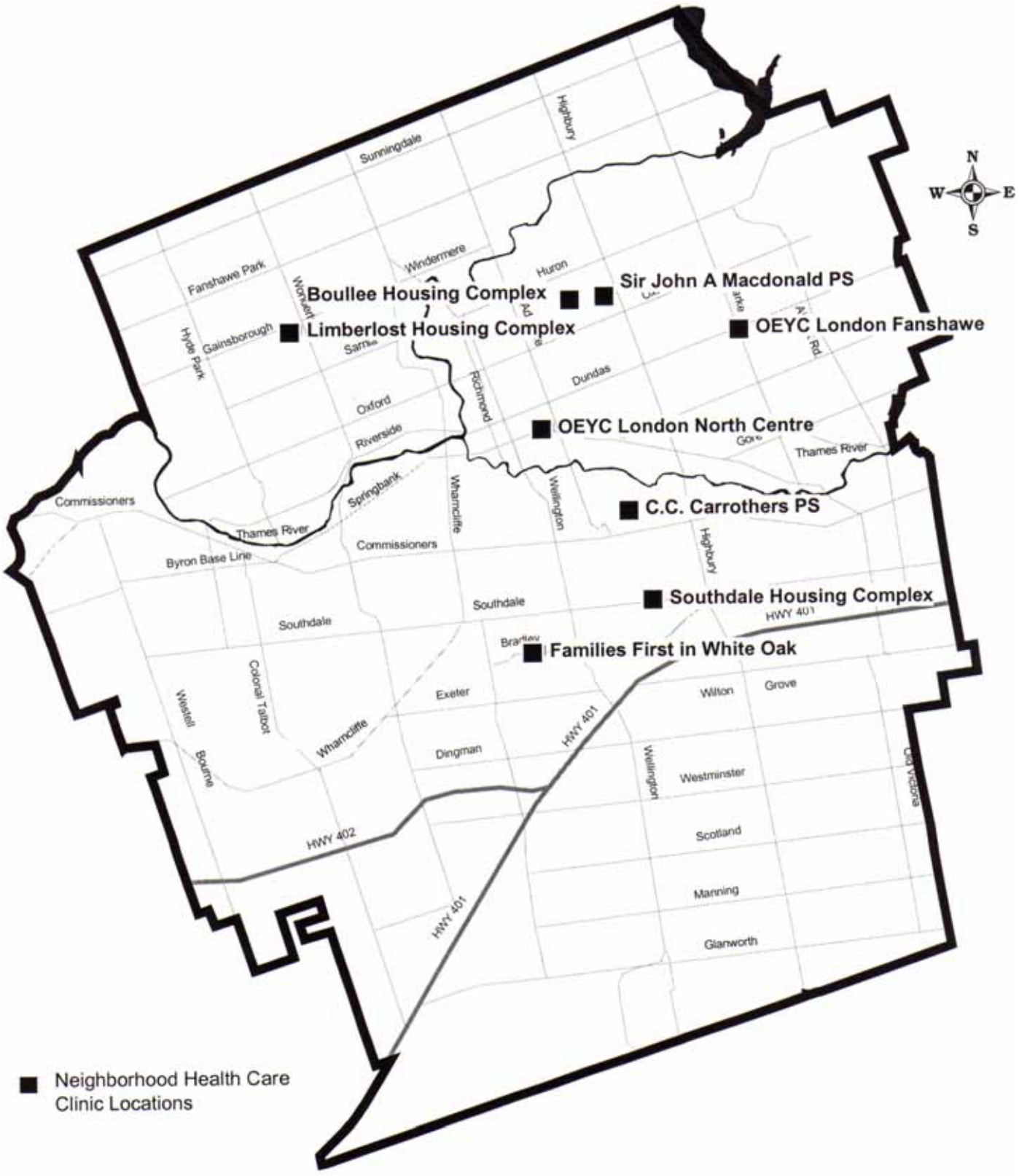
site-related concerns that may arise in the operation of the clinics. It was felt that any concerns could be better addressed at this level, rather than bringing them to the Advisory Committee. Each NHC team member took responsibility for being the primary liaison for two of the eight sites. The Site Lead Committee was initially set to meet four times per year. The process worked very well, and helped establish excellent communication channels, so much so that formal meetings became unnecessary by the end of 2005.

Site Location

In the funding proposal, it was anticipated that five NHC clinic sites would be opened around the community. The proposal included a demographic and mapping analysis in order to make tentative recommendations as to where clinics should be situated. Factors considered were distribution of children (0 to 6 years), average family income, distribution of new immigrants, as well as locations of existing medical clinics, hospitals and OEYCs. Locating some of the clinics at OEYC sites (there are three in London) was clearly intended at this stage. The proposal also clearly articulated the intention to conduct some NHC clinics in sites where MLHU Well Baby/Child and Breastfeeding Clinics already operate.

With the analysis done for the proposal as the starting point, and the intention to situate clinics in "under-serviced, high-risk areas" it was the task of the Advisory Committee to select the actual sites for the clinics. In the end, clinics were opened at eight different locations around the city. Two operated in OEYCs, three in public housing complexes, two in public elementary school settings, and one in an early years oriented "community action program" funded by the federal government and sponsored by a neighbourhood organization. Figure 1 displays the locations of the eight NHC clinic sites.

Figure 1: MLHU Neighborhood Health Care Clinic Locations - 2004 to 2006



Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Program Theory

In the early stages of the program, the Middlesex-London Health Unit Program Evaluator worked with the NHC team and Program Manager to collaboratively develop two logic models that would assist in both program implementation and evaluation. An *implementation logic model* was developed in the period prior to program start up. A formative evaluation process was conducted after about two months of operation, based on the operational plan detailed in the logic model. (See Appendix A for a copy of the implementation logic model).

Based on the formative evaluation process, the Program Evaluator developed a *Program Theory Logic Model* which is meant to present a clear picture of how the program activities are supposed to lead to its intended outcomes. The purpose of this model, (Figure 2) was to guide the development of an evaluation plan. This model will be referred to elsewhere in this document. As indicated by the headings at the far left side of the diagram, there are four interconnected components to this model: reduce barriers to health care, promotion, service provision and health promotion.

Evaluation Plan

Based on the program theory, the Program Evaluator worked with the NHC team and Program Manager to develop an evaluation plan. Feedback on the plan also sought from the Advisory Committee.

Several methods and data sources were used in eliciting and analyzing the data that forms the basis of this report, as summarized in Table 1.

More specific detail as to how the data were collected and analyzed are presented within the relevant sections of the report.

Table 1: Overview of Data Sources

Report Sections	Data Sources
Description of Program and Background	• Document analysis, original funding proposal • Informal interviews with Program Manager
Program Start-up and Early Implementation	• Formative evaluation documentation • Focus group with NHC team members • NHC intake data
Statistical Overview of Services Provided and Characteristics of Clinic Users	• NHC intake data • Census data
How the Clinics Operated	• Administrative records • Direct observation of clinics
Clients' Experience of the Clinics	• Three focus groups with NHC Clients
NHC Team Members Assessment of Program	• Focus group with NHC team members • Informal interviews with NHC team members and Program Manager
Lessons Learned by Community Partners	• Informal focus groups with Site Liaison Committee and Advisory Committee

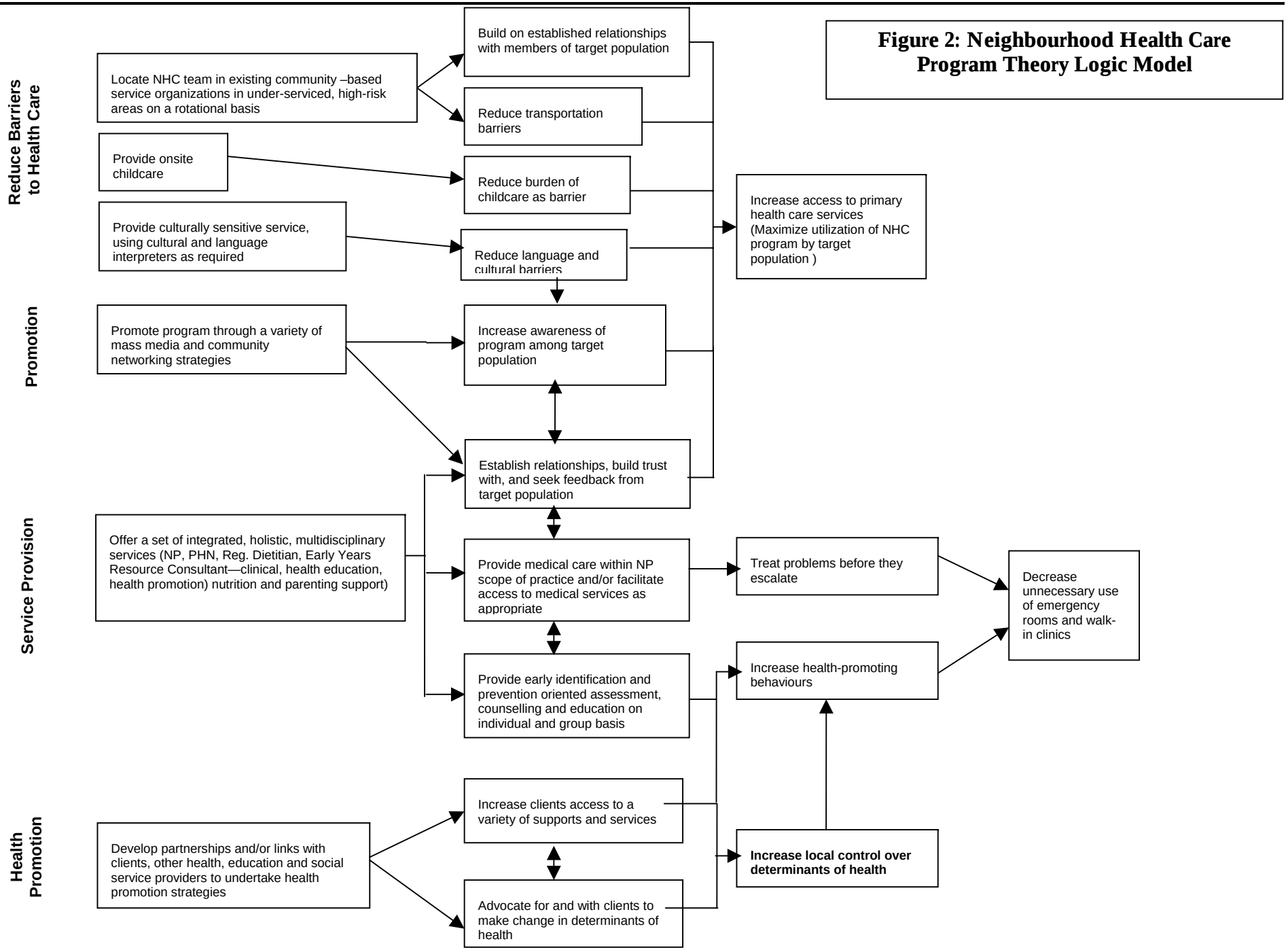


Figure 2: Neighbourhood Health Care Program Theory Logic Model
Reduce Barriers to Health Care
Promotion
Service Provision
Health Promotion
Locate NHC team in existing community –based service organizations in under-serviced, high-risk areas on a rotational basis
Provide onsite childcare
Provide culturally sensitive service, using cultural and language interpreters as required
Promote program through a variety of mass media and community networking strategies
Offer a set of integrated, holistic, multidisciplinary services (NP, PHN, Reg. Dietitian, Early Years Resource Consultant—clinical, health education, health promotion) nutrition and parenting support)
Develop partnerships and/or links with clients, other health, education and social service providers to undertake health promotion strategies
Build on established relationships with members of target population
Reduce transportation barriers
Reduce burden of childcare as barrier
Reduce language and cultural barriers
Increase awareness of program among target population
Establish relationships, build trust with, and seek feedback from target population
Provide medical care within NP scope of practice and/or facilitate access to medical services as appropriate
Provide early identification and prevention oriented assessment, counselling and education on individual and group basis
Increase clients access to a variety of supports and services
Advocate for and with clients to make change in determinants of health
Increase access to primary health care services (Maximize utilization of NHC program by target population)
Treat problems before they escalate
Increase health-promoting behaviours
Increase local control over determinants of health
Decrease unnecessary use of emergency rooms and walk-in clinics

Overview of the Report

Section 1 of the report provides a description of the program start up. It recounts difficulty that was encountered in recruiting a Nurse Practitioner for the program, and the consequences that had for its implementation.

Section 2 of the report provides a description of early implementation efforts and the formative evaluation process that was conducted. It recounts some early lessons learned and adjustments to the program that were made.

Section 3 provides a broad statistical overview of the various services that were provided to NHC clients from October through the end of May 2006. It presents a picture of the extent of utilization of the NHC program over time, and across the various clinic locations. It also presents a picture the types of problems people came to the NHC clinics for.

Section 4 provides a demographic profile of NHC clinic users. It answers the question: How does the profile of those who actually used the NHC program compare to our target population?

Section 5 provides a description of services that were offered at the clinic, a description of the settings in which the clinic operated, and an account of what happened at four different clinics based on first hand observation by the Program Evaluator.

Section 6 presents a description of how NHC clients experienced the clinics, based primarily on three focus groups that were held with clients. The section includes clients' perspective on how the NHC clinics differed in their experience from other primary health care providers. Clients articulated some distinct advantages and benefits to the NHC model.

Section 7 presents the NHC team members' and Program Manager's assessment of the impact of the NHC program, and includes recommendation for any possible future replication of such a model.

Section 8 presents lessons learned by and recommendations from the community partners.

Section 1: Description of Program Start Up

Difficulty Recruiting a Nurse Practitioner

Initial recruitment, hiring and orientation for the NHC team took place in June 2004. There were a number of qualified candidates for the Registered Dietitian, Early Years Resource Coordinator and Administrative Assistant, and these positions were readily filled. The opening for the Public Health Nurse position was posted internally only at Middlesex-London Health Unit. There were very few MLHU nurses interested in the position, however the project was successful in recruiting a very suitable person for the position.

There was a great deal of difficulty finding a suitable candidate for the Nurse Practitioner position. Ultimately, it took 17 months to secure the services of a full-time Nurse Practitioner. This fact had a very significant impact on the project. The basic facts relating to the effort to recruit a Nurse Practitioner are as follows.

As shown in Table 1.1, seven "waves" of advertising took place between May 2004 and June 2005. During the first waves, ads were placed on a number of web sites that would be visited by nurses, including nursing profession web sites, hospital web sites and public health web sites. Initially paid advertising, particularly newspaper advertising, was fairly restricted. After several months of little success in identifying qualified candidates through the local newspaper and free or inexpensive web sites, advertisements were placed in newspapers in Windsor, Hamilton and Toronto. A nurse recruitment consultant in Toronto was also utilized. In the end more than $20,000 was spent to identify eight qualified candidates. Two of these were identified through the nurse recruitment consultant. Two candidates withdrew before being interviewed. Six candidates were interviewed. One withdrew after being asked back for a second interview. Three declined an offer because the position did not fit their needs. One candidate (a U. S. citizen) was offered and accepted the job but was unable to resolve immigration and licensing issues in a timely enough fashion. Finally, after 17 months, a suitable candidate was identified and accepted an offer of employment for a seven month contract, from January 2, 2006 through July 31, 2006.

The following factors seem to affect our ability to identify and hire a suitable candidate for the Nurse Practitioner position.

- Labour market shortage. There has been a very small pool of qualified candidates to choose from. Nurse Practitioner is a relatively new profession. The education system has not been able to produce a sufficient number of graduates to meet demand.
- Importance of a good fit with the team. It was agreed that the Nurse Practitioner would have to be perceived to be a very "good fit" with other members of the team, in terms of being able to form a cohesive, integrated, cooperative working team. At least one candidate was turned down because of a perceived "poor fit".
- Relatively short-term contract with a relatively low salary. With a shortage of qualified Nurse Practitioners, it has been a "seller's market."
- Community setting is less familiar than clinical setting.
- No direct day-to-day clinical supervision. At least one "newly minted" candidate turned down the position because they felt they needed more regular and direct access to clinical support and supervision from an experienced physician or Nurse Practitioner.

Moving Ahead

Despite the inability to recruit a Nurse Practitioner by the time the clinics were scheduled to open in October 2004, the decision was made to go ahead and begin implementing the NHC model, based on the assumption that a NP would be successfully recruited in the near future. The NHC clinics were to be promoted to the community based on the assumptions of the original model, including the availability of Nurse Practitioner services.

As a stop gap measure, one of the community partners, the London Intercommunity Health Centre (LIHC) seconded one of their Nurse Practitioners on a temporary, short-term basis. The LIHC Nurse Practitioner went on to provide service for the first six months of the program (October 2004 though March 2005).

Table 1.1: Advertising for Nurse Practitioner

Location	Date(s)	Total Cost ($)	# of Qualified Candidates Identified	# of Candidates Interviewed	Result
www.healthunit.com (NLHU website)	May 1, 2004 - April 1, 2005				
Ontario Health Promotion E-mail Bulletin	April 30/04	$0	1	1	Interview team had some concerns regarding candidate's fit with team. Asked candidate to attend a second interview. Candidate cancelled second interview.
The London Free Press	May 1 & 5, 2004	$1,965			
www.ontarionursing.ca	May 2/04	$0			
NPAO.org site	May 3/04	$250			
All Health Units	May 3/04	$0			
www.brainhunter.com	May 3/04	$250			
Community Care Access Centre	May 3/04	$0			
Schools of Nursing & Distance Education	May 3/04	$0			
RNAO site	May 18/04	$250	1	1	Candidate wanted part-time.
Schools of Nursing & Distance Education	May 19/04	$0			
The London Health Sciences Center	May 19/04	$0			
St. Joseph's Health Centre	May 19/04	$0			
All Health Units	June 17/04	$0	1	0	Candidate cancelled interview.
Schools of Nursing & Distance Education	June 18/04	$0			
St. Joseph's Health Centre	June 18/04	$0			
The London Health Sciences Center	June 18/04	$0			
The London Free Press	June 19 & 23, 2004	$942			
Ontario Health Promotion E-mail Bulletin	June 25/04	$0			
The London Free Press	Sat. Sept. 11/04	$848	1	1	Candidate declined offer.
The Windsor Star	Sat. Sept. 18/04	$751			
www.brainhunter.com	Nov. 17/04	$250			
The London Free Press	Sat. Dec. 4/04	$808			
The Windsor Star	Sat. Feb. 26/05	$850	2	1	One candidate withdrew before interview arranged. Second candidate (a male) declined offer. - before interview arranged)
The Toronto Star	Sat. Feb. 26/05	$3,529			
The Hamilton Spectator	Sat. Feb. 26/05	$1,637			
The London Free Press	Wed. Feb. 23/05 & Sat. Feb. 26/05	$1,266			
The Globe & Mail	Fri. May 13, Sat. May 14, Wed. May 18/05		2	1	Candidate (a U.S. citizen) could not resolve immigration issues, nor obtain temporary registration for RN (Extended Class.)
All Health Units	May 14/05	$0			
NP student newsgroup (np-eductation.ca)	May 11/05	$0			
Ontario Health Promotion E-mail Bulletin	May 14/05	$0			
The London Free Press	Sat. June 11/ 05	$780			
Final candidate had seen an earlier local ad, and made inquires about position in December 2005.				1	**Candidate hired; contract for Jan. 2-July 31 2006.**
TOTALS:		**$ 14,376**	**8**	**6**	

Also, utilized Nurse Recruitment Consultants at Beresford Blake Thomas Canada beginning early June 2004. They found 2 of the 5 qualified candidates.

Developing an Operational Plan

In implementing the program, the NHC team faced the challenge of transforming a service concept that had only been outlined in broad strokes, into an operating program. During the period of about six weeks prior to the opening of the first group of clinics, the Program Evaluator met with NHC team to collaboratively develop a program logic model to help guide the implementation of the program.

Over the course of several face-to-face sessions the team imagined, discussed, and described in concrete terms, exactly the activities and tasks they anticipated undertaking in implementing the program. Descriptions of program activities were grouped into related sets and arranged in logical sequence and labeled. These labels became the headings for the logic model components. For each set of activities, a set of short-term and intermediate-term outcomes were identified. This *implementation logic model* went through six revisions before the first set of clinics opened on October 4, 2004. (See Appendix A.) It portrays in detail the team's initial operational plan.

The five components of the model were:

- Host Agency Liaison: Activities intended to establish and maintain good working relationships with the various host sites.
- Community-Based Program Promotion: Activities intended to directly create awareness of the program among the target population, as well as indirectly through promotion to health and social service providers serving members of the target population.
- Intake: Procedures to respond to inquiries, receive clients, obtain information needed for clinical, administrative and evaluation purposes, and provide appropriate services and/or referrals to other health-related service providers.
- Integration of Services: Activities and processes designed to enable the four individual NHC team members to provide a holistic service by functioning as a coordinated, integrated, multidisciplinary team, as well as link with other health-related service providers
- Program Management and Evaluation: Activities intended to ensure regular and active team reflection about individual practice and program operation, processing of feedback from clinic sites to assess fit of program, and continual adjustments to program as appropriate to address barriers and gaps, and meet individual and community needs

Developing an Administrative/Evaluation Data Collection System

In the process of developing the logic model, the team determined what information should be collected from each person who would come to a clinic for health services. An *Intake/Brief Intervention Form*, referred to hereafter as the *intake form*, (Appendix B) was designed to enable the team to collect, in one place, data that would be useful for administrative and evaluation purposes, as well as limited clinical charting.

The intake form enabled a team member during the first visit to collect basic *family information* for an entire family, including contact and identifying information. This included whether the family had any language barrier, whether they were newcomers to Canada, and how they heard about the NHC program. This information would only need to be collected one time for each family.

The intake form also enabled the team to capture *client history*, that is, specific information pertaining to each clinic visit for each individual. This includes a number of activity indicators that were specified under the "Intake" component of the logic model including:

- Whether client meets eligibility criteria for receiving service (i.e., whether they have a family doctor, are pregnant or have children under 6 years old)
- Whether there were any barriers that prevented client from accessing their family doctor other health services
- Whether the individual is a new or returning client
- The reason for the visit
- Whether the visit was for a new problem, or was a follow-up visit
- Which NHC team members provided service
- Whether the client was referred to other health-related services.

In addition to capturing the reason for the visit, there was a limited amount of space for team members to make brief "clinical notes" about the nature of the service provided. There was also room to indicate for each practitioner if they were providing "in-depth service" in which case a file would be opened up to record more detailed clinical information in accordance with each team members professional standards. It was anticipated that any time the Nurse Practitioner provided any service beyond informal health counselling or education, she would open and maintain a proper clinical file.

Intake forms would be carried by the team from site to site during the week. Anytime a client made a return visit, their intake form would be retrieved and updated according to whatever service was provided that day. An

electronic database corresponding to the intake form was created using MS Access. Data from the intake form was to be entered into the database by the NHC Administrative Assistant.

A provisional version of the intake form was in place when the first set of clinics opened. It was anticipated that it would likely need to go through a trial period and revised as necessary.

Clinics Opened

In order to facilitate a smooth and orderly start up, program administrators decided to stagger the opening of the clinics. The first two clinics opened in townhouse settings within the Limberlost and Southdale Public Housing Complexes on October 4, 2004. (See Table 3.1 on page 22 for a schedule of clinic open dates.)

Summary

Various processes undertaken to get the NHC clinics ready to open on schedule, including building community partnerships, hiring staff, team building and developing an operational proceeded smoothly. A good deal of deliberate and careful attention was devoted to the hiring process, with the intention of assembling individuals who would be able to function as a cohesive group in delivering service as in integrated, multidisciplinary team. It proved extremely difficult to identify a suitable and qualified candidate to fill the role of Nurse Practitioner. In the end it took more than 17 months to fill the role. In the interim, a NP was temporarily seconded by one of the community partners. The NHC team developed an operational plan and data gathering system, in preparation for opening the clinics in October 2004.

Section 2: Early Implementation and Formative Evaluation

A formative evaluation process was conducted after two months of clinic operations in December 2004. At this stage only three of the eight clinic sites that would eventually be opened were in operation. The purpose of this formative evaluation was stated in terms of the following questions:

- What can we learn from our experience so far to help us improve our practice?
- What aspects of our practice have been/should be changed in order to reach our objectives?

Using the program implementation logic model as a frame of reference, the Program Evaluator drafted a series of questions to be considered by the NHC team during a daylong retreat. The session focused on the first three components: host site liaison, community-based program promotion, and intake. The results of this session are summarized below.

Host Site Liaison

As illustrated in the NHC program theory logic model (p. 11), the crucial means by which the objective of increasing access to primary health care in under-serviced high-risk areas would be achieved was the locating of clinics in existing community service organizations, and building on relationships that these organizations had established with members of the target population. A series of specific activities were specified in the program implementation logic model to help guide this process. During the formative evaluation session, team members considered the following questions.

1. To what extent has feedback been obtained from host agency personnel at each site regarding 1) site needs/issues, 2) "fit" of program and 3) barriers to service?
2. Are we satisfied that an adequate mechanism is in place to obtain and process needed feedback on an ongoing basis?

The team felt that while they were receiving some feedback from host agency personnel regarding these matters, a more reliable method should be instituted for eliciting and processing feedback. The decision was made to institute regular *Site Lead meetings*, to deal with such matters as close to the source as possible, rather than to bring them to the Advisory Committee. Each site would be asked to identify one person to serve as Site Lead. Each NHC team member would be responsible to serve as team liaison for two sites. This involved attending community meetings that might foster building relationships in the community, and proactively linking with the Site Lead on a daily or weekly basis as needed. Site Lead meetings would be convened four times per year. As well, site issues, including any matters discussed at Site Lead meetings would become a standing item on the weekly NHC team meetings. Where necessary or appropriate, site related issues would be brought to the Advisory Committee for consideration. This site liaison process was so effective that it was decided as of the end of 2005 that formal Site Lead meetings were no longer necessary.

During this formative evaluation process, NHC team reflected on how lessons learned about establishing and maintaining good working relationships with host sites should be applied when setting up the next set of clinics. The following plan was made:

- Meet with all front-line staff at new sites that will have any involvement with the NHC clinics to clarify/negotiate what elements of the site NHC need to control in order to run the clinics.
- Institute a weekly "check-in" by NHC team with Site Leads during start up phase

Community-Based Program Promotion

In order for any program to work, people need to know about it, and come through the door. As indicated in the program theory logic model, a number of strategies were employed to maximize utilization of the NHC program by the target population. These included the decision to locate the clinics in existing community-based service organizations as well as a range of mass media and community networking strategies described in detail in the implementation logic model.

At the time of the formative evaluation session, two clinics had been open for two months, and a third had been open for about one month. As indicated in Table 2.1 and as might be expected at such an early stage, utilization of the clinics by the members of the target population was limited.

Table 2.1: Number of Visits to Clinics, First 3 Months

	Oct-04	Nov-04	Dec-04	Total
Limberlost	10	10	8	28
Southdale	17	12	4	33
OEYC-Fanshawe	0	4	4	8
Total	27	26	16	69

Our formative evaluation discussions revealed that the NHC team experienced challenges in carrying out the face-to-face promotion activities specified in the implementation logic model. These challenges related mostly to time constraints and competing demands involved in setting up and running the clinics.

There was consensus that adequate resources were not dedicated to "health promotion" in the original service model, in terms of capacity for building relationships and undertaking various activities necessary for achieving the outcomes specified in the community-based program promotion component of the implementation logic model. It would be very desirable in terms of an ideal model, for the NHC program to have a Health Promoter as a full-time team member. It would seem to be a key piece in terms of the sustainability of the model.

In the meantime, the NHC team made a commitment to renew efforts to build on existing relationships and tap existing networks to promote the clinics. Team members agreed to make a deliberate effort to identify promotional avenues, line up presentations, and go out and promote the clinics in each community during clinic hours, to the extent that low attendance would allow a designated team member to be absent from a clinic on a given day.

In order to support team members efforts and problem solve around the challenges associated with program promotion, "promotion" was to become a standing item on the weekly NHC team meeting agendas. The team would reflect on the efficacy of promotion activities and revise plans as needed on an ongoing basis.

As well, the Program Manager decided to explore the possibility of hiring a Health Promoter on a part-time basis, with funds that had been earmarked for the Nurse Practitioner. A Health Promoter was hired on a part-time basis, and began working as part of the NHC team in September 2005 to undertake the activities specified in the implementation logic model under Community-Based Program Promotion.

Public Housing, Social Determinants of Health and Barriers to Access

A question that emerged during the formative evaluation session was whether or not the Southdale housing complex was a suitable location for operating one of the NHC clinics. Concern was expressed that the Southdale site was perceived in the surrounding neighborhood to be an unsafe place, and that therefore the location itself may be a barrier to access, especially for those residing outside the immediate complex. This issue had been discussed at a meeting of the "Southdale Network" less than two weeks prior to the formative evaluation session, and was slated for further discussion at future meetings.

It was agreed that this concern illustrates very clearly how more fundamental social determinants of health (such as safe neighbourhoods and healthy housing) affect the ability to implement the health promotion strategy of "reorienting health care services." From a social determinants of health perspective, working with other community members to address these more fundamental determinants may very well constitute the higher priority in terms of health promotion strategies that need to be undertaken. The dilemma is that the team only had 2½ to 3 hours per week to work in each of the eight neighbourhoods.

An issue related to the question of the appropriateness of locating clinics in a public housing complex came up in the NHC client focus groups that were held in March 2006. Several participants thought that NHC clinics operating in public housing complexes were open only to residents of those complexes.

The NHC team affirmed that they should keep a social determinants of health perspective in mind in working for the long-term health of the community. It was agreed that in addition to their clinical work, and to the extent that time permitted, they should employ appropriate health promotion strategies, such as community development work (e.g., advocacy and coalition building). It was agreed that this ideally would be the work of a full-time Health Promoter.

In the end, a decision was made to continue operating a clinic in the Southdale housing complex, while working with various community members on community development efforts, as part of a strategy of establishing relationships and promoting the NHC program in the community.

Reconsidering Eligibility Criteria

The original service concept stipulated that only persons who did not have a family doctor would be eligible for NHC services[3]. The decision to restrict service in this way was based on two related factors. First, the main need the NHC program was intended to address was the insufficient access to primary health care in the population due to the shortage of physicians. Second, the key element of the NHC program by which access to primary health care would be increased was the provision of certain medical services by a Nurse Practitioner. This led to restriction of service because of the professional conventions guiding the delivery of medical services that prohibit "double doctoring". The extended scope of practice for the Nurse Practitioner role includes the right to provide services such as the diagnosis of certain minor illnesses, ordering of diagnostic tests and prescribing of drugs. The right to provide such services had traditionally been the exclusive prerogative of physicians. In gaining an extended scope of practice, Nurse Practitioners also have to abide by the prohibition against double doctoring.

[3] It was also allowed that those who had some "legitimate" barrier to accessing their family physician would also be eligible. The limits of what constituted a legitimate barrier to access were not precisely defined. Transportation barriers or being on a waiting list of 3 months or longer were considered a barrier. In addition, the team member doing the intake work was empowered to make a judgement whether there was some other legitimate barrier to access, and document what that barrier was on the intake form.

The Nurse Practitioner role was seen as essential, if not central to the original service concept. It was anticipated that Nurse Practitioner's services would be in very high demand, in light of the shortage of family physicians in London. It was thought that the availability of Nurse Practitioner services would act like a magnet, drawing clients into the clinics. Therefore, the Nurse Practitioner service was thought to be the most likely entry point into the NHC program. Once a client accessed the Nurse Practitioner, he or she would be introduced to the full range of services available, which would be delivered in an integrated and holistic manner. It was further anticipated that because of the high demand, there could well be a need for a triage system at the clinics, to ensure those with the most urgent needs were taken care of first.

By the time of the formative evaluation session in December 2004, a number of factors coincided that prompted the team to reconsider the eligibility criteria. First, in the early stages, there was relatively low level of utilization of the service. It was taking longer to build linkages in the neighbourhoods and attract clients than originally anticipated. Second, the LIHC Nurse Practitioner was only available on an intermittent basis, and was thus unable to function as a fully integrated member of a cohesive team. That is, a key component of the service was only partially functioning. Third, people living in the neighbourhoods where the clinics were located, but who had family doctors, were responding to the program promotion efforts and presenting for service. Team members felt uncomfortable sending them away. As was recalled by one of the team members during the focus group held with the NHC team in November 2005,

> I know the team had a huge issue or concern with that they had to turn some residents away because they had family doctors already... It's really hard to do that when we're in their complex, we're in their environment, yet we're kind of almost picking and choosing who we can see... So I think that (opening up the eligibility criteria) was a positive (change)... It was then a lot more comfortable in that environment because they could welcome everybody in rather than having to turn people away.

Thus, the decision was made during the formative evaluation session to restrict *only* Nurse Practitioner services to those without a family physician. This decision would stand as long as increased demand did not force the team to restrict all services to those without family doctors.

Change from Half-time to Full-time Dietitian

The role of Registered Dietitian was restricted to a half-time position in the original model. In December of 2004 the person originally hired in the role left the job to take a full-time position. Concurrently, the NHC team decided that the model really required a full-time Registered Dietician. The role was successfully filled in February 2005.

Revising the Service Concept

As mentioned, the secondment of a Nurse Practitioner on a part-time basis by the LIHC was intended as a temporary measure, to be in place only until a suitable candidate could be recruited. At the time of the formative evaluation session, it was still anticipated that a full-time Nurse Practitioner would soon be hired. As discussed earlier, it proved to be much more difficult to find a Nurse Practitioner than anticipated. After five months, LIHC reassigned their Nurse Practitioner back to her usual responsibilities.

This had significant implications for the NHC program. Although the original service concept emphasized the *multidisciplinary team approach*, it is arguable that based on the way the clinics were being implemented initially, the model might have been better characterized as a *Nurse Practitioner-centred model.* With no Nurse Practitioner available to provide service as of the end of March 2005, a key premise of the NHC model no longer held.

In light of the ongoing difficulty in recruiting a suitable candidate, program administrators[4] even briefly considered asking the Ministry of Health and Long-term Care to put the funding for the program on hold until the labour market for Nurse Practitioners became more favourable. The argument being considered was that viability of the model *hinged on* the services of a Nurse Practitioner and that the very premise of the model was invalidated without the Nurse Practitioner. Without a Nurse Practitioner, it was thought that the model could not be put to a fair test.

After considering various options, the program administrators in consultation with the Advisory Committee and staff decided to continue to deliver the program without the services of a Nurse Practitioner. The search for a suitable candidate would continue, recognizing such a candidate may not be found in time. This required some revision of the service concept.

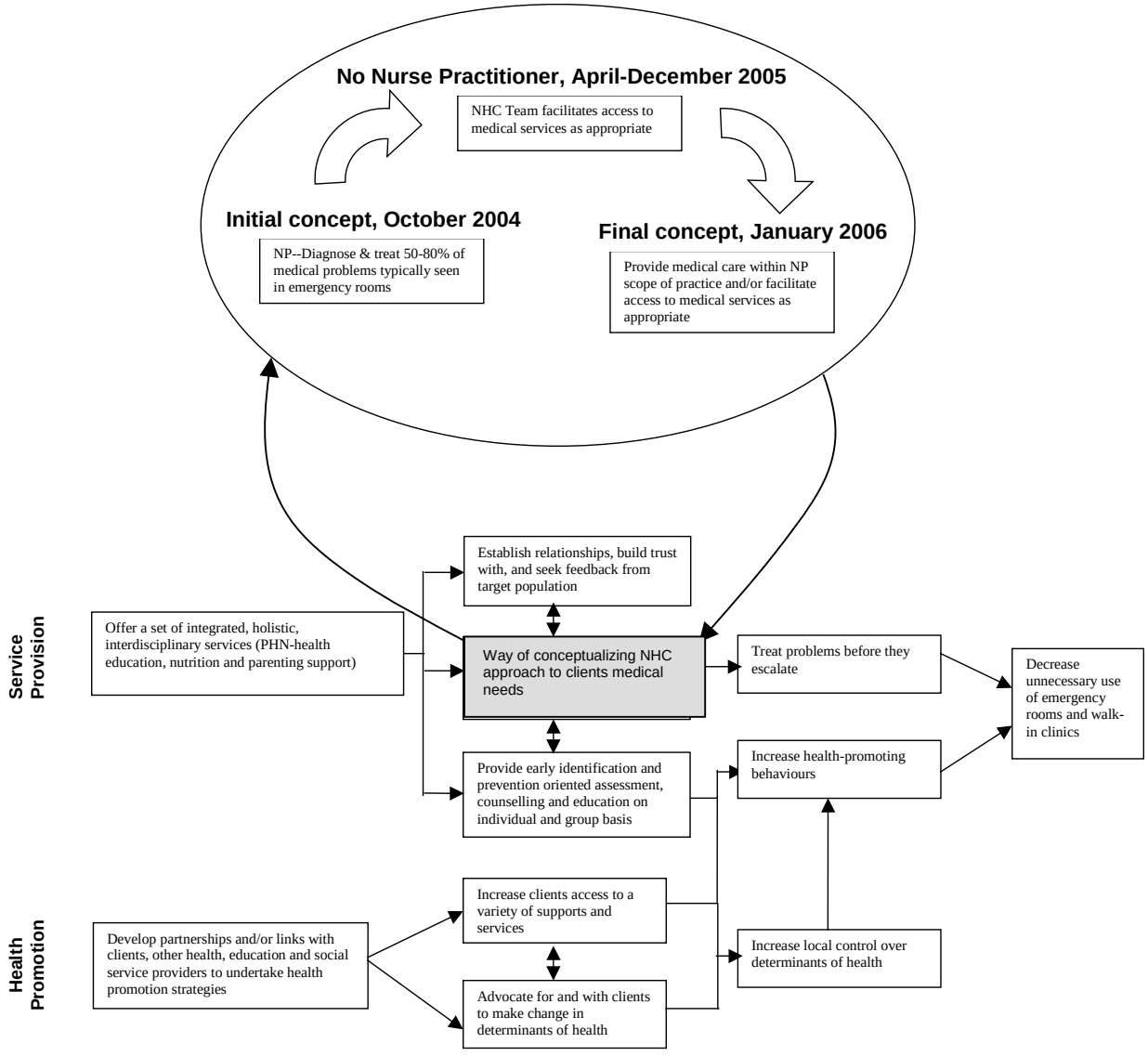
Figure 2.1 portrays how the NHC service concept was adapted in light of the challenge of filling with the Nurse Practitioner role, in the context of the NHC program theory.[5]

The gray-highlighted box in the middle of the diagram indicates the place in the model where the function of the Nurse Practitioner was represented. By this depiction one can see how the role of the Nurse Practitioner was considered central to the model. The

[4] Director of Family Health Services and NHC Program Manager.
[5] The bottom portion of the diagram corresponds to a key portion of the program theory logic model, page 11.

circle in the upper part of the diagram represents how the service concept was adapted during the course of the program, in response to the availability of a Nurse Practitioner.

Figure 2.1: Adaptation of the NHC Service Concept over Time With and Without the Role of Nurse Practitioner, in the Context of NHC Program Theory



As depicted, the initial conceptualization of the Nurse Practitioner role was described as follows: "Diagnose and treat 50%-80% of medical problems typically seen in emergency room". Thus, the Nurse Practitioner role was clearly framed in terms of the medical model. The Nurse Practitioner was to play the role akin to that of a physician. As discussed, client eligibility for the *any* of the NHC services was initially framed in terms of being eligible for service from the Nurse Practitioner (i.e., only if they did not have access to a family physician). The most tangible intended outcome of the program is represented by the box at the far right hand side of the diagram; to "decrease unnecessary use of emergency rooms and walk-in clinics." The logic of the link between Nurse Practitioner provision of medical services (diagnosis and treatment to prevent escalation of an illness) and this intended outcome seems quite direct and straightforward. This also reinforces the sense of the centrality of the medical aspect of Nurse Practitioner role to the service concept.

Without a Nurse Practitioner available, if a client were to present with any specifically medical needs, the NHC team would attempt to facilitate clients' access to other medical providers, through referrals and where necessary, advocacy. As well and perhaps more significantly, a deliberate intention was made to think more in terms of a "determinants of health" as opposed to clinical/medical perspective. This change in emphasis, combined with the lifting of the *no family physician* eligibility criterion, seemed to expand the existing team members' sense of the NHC service concept.

The NHC team functioned without the services of a Nurse Practitioner for eight months, beginning April 2005 through January 2006. During that period of time, the remaining three NHC team members developed into a highly cohesive team.

Summary

In review, the formative evaluation of early efforts to implement the NHC model resulted in some significant changes to the program. These included:

- A mechanism was instituted to more reliably elicit and process feedback from the various community-based organizations that hosted NHC clinic at their sites. This mechanism was a *Site Lead Committee*, made up of a designated representative from each organization to play the role of Site Lead. As well, a NHC team member was designated to serve as liaison for each site. The Site Lead Committee was to meet three times a year. Between meetings, NHC team members were to actively maintain open channels of communication with each site through the Site Lead.
- It was concluded that inadequate resources had been devoted to community-based promotion processes needed to develop strong links among the target population. Utilizing some of the funds that had been earmarked for a Nurse Practitioner, a decision was made to hire a Health Promoter on a part-time basis to perform this essential function.
- It was recognized how fundamental social determinants of health affected the ability of the NHC team to increase accessibility of primary health care among members of the target population. The team affirmed that they should keep social determinants of health perspective in mind, and to the extent possible, employ community development as well as clinical and health education strategies.
- A number of factors prompted the NHC team to reconsidered eligibility criteria for clients to receive services including: relatively low utilization in the early stages; the recognition of a real need for services among people who may have a family physician; and the lack of a full-time, fully integrated Nurse Practitioner practicing as part of the team. It was decided to open up all but NP services to anyone presenting for service, even if they have a family physician, if they otherwise met the eligibility criteria.
- The difficulty in recruiting a Nurse Practitioner had the unintended positive consequence of broadening the NHC service concept beyond a primarily clinical focus, to a more determinants of health perspective and approach.
- The role of Registered Dietitian was changed from a part-time to full-time role. The remaining NHC team members began developing in to highly cohesive team.

Section 3: Statistical Overview of NHC Services Provided

Number of Clinic Visits

The eight NHC clinics were opened in succession over the course of 12 months, beginning in October 2004. There were a total of 2,410 visits to various NHC clinic sites recorded during the period of October 4, 2004 through May 25, 2006. A "visit" refers to an instance in which a NHC team member or members provide some service or combination of services to an individual on a given day. Table 3.1 presents basic visit statistics for each clinic site, arranged in the order in which the clinics were opened.

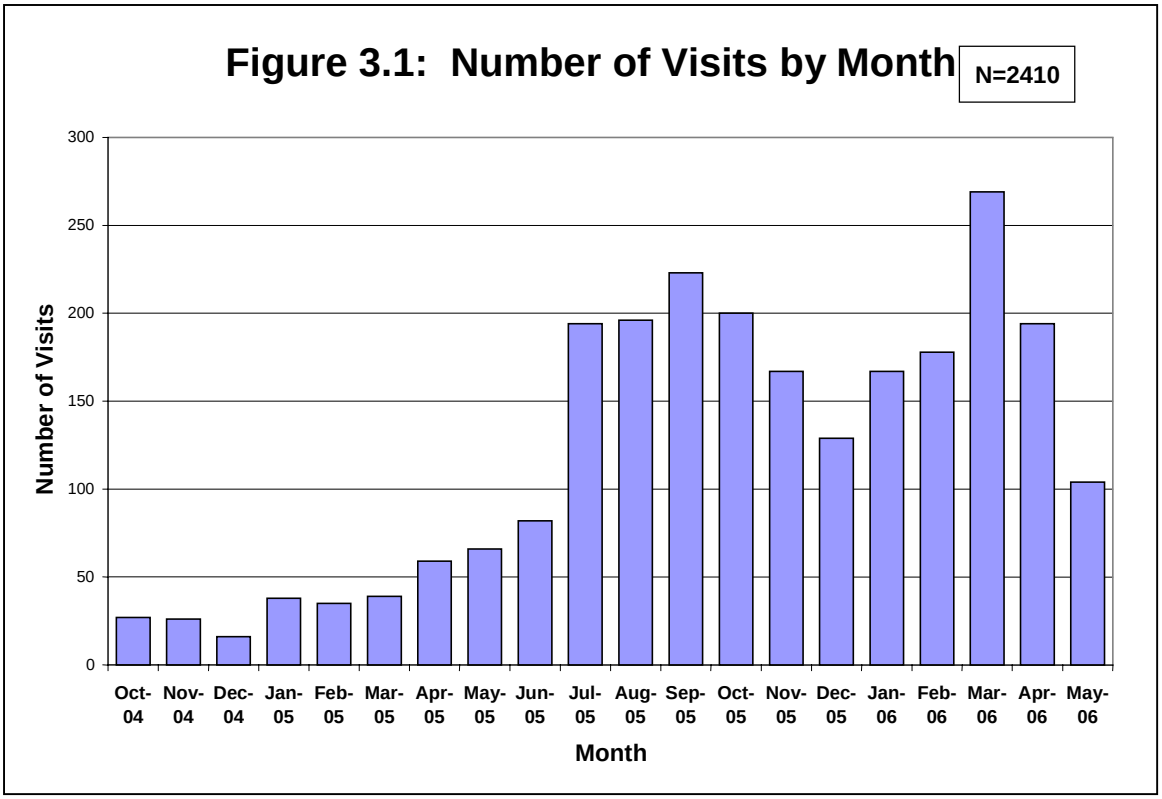
Clinics held at the two *Ontario Early Years Centres* attracted the greatest number of clients, together accounting for just over half of all visits to NHC clinics. This had a great deal to do with their connection with MLHU Well Baby and Breastfeeding Clinics that had been already established at those sites. Clinics that were held at the first two sites to be opened, i.e., those located at the Limberlost and Southdale public housing complexes, accounted for about 15% and 19% of clinic visits respectively. The clinic held at the Boulee Street public housing complex, which opened nine months after the first clinics were opened accounted for about 13% of clinic visits. Clinics held at the two public school sites attracted relatively few clients. This was a dilemma that the NHC team worked hard to overcome with limited success. The clinic held at *Families First in White Oaks*, opened at the same time as the Boulee Street clinic, and attracted fewer clients than the sites at the public housing complexes, but more than those located in the public elementary schools.

Visits per Clinic by Month

As portrayed in Figure 3.1, it took about nine months for clinic utilization to build to a fairly steady level. Increase in clinic utilization coincided with the decision to combine the NHC clinics with the Well Baby/Child Clinics held at the two OEYC sites beginning in July 2005.

Table 3.1: Length of Operation and Basic Visit Statistics by NHC Location

Clinic Location	Type of Location	Date Opened	Approx. Months of Operation	Total Visits		Average # of Visits per Month
				N	%	
Limberlost Housing Complex	Public Housing Complex	4-Oct-04	20	361	15.0%	18.1
Southdale Housing Complex	Public Housing Complex	4-Oct-04	20	450	18.7%	22.5
OEYC-Fanshawe	Ontario Early Years Center	18-Nov-04	18.5	615	25.5%	33.2
OEYC-Childreach	Ontario Early Years Center	12-Jan-05	16.5	631	26.2%	38.2
CC Carrothers Public School	Public Elementary School	15-Apr-05	13.5	65	2.7%	4.8
Boullee St. Housing Complex	Public Housing Complex	6-Jul-05	11.75	151	6.3%	12.9
Families First in White Oaks	Community Action Program	7-Jul-05	11.75	67	2.8%	5.7
Sir John A MacDonald Public School	Public Elementary School	14-Sep-05	8.5	21	0.9%	2.5
Unknown or other type of contact				49	2.0%	
Total Number of NHC Visits				2410	100.0%	



Number of Families Served

There were a total of 712 identifiable families served by NHC clinics from the time the clinics opened until the end of May 2006. For purposes of this report, "families" were made up of all individuals living in one household that came to any of the NHC clinics requesting service. Most typically, families included a mother and her biological children. NHC client families were comprised of a total of 1055 individuals. The total number of visits to clinics, number of families served, and the number of individuals that make up those families are summarized in Table 3.2.

Table 3.2: Basic Utilization Statistics

	N
Number of Families Served	712
Number of individuals (Within Families) Served	1055
Number of Visits (by all individuals)	2410

Number of Visits per Family

The NHC team documented each visit to a NHC clinic, for each member of a given household or family. For example, if a mother with two children visited a clinic on a given day, and each of the three individuals received some service, three "visits" to the clinic were recorded for that family on that day.

The average number of visits to NHC clinics per family was 3.4. Taken together, members of a given family received NHC service anywhere from 1 to 54 times. However, as indicated in Table 3.3, only one visit was recorded for 40% of families. Seven visits or less were recorded for the great majority of families.

A relatively small percentage of all families (10%) had 8 or more clinic visits recorded. This data is presented in both tabular and graphic form. Figure 3.2 is presented to convey a clear sense of the spread of those families who visited the clinics eight or more times.

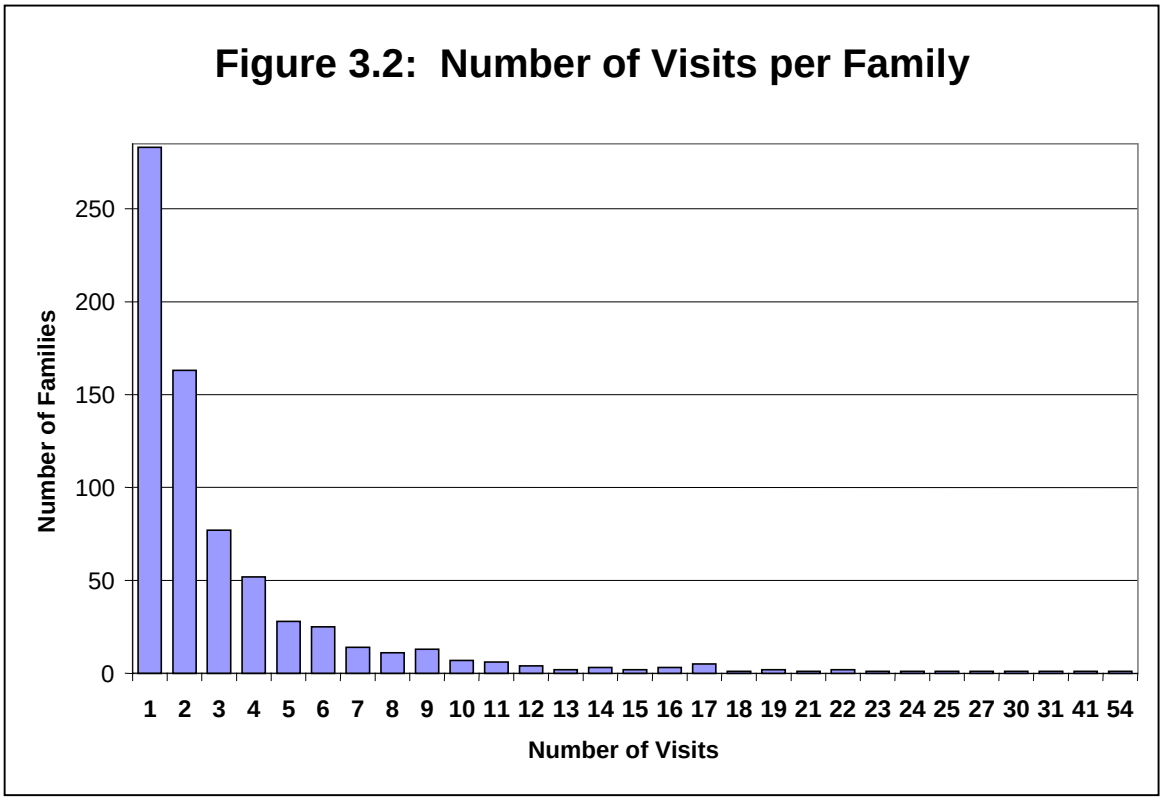


Table 3.3: Number of Visits Per Family

	N	%
1 visit	283	40%
2 to 3 visits	240	34%
4 to 7 visits	119	17%
8 visits or more	70	10%
Total	712	100%

Number of Families by Clinic Location

Figure 3.3 reports the number of families associated with each clinic location based on where the family's initial visit occurred.

As expected, the pattern is very similar to the distribution of visits by location reported in Table 3.1 above. There is some difference because in some cases clients visited more than one clinic site, or changed clinic locations.

Geographic Location of Client Families in Relation to Clinic Sites

The intent behind locating clinics in the various neighbourhoods was to make services more readily accessible to members of the target population. The data indicates which clinic site a client family initially visited, but does not indicate where they live. In order to determine the relationship between clinic site visited and place of residence, a mapping analysis was conducted based on clients reported postal code.

A separate map for each clinic site, with client family places of residence plotted on it, may be found in Appendix C. A description of the relationship between clinic sites and family's place based on an analysis of the maps is presented below.

Maps for each of the clinics held at public housing complexes show especially dense clusters of dots surrounding the clinic locations, suggesting the great majority of clients reside *within* the housing complexes. However, there are relatively few but still notable numbers of users of these clinics that reside some distance from the clinic sites. This may be explained partly by comment made in both the NHC team focus group and the NHC client focus groups that some clients traveled around to different clinic sites to obtain service.

The family locations of clients using clinics at the two public schools are also generally quite close to the clinic locations, however there are many fewer cases, and the family locations are not as tightly clustered around the clinic sites. This indicates that most of the relatively few users of these clinics did reside near the clinics. A similar pattern is found for the Families First in White Oaks clinic site.

The pattern observed for the two OEYC sites are quite similar to one another, and different from the other sites

discussed. While the densest concentration of family locations is near the clinic sites, there are proportionally many more families travelling further distances to attend these clinics. This is consistent with observations made elsewhere in this report that the OEYCs seem to draw from a socio-demographically broader population base than the other clinic sites.

Visits by Type of Client and Problem

Figure 3.4 reports the percent of visits made to all NHC clinics, in terms of three broad measures, child versus adult visits; new clients versus returning clients; and new problems versus follow-up problems. As shown, 56% of the visits to clinics were child visits, while 44% were adult visits. Fifty eight percent (58%) were first time visits (i.e., new clients) while 42% of visits were return visits by clients who had previously come to a NHC clinic for service. Sixty five percent (65%) of the visits concerned new problems (problems for which the client had not previously visited a NHC clinic), while 35% of visits were visits to follow-up on previously presented problems.

Figure 3.3: Number of Families by Clinic Location

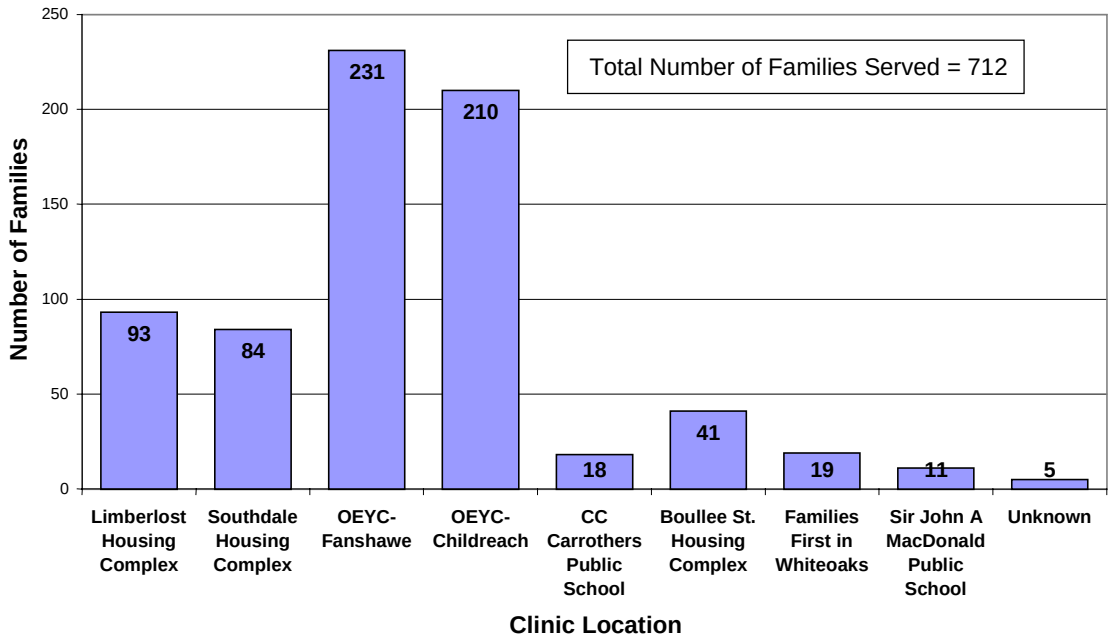
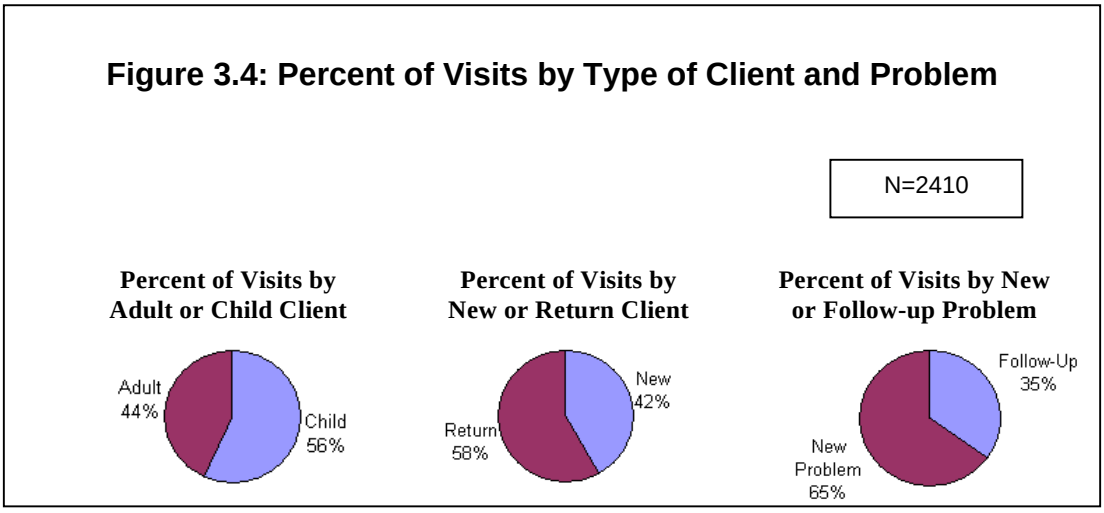


Figure 3.4: Percent of Visits by Type of Client and Problem



Types of Presenting Problems

In order to get some understanding of the types of problems clients came to the NHC clinics with, an analysis of types of services provided to new clients during their initial visit to a NHC clinic is presented below.

To review, there were a total of 2410 visits recorded among 712 families comprised of 1055 individuals. During any given visit, a client may have received one or more services from one or more of the NHC team members.

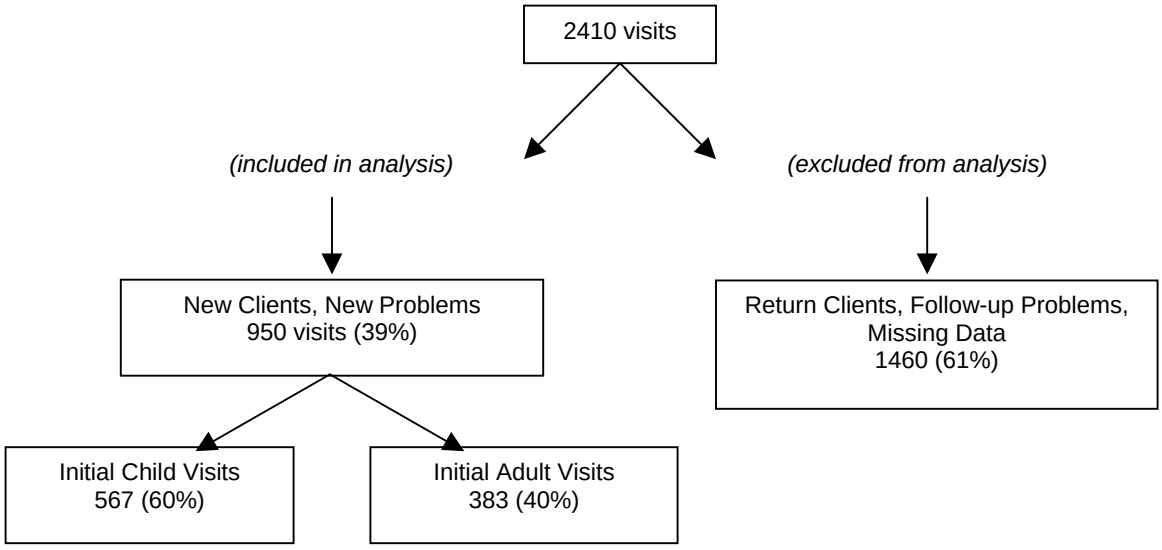
NHC team members documented all services provided during each visit on the client intake record, according to the categories presented in Table 3.4. In addition, the team member doing intake would write down the *reason for visit* on the intake form.

Table 3.4: Types of Services Provided to Adults and Children

Adults	Children
Breastfeeding	Dental
Immunization	Development
Mental Health	Growth/Weight
Nutrition	Immunization
Parenting	Nutrition
Physical Well-Being	Physical Well-Being
Postpartum Depression	Safety
Prenatal	
Sexual Health	
Smoking	
Woman Abuse Screening	

As portrayed in Figure 3.5, there were a total of 950 documented visits involving new clients presenting new problems (almost 40% of all visits.) Of these, 567 (57%) were child visits, and 383 (40%) were adult visits.

Figure 3.5: Cases Included in Analysis of Services Provided During Initial Visits



Types of Services Provided During Initial Visits

As reported in Table 3.5, the NHC team provided services related to monitoring children's growth and weight at about three quarters of all initial children's visits. This figure is substantially greater than any other services offered. This is consistent with the finding that most NHC visits happened at the OEYCs, where the NHC clinics were combined with the MLHU Well Baby/Child and Breast Feeding Clinics. The type of service provided to clients under the heading *growth/weight* are very similar to those provided at Well Baby/Child Clinics. Babies are weighed and measured to make sure they are developing normally. Nurses assess parents' knowledge, skills, and any concerns they may have and provide teaching, information and referrals. Though the services provided as categorized under this heading are similar to Well Baby/Child clinics, the difference between NHC and WBC Clinics (as described in some detail in starting on page 53) has to do with the depth and range and service the NHC team was able to provide because of the multidisciplinary team.

Table 3.5: Types of Services Provided to Children at Initial Visit (N=567)

Type of Service	Number of Initial Child Visits	% of Initial Child Visits
Growth/Weight	434	76.5%
Physical Well-being	163	28.7%
Nutrition	158	27.9%
Development	129	22.8%
Immunization	54	9.5%
Safety	18	3.2%
Dental	16	2.8%

Next in order of frequency, nearly 30% of initial children's visits involved service related to children's *physical well-being.* This category would generally include problems that would be considered "medical" concerns, but encompassed a wide variety of reasons for visit. To get a sense of the type of problems that NHC team members categorized under this heading, see Appendix D. This appendix lists the *reason for visit* charted for all new child, new problem visits which the NHC team member who documented the services categorized under the heading physical well-being. Any given reason for visit may have been categorized under more than one heading.

As reported in Table 3.6, most of the documented services provided to adult clients at initial visits had to do with breastfeeding and physical well-being.

Table 3.6: Types of Services Provided for Adults at Initial Visit (N=383)

Type of Service	Number of Initial Adult Visits	% of Initial Adult Visits
Breastfeeding	101	26.4%
Physical Well-being	84	21.9%
Parenting	50	13.1%
Sexual Health	33	8.6%
Mental Health	32	8.4%
Nutrition	28	7.3%
Prenatal	28	7.3%
Immunization	25	6.5%
PPD	16	4.2%
Woman Abuse Screening (RUCS)	11	2.9%
Smoking	10	2.6%

The types of problems which the NHC team members recorded under *the physical well-being* category included medical as well as other concerns. To get a sense of the type of problems that NHC team members categorized under this heading, see Appendix E. This appendix lists the *reason for visit* charted for all new adult, new problem visits which the NHC team member who documented the services categorized under the heading physical well-being.

Types and Total Units of Service Provided for all Visits

Table 3.7 considers services provided at *all* children's visits to clinics. The distribution is very similar to the distribution of services at children's initial visits. As shown, totaling the number of visits for each category of service given yields a figure of 2,226 units of service to children at NHC clinics.

Table 3.7: Services Provided at All Children Visits (N=1361)

	Number of Visits	% of Visits
Growth/Weight	1078	79.2%
Nutrition	378	27.8%
Physical Well-being	334	24.5%
Development	256	18.8%
Immunization	107	7.9%
Safety	48	3.5%
Dental	25	1.8%
Total Units of Service to Children	2226	

Similarly, Table 3.8 considers all adult visits to clinics. Again, the distribution of services provided at visits is very similar, with one notable exception. As comparison of Tables 3.6 and 3.8 indicates there was a substantial difference between the percentage of *initial visits* during which breastfeeding related services were provided (26.4%), compared to the percentage of *all* adult visits

during which breastfeeding related service was provided (13.4%). This amounts to 13% difference. It suggests that while breastfeeding concerns were often the initial presenting concern of women visiting the NHC clinics, in the end the team provided a more comprehensive service. This conclusion is consistent with findings from both the NHC client focus groups and NHC team focus group. Those data suggest that the Well Baby/Child and Breastfeeding Clinics were often the initial access point for NHC clients, and that once introduced to the service, clients were provided a much more in-depth service and holistic than could be provided at the Well Baby Clinics alone.

Table 3.8: Services Provided to All Adults Visits (N=1049)

Type of Service	Number of Visits	% of Visits
Physical Well-being	231	22.0%
Breastfeeding	141	13.4%
Parenting	132	12.6%
Mental Health	87	8.3%
Sexual Health	81	7.7%
Nutrition	68	6.5%
Prenatal	57	5.4%
Immunization	51	4.9%
PPD	26	2.5%
Smoking	23	2.2%
Woman Abuse Screening (RUCS)	19	1.8%
Total Units of Service to Adults	916	

Summary

- Based on intake data collected by NHC team members between October 4, 2004 and May 25, 2006, a total of 2,410 visits were made to NHC clinics by 712 families which were comprised of a total of 1,055 individuals.
- Clinic held at the two Ontario Early Years Centres were the most highly utilized, accounting for more than half of all client visits. Clinics held at the public housing complexes also accounted for substantial numbers of visits at between 13% and 19%. Clinics held at the public elementary schools and Families First in White Oaks attracted relatively few clients.
- It took about nine months for clinic utilization to build to a fairly steady level. Increase in clinic utilization coincided with the decision to hold two of the NHC clinics in conjunction with Well Baby/Child and Breastfeeding Clinics at the OEYC sites.
- The average number of visits to NHC clinics per family was 3.4. Forty percent of families visited a NHC clinic only once. Almost 75% of families visited clinics 1 to 3 times. About 10% of families visited a NHC clinic 8 or more times.
- Child visits accounted for 56% of all visits, while adult visits accounted for 44% of all visits. Fifty eight percent of visits were first time visits, while 42% were return visits. New problems were presented at 65% of clinic visits, while 35% of visits were follow-up visits dealing with previously presented concerns.
- As proxy measure of what types of services clients were seeking when they first visited a NHC clinic, we considered what types of services clients received at initial visits, in terms of 11 types of adult services and 7 types of child services tracked by NHC team members at the point of service.
- Monitoring growth and weight was the focus of about 75% of all initial children's visits. This service is very similar to services provided at Well Baby Clinics, and the prevalence of its provision would appear to reflect the conjoint offering of the two types of clinics.
- Next in order of frequency at 30% of initial child visits, was service related to physical well-being. This category would generally include (but not be restricted to) services that deal with "medical" concerns.
- Similar to what was found with children, most of the documented services provided at initial adult visits had to do with either breastfeeding (at 26%) or physical well-being at 22%.
- When considering *all* visits versus *initial* visits, a noteworthy difference was found. The distribution of services across *all visits* for *children* was almost the same as for *initial visits*. However, for adults there was a change. While 26% of *initial* adult visits were concerned with breastfeeding, only 13% of *all* adult visits were concerned with breastfeeding. This suggests that while breastfeeding is often the initial presenting concern for many clients, in the end, the NHC team provides a more comprehensive service than is available at the Well Baby Clinics alone.

Section 4: Characteristics of Clinic Users

The purpose of this section of the report is to compare the characteristics of users of the NHC program with the target population. As discussed in the introduction, the target population included:

- Persons with no access to a family physician (was not enrolled with a family physician or had some legitimate barrier to access)
- Young families with children 0-6 years of age (includes parents, children, caregivers)
- "Vulnerable families" understood as persons residing in "under-serviced, high-risk neighbourhoods" including recent immigrants.

Gender Profile of Adults in Families Receiving NHC Services and Number of Children per Family

Before assessing the extent to which the program served the target population in terms of criteria defined in the original funding proposal, it is appropriate to consider some basic characteristics of families who used the NHC program.

As reported in Table 4.1, of all the families that presented for service, in nearly 78% of the cases, one adult female presented at the clinic seeking service for herself and/or on behalf of her family. No other adult sought or was provided service as part of any of these families. We have no data as to the marital status of these women. They may or may not have had a partner at home.

Table 4.1: Gender Profile of Adults in Families Receiving NHC Services

	N	%
One Adult Female	552	77.5%
Male and Female Adult	114	16.0%
One Adult Male	37	5.2%
Two Adult Female	6	0.8%
Unknown	3	0.4$
Total	712	100.0%

Sixteen percent of families had one adult male and one adult female present for service. About 5% of the families had one adult male present for service. A very small number of families had two adult females present as members of one family. (We have no data to suggest what type of relationships these represented for e.g., mother and daughter or same sex couple).

As presented in Table 4.2, almost 60% of NHC families lived in households with one child. About 19% lived in households with 2 children. About 7% lived in households with 3 children. Less than 4% of household had 4 or more children residing there. The 11.7% of families for which data is missing likely includes some families with women who were currently pregnant and had no other children living with them at the time..

Table 4.2: Number of Children

	N	%
One Child	424	59.6%
Two Children	134	18.8%
Three Children	48	6.7%
Four Children	10	1.4%
Five Children	13	1.8%
Unknown	83	11.7%
Total	712	100.0%

Assessing Eligibility Status

Each time a client visited a NHC clinic, the team member doing intake was supposed to obtain or confirm basic eligibility information, including whether they currently had a family physician, whether they were pregnant or had any children up to age six years old. If they did have a family physician, the team member was supposed to inquire whether there were any barriers that prevented them from accessing their family physician, in which case they would be deemed still eligible for service. It was decided to collect this information at each visit rather than only at first visit, in recognition that eligibility status could change over time. Therefore the data reported immediately below is based on individual visits rather than on family information.

Access to Family Physicians

As indicated in Table 4.3, clients reported not having a family physician at almost one quarter (23%) of all clinic visits. (We have no data for about 3% of the cases.)

Table 4.3: Family Doctor Status of Clients at Time of Visit

	N	%
No Family Doctor	554	23.0%
Does Have Family Doctor	1789	74.2%
Missing	67	2.8%
Total	2410	100.0%

Children/Pregnancy Status

As indicated in Table 4.4, clients were reported to live in households with pregnant women or children ages 0 to 6 years at almost 92% of clinic visits. In about 4% of the cases it was reported that clients did not fall into this category, and in another 4% of cases no data was reported.

Table 4.4: Whether Client Lived in Household with Pregnant Woman or Child 0-6 Years at Time of Visit

	N	%
No	98	4.1%
Yes	2215	91.9%
Missing	97	4.0%
Total	2410	100.0%

Eligibility for NP Service

If a client had a family physician (or no legitimate barrier to accessing that physician), and if they did not live in a household with a pregnant woman or children ages 0 to 6 years old, technically they were not eligible for receiving the services of the Nurse Practitioner.[6]

Based on data reported for each client visit in terms of these criteria, clients were eligible for Nurse Practitioner services in just over 26% of clinic visits. (No data was available for 4.2% of the cases.)

Table 4.5: Client's Eligibility for NP Service at Time of Visit

	N	%
Not Eligible	1678	69.6%
Eligible	630	26.1%
Missing	102	4.2%
Total	2410	100.0%

Utilization by Recent Immigrants

As displayed in Table 4.6, 8.4% of the families served by the NHC program were identified on the intake form as having immigrated to Canada within the past 5 years. If we exclude the 84 families for whom we do not have information about immigration status from the analysis, we would estimate that 9.6% of families were recent immigrants.

[6] According to the original service concept as outlined in the funding proposal. See page 18 for further discussion of how the eligibility criteria were revised due to the inability to recruit a full-time Nurse Practitioner until late in the program.

Table 4.6: Immigrant or Refugee Family Living in Canada Less Than 5 Years?

	N	%
No	568	79.8%
Yes	60	8.4%
Total	628	88.2%
Missing	84	11.8%
Total	712	100.0%

To get some indication of the extent to which the program was successful in reaching new immigrants, we can compare the proportion of new immigrants among NHC clients, with the proportion of new immigrants in the general population. Census data is available which indicates the proportion of the general population that has immigrated to Canada within the last *10 years*. Although the difference in time frame between our data and the census data does not allow a direct comparison, some comparison may be meaningful. According to 2001 census data from Statistics Canada for the City of London, 5.5% of the population of London (18,475 of 332,935 residents) had immigrated to Canada in the 10-year period between 1991 and 2001. If we had asked NHC client families whether they had immigrated in the last *10 years* (rather than 5 years) it is reasonable to assume that a higher proportion of families—perhaps up to twice as many—could be characterized as recent immigrants.

To review, 8.6% of NHC clients were recorded as having immigrated to Canada within the last 5 years, compared with 5.5% of the general population of London having immigrated within a recent 10-year period. It is likely that substantially more than 5.5% of NHC clients immigrated to Canada within the last 10 years. Therefore, it is reasonable to conclude that the proportion of recent immigrants served by the NHC program was *moderately higher* than the proportion of recent immigrants in the general population of London.

Recent Immigrant Status and Which Clinic Site Utilized

Clinic sites were chosen in part to be accessible to areas with relatively high proportions of immigrants and refugees. Were newcomers more likely to visit any particular sites? Table 4.7 allows us to compare the percentage of families associated with each site that were newcomers, with the 9.6% of all NHC families in total[7] that were newcomers. It indicates that the sites at the Limberlost and Southdale public housing complexes attracted a relatively high proportion of newcomer families (19% and 16% respectively), especially compared to the OEYCs. The highest relative percentage of newcomer families attended Families First in White Oaks (42%), however this figure is based on relatively few cases, and should therefore be interpreted with caution.

[7] The 84 families for whom we do not have data on immigration status were eliminated from this analysis.

Likewise, the public schools probably did not have enough cases upon which to base any firm conclusions about their accessibility to newcomer families relative to Canadian born families.

Table 4.7: Crosstabulation of Clinic Location by Immigrant Status of NHC Families (N=628)

		Immigrant or Refugee less than 5 years in Canada?	
		No	Yes
Limberlost Housing Complex	N	59	14
	%	80.8%	19.2%
Southdale Housing Complex	N	64	12
	%	84.2%	15.8%
OEYC-Fanshawe	N	200	8
	%	96.2%	3.8%
OEYC-Childreach	N	181	11
	%	94.3%	5.7%
CC Carrothers Public School	N	13	1
	%	92.9%	7.1%
Boullee St. Housing Complex	N	32	4
	%	88.9%	11.1%
Families First in White Oaks	N	11	8
	%	57.9%	42.1%
Sir John A MacDonald Public School	N	8	2
	%	80.0%	20.0%
Total	N	568	60
	%	90.4%	9.6%

Income Profile of NHC Families Based on Postal Code Analysis

One social indicator that may be used as a measure of both "vulnerable families" and "high-risk neighbourhoods" is income. In the interest of privacy protection, we did not collect income information from NHC clients. We did however collect postal code information. Postal code information allows us to obtain average income information about families living in the area denoted by a given postal code (referred to as a "dissemination area") through Statistics Canada census data.

We are not able to determine the income level of any specific NHC family, however we assume that in most cases a family's income level will be similar to others living in the same dissemination area. (For purposes of this analysis we are referring to dissemination areas as "neighbourhoods", although by most sociological definitions, neighbourhoods would be made up of several dissemination areas.)

The incidence of low income in neighbourhoods where NHC families live is compared with the general population of London in Table 4.8. The data in this table is derived from income values associated with postal codes in the 2001 census. The income measure used in this table is *incidence of low income*.[8] This table can be interpreted as follows. Read across the first row of the table labeled "0 to 16% Low Income Families". This row indicates that 62.4% of families in London lived in neighbourhoods in which between 0 and 16% of the families are low income, compared with 47.8% of NHC families.

Table 4.8: Incidence of in NHC Families and City of London Families Living in Low Income Neighbourhoods

Proportion of Low Income Families in Neighbourhood	City of London "Census Families" #		NHC Families	
	N	%	N	%
0 to 16% Low Income Families	55,980	62.4%	267	47.8%
> 16% to 35% Low Income Families	24,020	26.8%	130	23.3%
> 35% to 50% Low Income Families	6,920	7.7%	59	10.6%
> 50% Low Income Families	2,845	3.2%	103	18.4%
Total	89,765*	100.0%	559**	100.0%

Source: Statistics Canada, 2001 Census.

*Based on dissemination areas with valid low income numbers; 2,065 census families excluded from analysis.

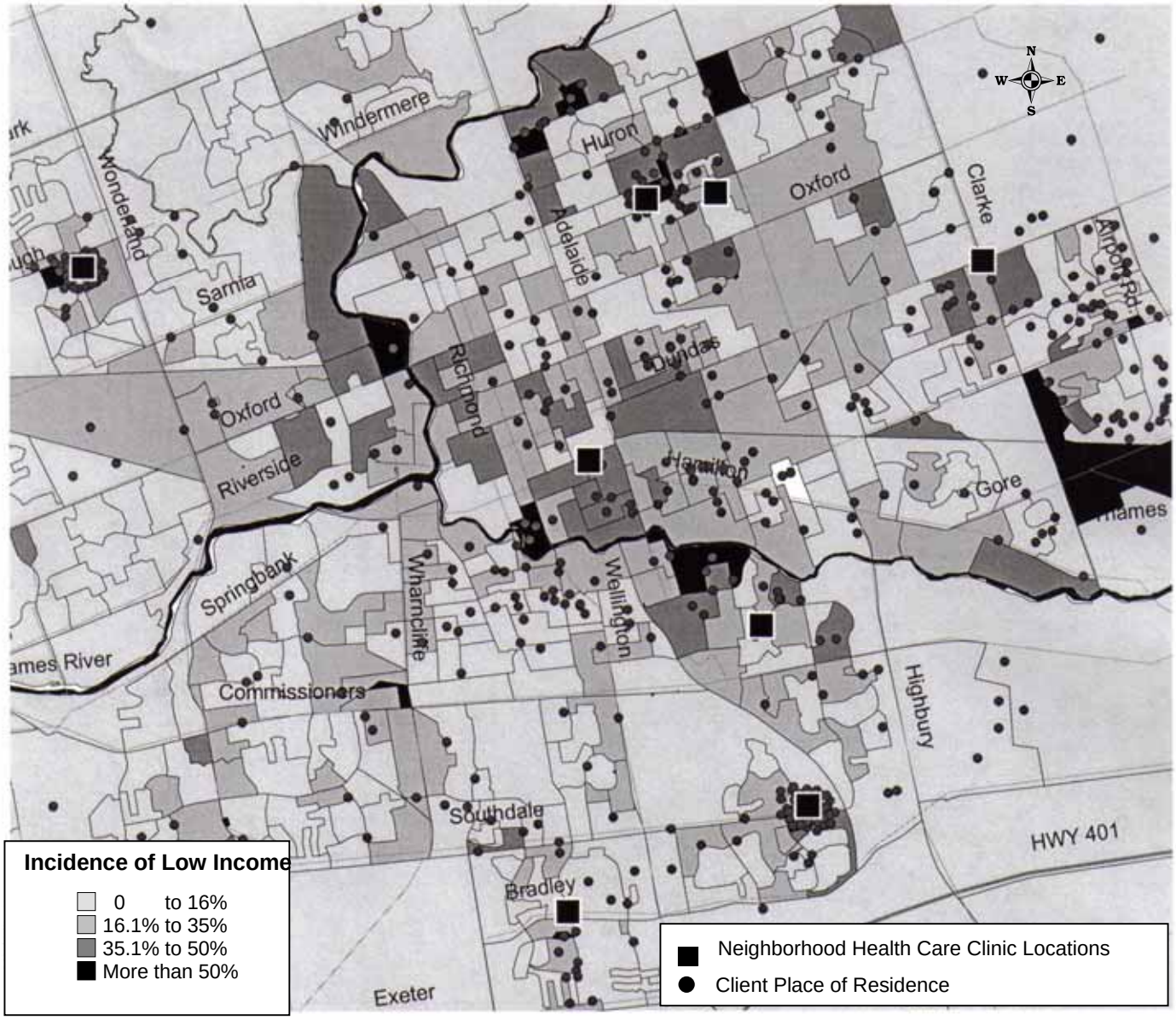
**153 NHC with no postal code data excluded from analysis.

[8] *Incidence of low income* is defined by Statistics Canada as "the proportion of economic families or unattached individuals in a given classification below the low income cut-offs."

Table 4.8 indicates that the NHC clinics drew clients from a range of income levels. The greatest proportion of NHC clients (nearly 48%) lived in areas with relatively low incidence of low income. By comparison however, substantially more families in the general population of London lived in areas with low incidence of low income (about 62%). In other words, most NHC clients lived in reasonably well off neighbourhoods, though to a lesser degree than the general population. However, compared to the general population, a substantial proportion of NHC families lived in low-income neighbourhoods (3.2% compared to 18.4%). If we collapse the last two categories into one category (> 35% low-income families), 29% of NHC families lived in lower income areas compared to 11% of families in the general population of London.

A supplemental mapping analysis has been conducted to add further perspective on the relationship between client families' places of residence and incidence of low income, based on postal code analysis using data available from Statistics Canada. In Figure 4.1 client families' places of residence are plotted on a map of the City of London which also displays incidence of low income by postal code area and NHC clinic locations. The map indicates while NHC clinic users are distributed across areas with a range of income-levels, there are clusters of families near lower-income levels.

Figure 4.1: NHC Families' Areas of Residence and Incidence of Low Income - City of London (2001 Census)



Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Summary

In terms of a gender profile of adults and number of children per household, the characteristics of NHC families can be summarized as follows:

- Almost 78% of the families recorded in the NHC intake database had one female adult as the only adult member of the household presenting for service. Sixteen percent (16%) had an adult female and adult male registered. About 5% had a one male adult registered as the only adult member of the household presenting for service.
- Almost 60% of NHC families lived in households with one child. About 19% lived in households with 2 children. About 7% lived in households with 3 children. Less than 4% of household had 4 or more children residing there.

The stated target population for the NHC program included persons without access to a family physician, young families (with children ages 0 to 6 years) and "vulnerable populations" (defined in terms of recent immigrant status and living in "high-risk areas"). In terms of these characteristics, the profile of NHC clinic users is as follows:

- Clients were recorded as having no family physician at about 23% of all client visits.
- Clients were recorded as being part of a young family at 92% of all client visits.
- People seeking service at NHC clinics were eligible to receive the services of the Nurse Practitioner only if they met all three eligibility criteria. Based on a strict definition of eligibility, clients were eligible for NP services at about 26% of all client visits.
- About 8.4% of NHC clients had immigrated to Canada within the last *5 years*. When comparing this to the 5.5% of the general population of London that immigrated to Canada within the last *10 years*, one may conclude that the proportion of recent immigrants served by the NHC program was *moderately hig*her than the relative proportion of recent immigrants in the general population.
- We used postal code data to determine the incidence of low income in the neighbourhoods NHC families' lived in compared to the general population, as an indicator of the extent to which the program served persons residing in "high-risk areas". The NHC program drew clients from a range of income levels. Almost half of the clients could be said to live in reasonably well off neighbourhoods. However, compared to the general population, a substantial proportion (18.4% compared to 3.2%) lived in low-income neighbourhoods (areas with more than 50% of incidence of low-income household.)

Section 5: How the Clinics Operated

The Services

As discussed, the NHC team was made up of four different health professionals. Each had her own area of specialization. However, the members were intended to function as an integrated, holistic, multidisciplinary team. How this worked in practice is discussed further below. Table 5.1 presents the services provided by each team member as it appeared on flyers that were produced for program promotion purposes.

Table 5.1: Services Provided by NHC Team Members

Public Health Nurse	Registered Dietitian	Early Years Resource Consultant	Nurse Practitioner
• Physical & mental health • Healthy relationships • Breastfeeding support • Quit smoking tips • Managing stress • Women's health issues • Birth control options • Pregnancy information • Well baby and weight checks • Immunization information	• Healthy eating & physical activity • Prenatal nutrition • Formula feeding • Introduction to solids • Fussy eaters • Food allergies • Diabetes education • Food banks • Community gardens • Collective kitchens	• Child development 0-6 years. • Positive discipline • Routines in the home • Toilet training • Temper tantrums • Child safety • Parenting resources • Speech and language checks	• Treatment of common illnesses such as fevers, colds, earaches & flu • Well baby care • Immunizations • Birth control, sexuality transmitted infections • Monitor and screening for chronic illnesses • Annual health exam (male & female) including PAPs and lab work • Health promotion • Disease prevention • Prenatal care

The Schedule

As described earlier, the eight clinics were opened in succession over the course of 12 months. As of September 2005, the clinics operated according to the following schedule.

Table 5.2: Weekly Neighbourhood Health Care Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
Mornings 9:30 a.m. - 11:30 a.m.	**C.C. Carrothers Public School**		**Sir John A MacDonald Public School**	**Childreach (OEYC London North Centre)** In conjunction with MLHU Well Baby/Child and Breastfeeding Clinic	
Afternoons 1:30 p.m. - 3:30 p.m.	**Limberlost Housing Complex**	**Southdale Housing Complex** Supported by OEYC London West	**Boulee Housing Complex**	**Families First in White Oaks**	**OEYC London Fanshawe** In conjunction with MLHU Well Baby/Child and Breastfeeding Clinic

Tuesday mornings from 8 a.m. to 10 a.m. were reserved for weekly NHC team meetings. Friday mornings were reserved for any other administrative matters that may have needed to be attended to. Charting was supposed to be done at the clinics to the extent possible. When clinics got busy, team members often did charting after hours.

The Settings

The different types of settings in which the NHC clinics operated offered certain advantages and disadvantages. The crucial advantage all sites had in common—the reason they were chosen—was their location in neighbourhoods close to members of the target population. Another perceived advantage, as reflected in the program theory logic model, was that by locating in existing community-based service organizations, the NHC team had an opportunity to build on established relationships that these organizations may have already developed with members of the target population.

One general disadvantage mentioned by NHC team members had to do with the very concept of travelling clinics that "borrow" space in various settings normally used for other purposes. NHC team members had to haul equipment, supplies and files from site to site, and set up and take down each clinic eight times a week. This was time consuming. As well, the adequacy of the space provided for the NP to conduct clinical examinations varied. In only one setting (one of the public housing complexes) did the NP have what she considered a proper clinical examination table to use. In the other settings she used portable massage tables.

Ontario Early Years Centres[9]

The two Ontario Early Years Centre sites in some ways were the most congenial settings in which to operate the clinics. Their clientele was very much consistent with at least a segment of the NHC target population, that is young families. The facilities were ideal in terms of being family-centred and child friendly settings, and accessible by bus. Some members of the target population were already accustomed to coming to OEYCs to access Well

[9] See http://www.ontarioearlyyears.ca/ for description and location of OEYC London Fanshawe and London North Centre.

Baby/ Child Clinics. Arrangements could be negotiated under some circumstances for children to be supervised by OEYC staff to allow parents to receive NHC services, such as physical exams from the NP. Most often however, the EYRC would interact with or supervise children when parents' attention needed to be diverted from their children in order to receive services.

The clinics were set up in two separate spaces within the facilities. NHC team members generally worked together as a team within a fairly large meeting room. The exception to this was when the NP was providing services such as internal examinations and pap smears. A smaller space was set up in separate room for the NP to provide these services. Clients were invited and welcomed into the main room by one of the NHC team members monitoring for arrival of clients, or directed into the space by an OEYC staff member. One or more stations were set up (depending upon if the NHC clinic was running in conjunction with the Well Baby Clinic) for assessing, weighing and measuring babies. There were chairs and a play space with toys set up in the room for anyone waiting for service. A NHC team member would receive clients and conduct an intake interview. Depending on the presenting need, clients were then directed to one or more NHC team members for a consultation. Consultations were done in a fairly informal manner, often with a fair degree of interaction between NHC team members, as well as passing clients back and forth in order to do assessments, and provide teaching and information as appropriate. When the OEYC clinics were busy, there were quite a few bodies circulating around this space at one time.

A private space was required in order to provide clinical NP services, such as internal examinations. At one of the OEYCs, a separate room with a sink and running water was made available for this. In the other, the service was performed behind a partition. The latter was much less satisfactory from the point of view of offering clients a sense of security and privacy.

Public Housing Complexes

Perhaps the most significant advantage of the clinics operating at each of the three public housing complexes was to be given exclusive use of an entire townhouse unit while the clinics were operating. The NP was able to set up a separate, private space for clinical examinations with access to running water. There was sufficient space for private consultation by any NHC team member with any given client as needed. There was also adequate play space for children to be kept amused while parents were receiving service.

The processing of clients through the clinics was similar to the process described above.

Another advantage of the public housing complexes was their proximity to another segment of the target population. That is, they are literally within "under-serviced, high-risk" areas. This fact amounted to a "double edged sword". As discussed earlier there was a perception among members of the target population who did not reside within the housing complex that the service was restricted to members of the housing complex. In other words, while the locating of clinics within public housing complexes was a *facilitator* to access for people residing within the complex, it appears to have been somewhat of a *barrier* for those who may have resided nearby, but outside the boundaries of the complex.

The idea of building on established programs that have established relationships with the members of target population was a key principle in choosing host sites. One of the sites, Limberlost, has had an active "chaplaincy program" sponsored by the United Church operating out of a townhouse unit for many years. A full-time chaplain is paid to do community development work with community residents. By contrast, the Southdale site did not have any ongoing organized community development work taking place within the housing complex. One of the challenges faced by the NHC team in getting the clinic established there was to forge links with community members and other service providers in the area.

Co-op Townhouse Setting

One of the last clinic sites established was at a "community action program" called Families First in White Oaks[10]. This organization operated out of a townhouse unit within housing cooperative complex of 76 units. Clinics were conducted in the townhouse unit in a manner very similar that described for public housing complexes. The townhouse unit served as the offices of the community action program, whose staff would vacate the unit during clinic operation. There was a main room used for most consultations, and a smaller private room for NP clinical services.

Public Elementary Schools

Choosing public elementary schools as NHC sites was not part of the initial plan as written in the funding proposal. The subsequent decision to locate in the schools was made in anticipation of the full development of an emerging program of the Province of Ontario; that is, the *Best Start* program[11]. To be supported by federal funding, Best Start was envisaged partly as a strategy to develop a national licensed child care system, and partly as a more general program to foster healthy early childhood development. Health units and school boards were among the community partners identified by the province in this plan. The thinking was that the *early learning and care hubs* which were key to the plan, were likely to be established in elementary schools. With this in mind, it seemed that locating NHC clinics in appropriate neighbourhood schools could dovetail nicely with the Best Start program. However the change of

[10] See http://www.ffwo.org/ for a description of the program.
[11] See http://www.children.gov.on.ca/CS/en/programs/BestStart/default.htm

federal government in 2006 resulted in changes in plans for a national child care strategy that affected funding of the Best Start program. As well, the pace of implementation of the early learning and care hubs aspect of the program, together with the lack of sustainability funding for the NHC at this time has meant that the vision of a NHC operating in conjunction with Best Start did not come to fruition.

Aside from the Best Start considerations, neighbourhood elementary schools were perceived to be a very good site to offer NHC services because of their public nature, their accessibility, obvious connectedness to young families, and their rootedness in local communities. The local school may be the quintessential neighbourhood institution.

The same basic principle for setting up clinics as described for the other settings applied in the public elementary schools, in terms having access to one reasonably large room for intake and general consultations from team members, and access to a more private space for the NP to conduct clinical examinations. In one of the schools, the space that was made available was a resource room located in the basement of the school. As such, the clinic site was not in a particularly visible location. This was perceived as a disadvantage by both NHC team members and clients. One young mother commented in one of the NHC client focus groups that it was very difficult to get up and down the stairs with a stroller.

As discussed earlier in this report, the public elementary schools were the least utilized of the types of NHC clinic locations. Resources were not available as the school clinics were being opened to rent signage as had been done in other locations. NHC team members spent a great deal of effort trying to generate more utilization by the families whose children attended and/or lived near the school. Efforts included promoting the program through teachers, sending home information with students, talking informally with teachers and parents at the school, going door-to-door in the community, and promoting the program through nearby community service organizations.

NHC team members were asked why they thought utilization of the school-based clinics was so low. One team member speculated that it might have to do with negative associations parents may have with schools from their own childhood experiences. NHC clients were asked during the three client focus groups why they thought people were not utilizing the school-based clinics. (Six of the 20 focus group participants had accessed a school-based NHC clinic.) The only possible reasons suggested were the stairs, and parking problems.

Observation of Clinics

The information presented in this section of the report is based on direct observation of NHC Clinics in operation by the report author. Because of the nature of the data, the information is presented below in a first person narrative style.

NHC clinics were observed at four different locations on four separate occasions. The approach taken was to observe each clinic in as low key and unobtrusive manner as possible. Brief notes were taken during and shortly after observing each clinic. The following is an amalgam of impressions gleaned from observing the four clinics.

Childreach (OEYC London North Central)—August 4, 2005

This clinic in particular was recommended for observation because it gets very busy. NHC team members present this day included the Registered Dietitian, the Early Years Resource Consultant and a Public Health Nurse who runs the Well Baby Clinic at this site. (This clinic was observed during the period when the NHC team was operating without a Nurse Practitioner.) This NHC clinic had begun operating in conjunction with the already established Well Baby clinic in July. The NHC PHN was not present at this clinic, as she was on holidays. The clinic was set up in the board room/meeting room, including a station with weigh scales and other necessary equipment and supplies for well baby checks, and a small play area with toys. The PHN explained to me that many people come to this site expressly for the Well Baby clinic, and are unaware about the NHC program.

I observed the EYRC conducting an intake interview with a young mother with infant. She explained the NHC concept, and asked for consent to collect some information that may be used for clinical, administrative and evaluation purposes. She then offered to conduct a Nippissing developmental screen to assess her child's development. The mother seemed very happy to be receiving this service.

The woman was then offered a consultation with the Dietitian. During that process, the woman's male partner, who had been in another room (the main child resource/play area) came into the room with their toddler to check in on things. The couple appeared to be in their teens. He allowed the toddler to walk about the room, and had to work to keep her reasonably contained. Meanwhile, another mother sat waiting for a nutritional consultation.

In another part of the room, the PHN consulted with another young mother with a newborn baby (3 weeks old.) The mother seemed anxious. She pointed out a rash on the baby's face, and described having latching problems while trying to breastfeed, and concerns with

whether she has enough milk. The PHN reassured the mother that the child's weight gain was appropriate. She suggested that the woman consult a physician to get the face rash checked further.

CC Carrothers Public School—February 27, 2006

I arrived at the school just before the 9:30 a.m. scheduled opening of the clinic, and had some difficulty finding parking (I had to park in the street rather than the school parking lot) as well as some difficulty finding the exact location of the clinic. The clinic was set up in the basement in a fairly large, L-shaped resource room. A small area with weigh scale appropriate supplies has been set up for well baby checks. On that day, all four regular NHC team members were present. I was told that the clinic had been open since April 2005, and to that point far there had been a total of only 22 visits at that site.

With no clients presenting for service, we had a chance to talk about the difficulty in attracting clients to this location. As discussed above, NHC team members related extensive efforts to promote the program in the community, and speculated as to reasons why few people are coming to this site. It was suggested that because of "turf issues" (that is, negative associations some people may have with schools) a food bank or neighbourhood resource centre may have been a better location for a clinic in this neighbourhood. The OEYCs were cited as being so successful because they enable the NHC team to build on well-established Well Baby clinics. Discussion ensued about other aspects of the service concept that presented certain challenges, particularly the "open concept" (i.e., conducting the clinic in one large room, sometimes with many people present at any given time.) Concern was expressed that clients are sometimes uncomfortable talking about personal issues with others so close by. Generally it was felt that the set up works "for the most part" for general assessments, but not so well for more personal or in-depth assessments, full health exams, and Pap tests.

A young couple with a newborn infant presented for services about 40 minutes after the scheduled opening of the clinic this day. I was told that the couple, who are first time parents, are known to travel to whatever site the NHC team may be at on a given day, in order to get a well baby check. With no other clients presenting for service, I left the clinic at about 10:30 a.m.

Limberlost Public Housing Complex—March 9, 2006

I arrived about 1:45 p.m. I had a little difficulty finding the townhouse unit, located as it is in the middle of the housing complex's maze of driveways, even though I had been there twice before. There was no sign outside indicating the clinic was in operation that day. All four team members were present. I asked one of the team members about this, and it was explained to me that the clinic is well known and utilized by residents in the community. Publicity was not an issue here apparently. I conversed with the NP while we walked around the townhouse unit. We went upstairs to the "examination room." She pointed out the real examination table, and discussed how much better it is for conducting internal exams with women, compared with the massage tables that were purchased for the other sites.

I spent most of the time sitting in the living room area of the unit. I observed a young woman—later identified as a recent immigrant from Eastern Europe—who was there with her toddler and an infant about 6 weeks old. I noticed that the woman had serious dental problems. The toddler was a very open and energetic little girl. She kept coming over to me and giving me presents of little pieces of paper from a post-it notepad. This little girl seemed quite well. She was happy, curious and comfortable in the situation. NHC team members knew her name well. It turns out that this woman comes every Monday to the clinic. One team member told me her story. She was initially brought to the clinic by a friend, but hung back, not asking for any service. This was before the baby was born. Over time, NHC team members established a relationship with her, to the point she comes regularly. When she decided it was time to leave, she had a difficult time with her toddler, who became quite obstinate because she did not want to leave.

During this time the PHN was in the kitchen consulting with another woman about some health concern. The kitchen afforded some degree of privacy. The EYRC left the unit to make a photocopy of some document. Apparently the client was having difficulty in dealing with some public agency, and needed help assembling proper documentation. The team was playing an advocacy role here.

A Spanish-speaking woman came in with an infant. She had been brought in by a woman who, I was to learn shortly, was a nun from Brescia University College. (There was nothing in her appearance such as a traditional nun's habit that would have given this away.) The nun, a fully bilingual veteran of development work in Latin America, had met the woman in an ESL class that she teaches. The new NHC client, who had only attained a Grade 6-level education in her home country, spoke almost no English. The nun was acting as her advocate and translator to help her obtain services. There was some issue they were dealing with having to do with OHIP and her ability to obtain health care services. One of the NHC team members was working with the nun to try to sort out the problem, which involved advocating on the client's behalf with the Ministry of Health and Long-term Care. This case seemed to be a good example of how the principle of building on pre-established community linkages between the host site (i.e., the Limberlost chaplaincy) and other community resources (the nun who teaches ESL) can make a big difference.

An Asian couple who appeared to be recent immigrants came in with a new baby. They were known clients from another site. Apparently they tried to access services

there earlier, but were unable to for some reason. They own a vehicle, and so were able to come out to Limberlost to obtain desired services. Apparently they have been coming regularly for well baby and breastfeeding support.

As I was getting ready to leave, I was told that the Chaplain, who has become very much a community insider, was usually there at the site whenever the clinic was in operation. I met her on her way in as I was leaving the site at about 3 p.m.

OEYC London Fanshawe—March 10, 2006

I arrived at the site at about 1:30 p.m., which is the scheduled clinic opening time. A few OEYC staff members were present for other programming, including a receptionist who welcomed me and asked me how she could help me. I explained my purpose and she pointed me to a room off to the side where the clinic had been set up for the afternoon. This NHC clinic was scheduled in conjunction with the regular Well Baby Clinic. Except the ERYC the NHC staff were all present along with the Well Baby Clinic PHN. The usual well baby check equipment was set up. A space for the NP to conduct clinical examinations was set up in a back room. The NP showed me the space. It was set up in a small, clean, private space with a sink. A massage table was set up for examinations.

Very quickly all NHC team members became busy with clients. Much of the time, both PHNs were conducting what seemed to be fairly standard well baby checks. I observed the Dietitian and the NP consulting together on a case. It was a new client, a young mother with about a 1-week-old baby. The woman described symptoms that she herself had been experiencing on the bus; dizziness, hot flashes, rattling cough. They determined that the woman does not have a doctor. Natalie took her to the back room to do an assessment.

Shortly after, I observed the NP consulting with the Dietitian on another case. The NP described a 9-month-old baby that had been diagnosed with pneumonia, had lost weight, and was dehydrated. The Dietitian asked about current diet, the frequency of wet diapers and bowel movements. They agreed to recommend to the mother to take her child to a walk-in clinic right away.

Next I observed two women with a child consulting with the two PHNs. The two women appeared to be the child's teenaged mother and 50-something-year-old grandmother. They asked whether they should take a 1-month-old child to the doctor due to certain symptoms. One of the PHNs commented along the lines that the baby is eating well, does not have fever, etc, and therefore suggested they just wait for now, and go to a physician if symptoms get worse.

Another young mother came in for a well baby check. The PHN observed that the child, a 4-month-old boy, seemed pale and not feeling well. The woman's male partner and two other children were present initially. Shortly thereafter, the husband took the children out into the main OEYC room to be cared for by OEYC staff while the mother accessed NHC services for their baby. The mother related their efforts to get into see a new doctor, but said they were on a waiting list to even pick up an application. The PHN asked questions about the baby's eating. She observed that the child was in the 25th percentile in terms of weight. The PHN was very warm and supportive.

In general, I noticed how much time NHC team members took with clients. There was no sense of clients being rushed. Team members were very familiar with some clients.

Summary

This section of the report presented a broad overview of how the NHC clinics operated, in terms of services provided, clinic schedule, and a description of the settings in which the clinics operated. Some impressions gleaned from first hand observation of clinics operating at four different locations were also presented. Some highlights from this presentation are presented below.

The Services

- The NHC team members collectively provided a wide array of health services. Some examples include: physical and mental health assessments, well baby checks and breastfeeding feeding support, reproductive health counselling and support; nutrition consultations and education for adults, pregnant and lactating women, and children, introducing solids to infants, dealing with a fussy eater, and diabetes education; parenting support including monitoring and stimulating child development, positive discipline, child safety and speech and language checks; treatment of common illnesses, immunizations, monitoring and screening for chronic diseases, annual health exams and health promotion.

The Schedule

- Clinics were scheduled to operate for 2 hours every morning and afternoon except Tuesday and Friday mornings. Team members were known to stay for 3 hours or more in order serve clients needing service.

The Settings

- Each of the three different types of settings offered advantages and disadvantages. They all had in common the advantage of being located close to members of the target population. They all had the disadvantage of operating in "borrowed space" which meant setting up and taking down the clinics eight times a week, hauling equipment and files, and

having to deal with less than optimal space for conducting services that required privacy such as clinical examinations.

- The two Ontario Early Years Centres were very congenial locations in which to operate, in terms being ready made for a key segment of the NHC target population; i.e., young families. The sites were family-centred and child friendly. The fact that Well Baby Clinics had been operating in these locations for some time facilitated the use of the NHC program by that client base.

- The public housing complexes (as well as the co-op townhouse complex in which Families First in White Oaks operated) lent the advantage of exclusive use of an entire townhouse unit during clinics hours. They also had the advantage of being highly accessible to a different key segment of the target population; i.e., "high-risk areas". Being located within a housing complex was a facilitator of access for complex residents, but also a perceived barrier to access to those residing nearby but outside the boundaries of the complex.

- The public elementary schools were perceived to be a potentially very good site by program planners, but despite great effort expended to promote the clinics to their respective communities, they never became well utilized. There appeared to be problems with visibility and accessibility. Staff speculated that many members of the target population might have negative associations with a school setting.

Some Observations at the Clinics

- Childreach (OEYC London North Central) was the first site recommended by the NHC team for observation because it gets very busy. Many people come to the site expressly for the Well Baby/Child and Breastfeeding Clinics, who are at first unaware about the NHC program. I observed a young mother with an infant going through an intake interview and being very pleased to have the Nippissing Developmental Screen administered to her by the EYRC. I then observed a consultation by the Dietitian with the teenaged mother, while the young father hovered nearby keeping an eye on the couple's toddler. The PHN consulted with a mother who was anxious about her child's weight gain and a rash on the child's face; she reassured the mother about the weight gain suggested she go to the physician to check the rash.

- There was little action at CC Carrothers Public School during the hour and a half I was there. I experienced some difficulty finding parking and locating the clinic site in the basement of the school. I had an opportunity to talk with the team about their experiences with and perceptions of the NHC program. A young couple with baby presented for services about 40 minutes after the scheduled opening of the clinic. They were first time parents who were known by the team to travel to whatever site the clinic may have been operating at on any given day to obtain well baby checks.

- The Limberlost clinic located in the centre of the public housing complex, would be a little challenging for an outsider to find. It is however well known to and utilized by residents of the complex. During a brief tour of the clinic site the NP pointed out that it is the one location where she had a real examination table for conducting clinical examinations. I observed a young woman (who was a recent immigrant from Eastern Europe) with her toddler and infant. I learned that a friend had brought her to the clinic before her baby had been born, and that she had initially hung back, not asking for any service. NHC team members established a relationship with her over time to the point she now comes every Monday. Her toddler was very energetic and comfortable in the setting. I observed team members advocating by phone with government health officials regarding access to health care, on behalf of a recent immigrant who spoke little or no English. An ESL teacher from the community who had brought the woman to the clinic was also assisting.

- Like the clinic at Childreach, the clinic at OEYC London Fanshawe operated in conjunction with a Well Baby Clinic. As in other sites I observed a number of consultations, including a joint consultation between the Dietitian and the NP about a baby who had had pneumonia, had lost weight and appeared dehydrated. They recommended to the mother to go to a walk-in clinic right away. I also observed the PHN consulting with a young mother with infant, and the infant's grandmother. The women had concerns about some symptoms that the baby was showing and wondered if they should go to a walk-in clinic. The PHN reassured the women, suggesting they wait for the time being, and gave them signs to watch for that would indicate a need for a physician visit. A couple with an infant and two other children were receiving a well baby check. They related the difficulty they were having getting a family physician, having to be on a waiting list even to pick up an application. Team members took their time with each client.

Section 6: Client's Experience of the Clinics

Data Sources

Most of the analysis reported in this section of the report is based on three focus groups that were held in March 2006 with 20 NHC clients. To a limited extent we also draw on data pertaining to all clients who used the clinics, as collected through the clinic intake form. It therefore is appropriate to describe the characteristics of the focus group participants at this point, and make some limited comparisons between certain characteristics of the focus group participants and the NHC clients as a whole.

Characteristics of Focus Group Participants Compared to NHC Clients as a Whole

Potential focus group participants were identified and invited to participate by NHC team members, based on a number of predefined characteristics. We wanted to have a sufficient variation among participants on these characteristics in order to be as representative as possible of the variety of people and types of experiences they might have had with the clinics. Focus group participants were asked to fill out a brief questionnaire just prior to each focus group session in order to enable us to put together a brief socio-demographic profile. The characteristics of the focus group participants are presented in Table 6.1.

A few general observations about characteristics of the focus group participants may be made. First, all were women. They represent a wide range of positions on the key characteristics we asked about. There were some similarities within and differences between the three groups. To some extent, Group A was a relatively better off economically, a more highly educated group, and its members were more likely to have attended a NHC clinic at one of the OEYCs. Group B members had lower to moderate income, were more likely to have no doctor, and more likely to have attended a NHC clinic at a public housing complex site. Members of Group C were also of lower to moderate economic means, had less formal education, and were more likely to have attended a NHC clinic at one of the elementary schools.

How did the socio-demographic characteristics of focus group participants compare to the group of NHC clinic users as a whole?[12] Focus group participants in general were more frequent users of the NHC program. Only 2 of 20 or 10% of the focus group participants reported using the clinics only once, compared with 40% of all NHC client families. Half of the focus group participants used the NHC clinics more than 6 times compared with only 12% of all NHC families. A higher proportion of focus group participants (12 of 20, or 60%) reported having no family physician, compared with 23% no family doctor reported for all NHC client visits. Income data on focus group participants and NHC clients as a whole is not directly comparable, however the data we do have suggests that focus group participants generally had lower income levels. Seven of 20, or 35% of focus group participants reported less than $20,000/year family income. This may be compared with 18% of NHC families who lived in low-income neighbourhoods (i.e., neighbourhoods where more than 50% of households were defined as low-income).

[12] The characteristics of NHC clinic users as a whole were reported in Section 4. Readers may want to refer back to that section for specific figures.

Table 6.1: Profile of Focus Group Participants

	Group A	Group B	Group C	Total
Number of Participants	6	8	6	20
Type of Clinic Site Attended				
Public housing complex	2	5	1	8
Public elementary school	0	1	5	6
Ontario Early Years Centre	4	2	0	6
Income Level				
Lower (< $20,000)	0	4	3	7
Moderate ($20,000 to $40,000)	1	3	3	7
Higher ($50,000 or more)	5	1	0	6
Education Level				
Less than high school graduate	0	2	2	4
High school graduate or some post secondary	0	1	3	4
Completed trade school, college or university	3	3	1	7
Some post-graduate or completed post-graduate	3	2	0	5
Family Doctor Status				
Did have family doctor	3	1	4	8
No family doctor	3	7	2	12
Which NHC Team Members Seen				
Saw Nurse Practioner	3	4	3	10
Saw Public Health Nurse	4	5	5	14
Saw Dietitican	4	4	4	12
Saw Early Years Resource Consultant	5	4	1	10
Number of Services Received				
Received only 1 service	2	2	1	5
Received 2 services	0	2	3	5
Received 3 services	2	1	2	5
Received 4 services	2	2	0	4
Number of Children				
None (Currently pregnant)	0	2	0	2
One	3	5	3	11
Two	3	0	3	6
More than two	0	1	0	1
Citizenship Status				
Canadian by birth	3	5	4	12
Landed Immigrant	1	2	1	4
Other (such as international student)	2	1	1	4
How long in Canada (if not citizen by birth)				
Up to 3 years	2	2	0	4
3 to 7 years	1	1	2	4
Total number of visits to clinic				
1 time only	0	2	0	2
2 to 6 times	2	3	3	8
More than 6 times	4	3	3	10

One may conclude from the preceding that the characteristics of focus group participants were more consistent with the intended target population than was the group of NHC clients as a whole.

How Client Heard About NHC Clinics

The following analysis is based on intake data for all NHC clients. Clients were asked at intake how they heard about the NHC program. This information was recorded for each of the 712 families. At the top of the intake form (see Appendix B) the team member conducting the intake interview was to indicate one of six general categories of sources of information. One option was "other", for which space was provided to further specify the source of information. "Other" was specified in 276 instances. All data recorded regarding how client heard about the NHC program was analyzed, where appropriate re-categorized, and then finally grouped into more general categories as reported in Table 6.2.

Table 6.2: How Clients Heard About NHC, as Reported at Intake (N=712)

	N	%
Local/Informal Sources		
Family/friend	103	14.5%
Signage, word of mouth, lives in area	40	5.6%
Chaplaincy at Limberlost	6	0.8%
Subtotal	149	20.9%
MLHU Programs or Services		
PHN	84	11.8%
Well Baby Clinic	69	9.7%
Other MLHU Resources (e.g., prenatal classes)	37	5.2%
NHC Team Members	5	0.7%
Subtotal	195	27.4%
Community and Social Services		
Community resource person (unspecified)	120	16.9%
Childreach or other OEYC	46	6.5%
Other community agency or social service	17	2.4%
School	5	0.7%
Day care	2	0.3%
Children's Aid Society	2	0.3%
Subtotal	192	27.0%
Mass Media		
Brochure/flyer (where obtained unspecified)	46	6.5%
Internet or other mass media	18	2.5%
Subtotal	64	9.0%
Medical Sources		
Hospital or clinic	35	4.9%
Physician	8	1.1%
Midwife	2	0.3%
Subtotal	45	6.3%
Unknown	67	9.4%

The most frequently reported sources of information about the NHC clinics were *community resource person* at 16.9% and *family/friend* at 14.5% of all families. Early in the program, the NHC program devoted resources to renting portable marquee-style signs, particularly for the clinics in the public housing complexes. *Local, informal sources* of information including family and friends, seeing signs, hearing about the program through word of mouth, and "living in the area" were clearly important sources of information about the program for clients. This would likely be the case especially in the public housing complexes.

In terms of the broader categories of sources of information presented in Table 6.2, most clients (27.4%) heard about the NHC clinics through one of several *MLHU programs or services*, especially through Public Health Nurses and Well Baby Clinics. The second most common source of information about the NHC clinics in terms of broader categories *was community and social services*, at 27%. It is important to note that the most frequently *written in* sources of information were Well Baby Clinics (9.7%) and Childreach or other OEYC programs (6.5%). These categories are not mutually exclusive. This is important to note because, as will be discussed further below, Well Baby Clinics were often mentioned during the client focus groups as the first access point to the NHC clinics.

Almost 7% of clients reported learning about the program through a *flyer or brochure*, however the source of the flyer was not determined. This category almost certainly overlaps with some of the other categories. It is noteworthy that a relatively small percentage of clients reported hearing about the NHC program through a source within the medical system, such as a hospital, physician or walk-in clinic.

How does this compare with how our client focus group participants heard about the NHC program? The most common response (6 of 20) was *through a community-based program* such as a playgroup at Families First in White Oaks and a mom's group at the Glen Cairn Community Resource Centre. Two of these women said they saw a presentation about the program from one of the NHC team members. The next most common response (4 of 20) was through a Well Baby Clinic. Two of these women said friends had told them about the Well Baby Clinic. Other sources of information reported by focus group participants were: schools (3), a sign (2), a PHN (1), the hospital (1), a midwife (1), and the Internet (1).

Why Clients Came to the Clinics

We asked focus group participants to think of a specific time they came to a NHC clinic, and share what health need or concern they came for. We were interested in understanding what their perceptions were as to what kind of services they expected or could receive through the program. Readers may want to compare findings presented in this report starting on page 22, which presents data on the types of services provided to *all* NHC clients with the findings reported immediately following. The two sets of findings are quite consistent.

Well Baby Clinics as Access Point

By far the most common experience was for participants to come for well baby checks and/or breastfeeding support. More than half of the focus group participants gave this as the reason for coming to the NHC clinic. The comments of several participants suggested that a Well Baby Clinic was their initial access point to the NHC program. In many instances it was clear that well baby checks led to more comprehensive health assessments and service. For example, a participant in Focus Group A reported,

> I guess originally we started coming to check the weight of the baby. I probably came the first time when she was probably a week and a half old. And also, I was having some breastfeeding problems, and just for confirmation that I was doing it right and that I wasn't drowning the poor child. (Mutual laughter.) And so that was originally the reason. Recently, it's been the Dietitian. We have some pretty clear food allergies with the baby. So I had a lot of questions...

A few participants said they came with specific concerns regarding low birth weight and child nutrition. At least two mentioned having been referred through the Smart Start program. As illustrated by the following quote, Well Baby Clinics and the NHC program provided a more readily accessible service for parents concerned with such concerns. The participant stated that before she gave birth she had been told her baby,

> ...was going to be a good size baby, about eight pounds and he ended up being 5 lbs. 15 oz. Very tiny. And it was May 24 weekend, so of course you know how you go to the doctor a week after he is born? Well they said no, come in in three days because of the long weekend. And they said you know ... you've got to realize he's very tiny and you've got to get his weight going. So I ended up starting coming here with the weight... and it was just one pound every week for like two months. He was just like gaining, gaining, gaining. That's what got me started here too, was the weight, to make sure this weight maintained.

Lack of Awareness Between Well Baby Clinics and NHC Clinics

Quite a few participants clearly did not understand the difference between Well Baby Clinics and NHC, as illustrated by the following comment.

> I don't think I was ever aware of the distinction between the Well Baby Clinics and the NHC... But I didn't actually go with the intent of (receiving) health care, per se. I went for more Well Baby, I was having breastfeeding issues. And that was what drove me initially, was just battles with breastfeeding. And that's what kept me going over and over again.

Lack of Awareness of Other NHC Services

When it became apparent during the focus groups that some participants were not aware of the distinction between the Well Baby Clinics and the NHC program, further questioning revealed additional misunderstandings about the program. In a few instances, participants thought services were only available for their baby. That is, they were not aware that services were available for themselves and other members of their family. In a few instances, participants were not aware of the full range of services available. For example, one woman expressed surprise that she could get her children vaccinated at a NHC Clinic. Another was not familiar with the parenting support services offered by the Early Years Resource Consultant. This lack of awareness seemed to be most common among recent immigrants, that is, participants who experience some degree of a language and/or cultural barrier to fully understanding the nature of the services available. Follow-up on this line of inquiry during the focus group revealed that in most instances, participants recalled being given a thorough orientation to the NHC program upon intake, including a information sheet which summarized the nature of the services available.

Reflecting on her own misunderstanding about available NHC services, as well as her belief that there was a general lack of awareness about the program among her peers, one participant offered the following comment in response to the question "What was the most important thing that was said during the focus group?"

> I think the most important thing would be lack of awareness of the different things that are offered at each of these clinics. Like even if say by chance I was in a prenatal class or at the hospital you learned that there were these clinics, either the Neighbourhood Health or the Well Baby, what can you do there? I don't think that that's out there. Because I have a couple of friends who are new moms... Today I learned that you can take any of your family members there. But they don't realize that the Clinic is there and what it can do for them and where they can go.

Seeking "Medical" Services

About a quarter of the focus group participants said they came because of what could considered non-urgent "medical" concerns such as wanting to check out their child's cold or flu symptoms. One mentioned that the NP consulted a physician on her behalf.

Two participants described coming specifically for vaccinations. Both, coincidentally, had moved to London from out of province and had not been able to

find family doctors. A few came looking for way to get enrolled with a family doctor.

Seeking General Health Support

Two participants said they came for what might be called general health information or advice. For example, one participant said she came to get help for her child's food allergies, but explicitly stated she was not really utilizing NHC service for herself because she preferred or trusted her physician and preferred to go to walk-in clinic close to her home. Another women mentioned coming just when she wants to check about some concern she may have about her or children's health, but would go to a physician if she were ill.

Three of the participants in Focus Group C, who knew each other from a program held at a nearby community resource centre had heard about the program through a presentation by an NHC team member at the community centre. They came specifically for a relaxation session conducted by the PHN to teach women stress management and self-care techniques. Once introduced to the program, they received comprehensive health assessments and began receiving other services.

What Would Clients Have Done if the NHC Had Not Been Available?

We asked focus group participants what they would have done if the NHC program had not been available. The same question was included on the intake form, to be asked of each family during their first visit. Among the reasons for asking this question was to get some indication if the NHC may deflect some unnecessary use of emergency rooms and walk-in clinics. It is also important to get an idea if the NHC clinic increases access to primary health care services, including preventative services for problems that may have otherwise gone unattended, resulting in unnecessary escalation. (See program theory logic model on page 11.)

Table 6.3 presents the findings from the intake data. The question was not consistently asked at intake, therefore we have data for just over half of the 712 families that used NHC clinics. Clients' responses to the question were captured in very brief terms—usually a word or phrase. These responses were analyzed, categorized, and are presented in rank order.

Table 6.3: What Would Client Have Done if NHC Had Not Been Available?

	N	%
Well Baby/Child Breastfeeding Clinic	87	23.9%
Nothing	85	23.4%
Physician	63	17.3%
Walk-in Clinic or Emergency Room	56	15.4%
Don't Know	20	5.5%
Another MLHU service (e.g., call a PHN, NP at Merrymount)	13	3.6%
Wait (e.g. to find a physician or get a doctor's appointment)	11	3.0%
One of the other NHC clinics	6	1.6%
Chaplaincy (Limberlost)	4	1.1%
Other community resource (e.g., church, school, food bank)	4	1.1%
London InterCommunity Health Centre	3	0.8%
Pharmacy	3	0.8%
Midwife	3	0.8%
Friend	3	0.8%
Telehealth type service or Internet	3	0.8%
Total	364	100.0%

As consistent with other findings reported here, we find that the Well Baby Clinics are an important source of primary health care for the population that used the NHC program. Many participants' comments have indicated that they value and much prefer the kind of well baby treatment they get at both Well Baby and NHC clinics, as over and against going to a physician's office, as illustrated by the following comment.

> I do have a family doctor and I could have made an appointment with her, but it would be a couple of days later.... And you want the weight checked. And you want all these things done and you can't go to your doctor once a week. I could have, I guess, gone to a health clinic but you'd rather have the same people looking at your children every week.

It is noteworthy that the second most frequent response was "nothing", suggesting that about a quarter of NHC clients would not have accessed health care services for their particular concern had the NHC not been available the first time they sought service. Another 3% said they would "wait" (for the problem to go away, to find a doctor, or to get a doctor's appointment.) These data suggest as well that about 17% of the NHC intake visits deflected clients from visiting physicians, and about 15% deflected visits to walk-in clinics or emergency rooms.

Presentation of a couple of responses from focus group participants to this question provides some additional perspective on these findings. A number of participants mentioned they would go to a walk-in clinic if they had to, but preferred the NHC clinic for reasons such as less waiting, more personal service, and more in-depth service, as illustrated by the following passage.

> I would have gone to the walk-in clinic if there was no other choice. And there you have to wait, sometimes for quite a while. And if your child is sick, and there are other sick kids around, it's not really the place where you want to wait for one or two hours. So I don't know where I would go if I won't have the Neighbourhood Health Clinic. I would have to go to Emergency or walk-in clinic. And there, you only get help for emergencies and not for breastfeeding problems. I also have to have my second child here...I needed way more help.

In terms of utilizing emergency rooms, one participant acknowledged that she would not hesitate to go in an emergency, but that sometimes the problem is not knowing when a situation really calls for an emergency room. She would have preferred to come to a NHC clinic to determine if a trip to the emergency room was necessary.

> I brought my daughter to Emergency once and I think that if the clinic would have been opened that day, I probably would have taken her there first and then taken her to Emergency if I felt it was necessary because I didn't have anybody to you know, tell me whether to go straight to Emerge.... She had fallen off her play equipment the day before and when she woke up in the morning she was vomiting and was very, very sick. And I was terrified. You know, like I panicked, obviously right away. But if the clinic had been open that's probably the first place I would have been. And you know, for me, taking her to a walk-in clinic and seeing her, like I can't sit there and wait for six hours in the waiting room while my daughter is vomiting and I'm terrified.

Clients' Accounts of What It Was Like To Receive Service at NHC Clinics

We asked focus group participants to describe in some detail their experience of coming to the NHC clinic. We asked them to talk about their experience of receiving service from a multidisciplinary team. We asked them to describe what may have happened as a result of visits, such as referrals and follow-up contacts. We asked them to discuss how the NHC experience may have differed from other health services such as going to family doctor or walk-in clinic.

The Experience of Receiving Multidisciplinary Service

Two participants from Focus Group C compared notes about their experience as recounted in the following transcription excerpts. These passages give a good feel for a first contact, and how the NHC service providers functioned as a team. (The visit described took place during the period when no NP service was in place.)

> First Participant: The first time I went in, there was three ladies. One offered to look after my daughter when I went to take my son in to get weighed and measured. (She was) really good with my daughter out there... And, they weighed and measured him and that's the first time I went. They told me that you know his head's a little bit big and you should follow up with your doctor with that. And they asked me all kinds of questions about his eating and what not. And that's when I explained to her that I have a hard time getting him to eat his vegetables or anything with meat in it. And she says, oh, well you should talk to the Dietitian... So then from her I went on to the Dietitian... Then I went on to another lady, who helped me through those checklists[13]...to make sure my son was up to speed...I thought it was great...and then they sent me out with free boxes of cereal and my kids were all happy. (Mutual laughter) It was awesome.

> Second Participant: Yeah, everything (was) the same (for me)....Rose (the EYRC) just plays (with my child) out in that room with all the equipment and stuff....Teresa's (the Dietitian) always been the one to help me.... I was hoping to nurse longer than I did. Like, with my daughter I went 10 months. But with my son he got his first tooth at six and a half months. And I said, the first time you bite me, I'm done. And he did, twice over the weekend... I was so depressed that I had to stop. I didn't want to stop that soon, but I didn't know what else to do... Joanne and Teresa both gave me tips on how to bring him like, in a dark area, cover his face to where it's dark. Just different ways to make him maybe not bite me.

Multidisciplinary service did not necessarily mean clients saw more than one team member at each visit. Participant accounts as well as feedback from the NHC team suggests that receiving service from more than one NHC team member was more typical at initial visits when initial assessments took place, and when clinics were not too busy. In many cases, clients came in for a specific consultation in follow-up to a specific problem or concern.

During Focus Group B for example, when asked how the team functioned as a team, several participants described the experience of consulting three or more NHC team members during one visit. One participant

[13] Referring to the Nippissing District Developmental Screen (NDDS) which "is a tool designed to provide an easy-to-use method of recording the development and progress of infants and children." The NDDS "provides a general overview (snap-shot) of the child's development on the day of screening. The areas of development covered by the Screen forms include vision, hearing, communication..., gross and fine motor, cognitive, social/emotional, and self-help. The Screens coincide with... key developmental stages up to age six." (Source: www.ndds.ca)

added, "I thinks it's different every time I go there. I think it's kind of like a group discussion between them. I think it depends too if there's other people there...sometimes you only go in there to speak to specific people too, right? So you go in there to talk to that person..."

"One-Stop Shopping"

Participants in all three focus groups highlighted the value of having the different health disciplines available in one service. When asked what was the most useful or helpful thing about the NHC clinics, a participant in Focus Group A responded that it's "that everything is together. You don't have to run to...four different places. Like it's all there." When the same question was posed during Focus Group C one participant said, "I think the most useful thing is that they have three different types of people...to answer three different types of questions you might have, instead of like in the Well Baby Clinic you have just one lady. If you want other help, you'd have to go somewhere else. Yes, you can get pretty much all your questions answered there." A participant from Group B stated, "having that wide range...there's the Dietitian and there's someone to help with developmental problems and there's someone else there for something else... Like they can deal with any issue that you have...and if they can't deal with the issue, they find somebody who can. So...any question that you do have gets answered one way or another."

Helping Clients Access Physicians and Other Health-Related Services

As indicated in the NHC program theory logic model, in addition to providing direct service one of objectives of the program was to facilitate clients' access to medical and other health-related services. In the passage quoted immediately above, one client makes reference to team members finding someone to deal with issues or finding answers to questions if they were unable to directly help.

Similarly, another participant in Focus Group B stated,

> I think if they can't provide the help that you're looking for, I think they take that extra step to go out of their way to help you find the resources that you need. And I think that their main thing was doing that. Especially like in the neighbourhood that we live in, there's a lot of families that might not talk English...so they take that extra step to overcome those barriers that there may be. And they go out of their way to provide that for you, I find.

As discussed earlier, several focus group participants said they came to a NHC clinic because they needed medical services and did not have a family doctor. The NHC team maintained a list of physicians that might accept new patients, and sometimes advocated with a physician's practice to enroll a NHC client. A number of the recent immigrants among the participants mentioned this in particular. One recent immigrant participating in Focus Group A related how after being examined at the NHC clinic, the NHC team member (presumably the NP), had concerns that led her set up an appointment with a physician, which led to the discovery of a lump in her breast. Another recent immigrant participating in Focus Group A said, "...We don't have the family doctor. They introduce to me the family doctor...I applied for them and...one of them accept us." A newcomer participating in Focus Group C said,

> I am new to Canada...and I don't have a family doctor, so I checked on the Internet and I found that if there's any needs they can refer you to the doctor... And also they can provide some information what you need. So I just went there and they gave me some information about how you can connect, contact with the doctor. And they also direct me to an OB to take care of me during the pregnancy. And also they give some information such as prenatal education program and early education program and the midwife. And I just went back home and call the midwife. And from then on I just was with midwives.

A Focus Group A participant described how the NHC team helped her husband access a medical specialist. "He ended up needing to see a specialist...He would have been on a waiting list for a long time. But because they kind of just smoothed the way, it was a lot quicker wait to get seen...The referral system is complicated. They have to see a regular physician and then they can see a specialist. So they made that happen for him and he was quite happy with that."

Referral Data from NHC Intake Database

To what extent did the NHC team regularly make referrals or efforts to link clients to physicians and/or other health-related services? The following analysis based on intake data will provide some sense of this.

A total of 360 out of 1055 (or 34%) of individual clients received at least one referral to an outside resource. Table 6.4 reports on four different types of referrals made to individual clients. This table should be interpreted as follows. Reading the first row of the table for example indicates that 214 (or 20.3%) of individual clients received one referral to an MLHU resource; 48 (or 4.5%) of individual clients received 2 to 4 referrals to MLHU resources, etc.

Table 6.4: Number of Referrals to Individuals by Type of Referral (N=1055)

	Number of Referrals					
	1		2 to 4		5 or more	
	N	%	N	%	N	%
MLHU Resources	214	20.3%	48	4.5%	9	0.9%
OEYC	34	3.2%	0	0.0%	0	0.0%
Other Community Resources	149	14.1%	53	5.0%	10	0.9%
Formal Referral (file open, formal follow-up)	16	1.5%	2	0.2%	0	0.0%

To illustrate further, consider how one visit of one individual client was recorded in terms of referrals. In this case, the following text was entered into the NHC intake database.

> "Discussed with (Client's name) services available for her since she has no family doctor. Currently being followed by Dr. Sharma for bipolar - takes lithium. Managing well so far. Support from parents and husband. Info regarding sex after baby, car seat safely, community programs for children and teething given. List of doctors given. P: followup prn to clinic for any health need. Natalie"

The individual client's record was coded to indicate she received a referral to an MLHU resource, and an Other Community Resources. A scan of the NHC intake database suggests that referring clients to physicians was usually recorded as referral to Other Community Resources.

Consulting and Advocating with Physicians on Behalf of Clients

Several participants described various examples of NHC nurses consulting and/or advocating on behalf of clients with physicians. In many instances clients mentioned that the NP consulted with her supervising physician with respect to a medical concern, which reassured the clients as to the advice they were receiving. As one participant stated, "So you kind of get this confirmation that it's not just a nurse but she also talked to a doctor about it." Clients also mentioned that NHC nurses forwarded clinical information in advance of a client's visit to their doctor. "(The NP) consulted (with the doctor)...I like (that)...the doctor already knows my information when I reach the doctor."

One focus group participant related how the information she received as a result of a well baby check resulted in her physician beginning to attend more closely to a developmental concern that he had not previously picked up on. As a result more frequent service was provided in order to monitor a potential problem more closely.

> Usually you go (to the physician) every two months to get your child weighed and checked. But my doctor, because he never measured his head until I mentioned it to him that (a nurse at the NHC clinic) said his head was too big, (then) he had me come in once a month to have him checked. And he...had me come in between (usual appointments) to keep a graph of his growth.

Providing Health Education and Interpreting Health Education Resources

Participants in each of the three focus groups described in some detail receiving up-to-date printed health education resources, such as pamphlets and information sheets on a wide variety of topics. Among the aspects of this NHC service commented upon were the range of topics covered, that the materials were up-to-date, that they dealt with the client's specific concern and needs, that information was user-friendly and conveniently packaged. Several participants made a point of emphasizing how NHC team members went over the material with them to highlight key points and make sure it was clearly understood. The following exchange between two Focus Group A participants illustrates this point.

> Participant A: I find they're very quick to hand me information and make sure I understood what it was that they were handing me. Because we had gone in and (my daughter) had her first bump on her head. And they're like, "Oh, she's at that age." And the next thing I know, I had all these pamphlets in front of me on toxic plants and how to lock my cupboards and like, the falls down the stairs, like anything you could think of. All of a sudden, I had all these pamphlets. So I left with all this information knowing that hopefully, I'd not give her another bruise on her forehead. (Mutual Laughter)

> Participant B: That too. It's not only that you're left with all these pamphlets and they go over each pamphlet before you leave. So you're not just going, okay, now where am I going to find a half-hour to read through this. It's like, they've already done it. And it's just kind of back up.

> Participant A: Because you do get a lot of information at the hospital. You get a lot of parenting classes. Like you do all these things. And yeah, you sit at home and you're like, well

> I'm going to read all of these. But yeah, they go through them.

One of the participants commented on the difference between the NHC program and their physician, in terms the approach to providing health education resources.

> I got two pieces of paper from my doctor the entire time I was pregnant...(until) after she was born. One was on immunizations and when she should have them. The other was on what you can't do when you're pregnant, like the stuff to stay away from. The pages I have received (from the NHC program) on everything from breastfeeding to immunizations to allergies... gives me something to read and to at least know that someone can answer my questions. So, it's been helpful because it's (about) care that's specific....

Specific types of information mentioned by participants included information on breastfeeding, introducing solid foods, dealing with "picky eaters", car seat safety, a peer support group for Hispanic girls, and how to access public library resources.

Occasional Lack of Privacy

Probably the most noteworthy point to make about clients' critical comments about their experience of the NHC clinics was how few there were. One concern raised by a few focus group participants was also raised by NHC team members, namely the occasional lack of privacy, particularly in those settings where the available facilities necessitated running the clinic in an "open concept" format, and/or when clinics were busy. A concern about feeling crowded was mentioned in two of the three focus groups. An example is the following exchange during Focus Group A:

> Participant A: At this one location, if you want confidentiality it's really hard. And they have been exceptional here trying to put things into place so you do get confidentiality. But you know, a little child runs through behind the barrier and so the parent follows, so then you know, what you might be doing or talking about, someone else is in that space for a little bit. So that's the only thing, is that I find sometimes that I really wanted to ask more questions but because it was so busy or because there wasn't the privacy, that I just I didn't want to feel more vulnerable. Even with breastfeeding too, like you have to be comfortable with feeding in front of those other women that are there with their babies. Some places have like one other chair.

> Participant B: Yes, and I know for sure at (one site the PHN) took a chair and turned it around and you know, they say do you want me to give you help. And it wasn't bad but I was just starting out so I was very nervous about it. But they tried with the limitations that they have.

How the NHC Model is Different Than Other Primary Health Care Services

We asked focus group participants to discuss and compare their experience of the NHC clinics with other primary health care services they may have received, such as family physicians and walk-in clinics.

The discussion among focus group participants in response to this question was perhaps the richest and most energetic of all topics discussed. The theme *medical model versus the care model* emerged as a very distinct and prominent theme in the process of analyzing transcripts of these discussions. Several interrelated sub-themes that also emerged included: taking time, timeliness of service, creating a comfortable and friendly atmosphere, being supportive and relationship-oriented service.

Medical Model versus Care Model

A few of the focus group participants were remarkably articulate about the difference between the NHC program and their experience of being treated by their physician, in terms which seem to reflect a fairly sophisticated understanding the distinction between the traditional medical model and the kind of holistic model upon which the NHC program is based. For example, when asked to compare their experience of the NHC program with other types of primary health care, one participant in Focus Group A said,

> I'm beginning to believe that health care is more than just dealing with symptoms or a specific illness...you look at everything else around...you can prevent things by eating better and things like that.... When I go in to (my doctor and) say, you know, "I'm just not feeling great," you know, he's going, "Well, if it gets worse, come on back." I've sat in the room for 45 minutes, and I've got less than two minutes in [with him]. And it's -- "Is there anything else?" Well he definitely doesn't want to see if there's anything else because then he'll be more behind.... So I really feel that...because of the way his practice is set up, he doesn't have the time to deal with non-immediate things. If I've gone in with an immediate concern, I've had no problems (with my doctor). But if it's anything else that's not on the surface, it's (the quality of service) just not there. Whereas I find that what I receive through the Neighbourhood Health Care Program is a lot more. Even if it's just nutrition, or you know, taking time for me. I was ...(asked at the NHC clinic) "Are you taking any time for yourself?" Oh, I guess not. But I didn't realize that I was supposed to.

Similarly, a participant in Focus Group B commented,

> It seems like a more sort of holistic approach to health care too, right? So let's look at it from a diet standpoint, let's look at it from what's going on in your environment.... Whereas you go to G.P. -- and God love him but...it's all about the drugs, right? Whereas in this sort of health team, we're looking at your whole life and all the different things that go into it. So I think it's more advantageous than getting a prescription from whoever took him out to dinner the night before. (Laughs.)

Responding to this comment another participant said,

> Well I kind of agree with what you said before about how it's kind of full circle with the health clinic, they deal with all issues; emotional, behavioural, medical. And health is all of that. And even like being recommended the play groups, like that's for my health, or breastfeeding, that's for the mom's health too. Like it's full circle. And the fact that they can recommend stuff and give you advice plus the fact that they are women and probably moms really helps.... And they give you like all these different options and it makes you feel so much better. And like they address everything. You have to address everything. You can't just address one or two things. It's all these different things when it comes to the health, I think. It's not always just medical (it's also) your lifestyle or what your child is eating, or environment or anything. So they definitely take full advantage of getting that information and then using it to your advantage.

Taking time

Many participants appreciated how the NHC team was able and willing to take time with clients, as compared with a family physician. Several participants commented on how at walk-in clinics and in some cases family physician's offices, they were only allowed to deal with one or two questions or concern per visit. (Although several also expressed some appreciation for the pressures that seem to induce physicians to rush their visit.) The following exchange between two participants in Focus Group C illustrates the point.

> Moderator: Can we talk about the differences or the similarities between the NHC clinic and other kinds of health services?
>
> Participant A: Yeah... When I go to my doctor's, it's almost like you're a number. You go in there, (and it's) "What do you want? Here's your prescription", and out you go kind of thing. In there, (the NHC clinic) it's very warm and caring. They listen to you. They have the time to listen to your needs and find out and give you the information you need. Not just, okay, you're a number, get out kind of thing.
>
> Moderator: How does that compare with other people's experiences?
>
> Yeah, I agree. All the time when I go to the doctor, it's kind of in a hurry. You know, you have like three kids at the same time, you know and he just say, okay you go to this room, you to this one and he just -- you know, passes from one room to another and we just do everything we can. Like you don't feel comfortable, you know, to ask him, because you know, like he doesn't have enough time for you. But whenever I go to the (NHC) clinic... I feel comfortable, you know. Like I have enough time to ask.... (Even) if they have more people...they don't (shift attention) until you are finished with your questions....

Focus group participants in many instances expressed amazement at the amount of time NHC team members would spend with them. As one participant commented, "the Public Health Nurse, she took care of me (and my child)... and I thought I was there almost an hour -- and it was just us! And it was great!" And while it was true that in some locations clinics were often not very busy, even in instances when the team was pressed for time for various reasons, they made time to see clients who presented for service. For example one participant, a recent immigrant, related feeling a bit concerned that she had taken up too much of the NHC team's time. "I think oh, the time is, -- the clock is eleven, you have to go (but they said) 'No, we can stay' (laughs)". In follow-up to this comment the focus group moderator asked whether the team takes time when the clinics are busy. The participant responded with some enthusiasm, "Oh yeah. They do. Because I think the clinic is (scheduled from) 1:30 to 3:30, and it's now 4:30 and we're still there, waiting your turn or still being helped." Another recalled how she had come to the clinic 15 minutes before the scheduled closing. "And I was actually thinking they're not going to do anything. But they were fine. And it was just finding out about immunizations and they measured him and weighed him and talked to me about where he should be developmentally, you know, physically and emotionally. And we went through charts and she introduced me to all the people and I didn't feel rushed."

Timeliness

Another time-related aspect of the NHC program that was mentioned by several participants was timeliness, that is, the ability to access service quickly and frequently, especially as compared with getting an appointment with a physician and having to wait for service at a walk-in clinic. The following exchange illustrates the point.

> Participant A: And even if you have a family doctor it's like two weeks till you get in. Like what you were saying, when you have a problem you need to address it now, it's not like three weeks down the road. When your kid is sick, you need to find out what's wrong with them.
>
> Participant B: Well even going to a walk-in clinic you still have to wait up to two hours. Going to see them [NHC] I find every time I go in it's not busy, like they can see me within ten fifteen minutes, rather than going to a clinic where you have to sit and wait in a waiting room, you know.

Comfortable and Friendly Atmosphere

Many focus group participants commented at some length and with enthusiasm, how the NHC team created a comfortable, friendly, welcoming environment. One participant remarked, "They are very, very, they are very kind." Another said, "Oh, I love them there. They're wonderful. That's why I go. I didn't go last week. I've missed maybe one Monday a month, and that's about it. Like it's my weekly routine, just to go in." These comments were often contrasted with how it feels to go to a physician's office or walk-in clinic. One participant compared the NHC to the feeling of a family doctor in a small town making house calls.

> I think just in general...at the [NHC] Clinics you can feel comfortable, you're not rushed, you know they can answer your questions. You know, years ago you could have--I'm from a small town originally--and you could call a doctor up at like midnight and you know, you'd have your doctor come to your home. And you don't get that anymore, it's just rush, rush, rush. And like they were saying, in a [NHC] Clinic, you're more relaxed, they can take the time, and if they don't have the answer they will find it.

Supportive and Relationship Oriented Service

Many participants made comments highlighting the ways and extent to which the NHC created supportive and warm relationships with them, and how significant this aspect of the service was to promoting health. Participants commented on how they felt listened to and that their concerns were taken seriously. One recent immigrant participating in a focus group commented,

> The important thing to me is that they are there, they listen to me. They are patient and listen and their words are warm and very helpful. They make me feel really comfortable, like friends. They are like friends. They are not like doctors. (Group mutual laughter) So, very helpful.

One particularly poignant example came from another recent immigrant. She described struggling with concerns surrounding her early pregnancy, and suggested that without the caring support provided by the NHC she may have died.

> They have that heart...they are much welcoming.... They have that emotion to make you feel (better) when you feel sick. Because when I was starting this pregnancy this one I have now, I didn't know if I'm pregnant. But I went there, they keep on checking and check and give me hope, don't worry, if it is pregnancy we will see. Because they check the urine, they check blood, they couldn't see. They come to find it after three months. So for me, I just found they are so...supportive. I felt good. If I went home maybe I would die because I was feeling my heart coming out, I couldn't even eat anything, drink anything...
>
> Moderator: Are you saying if you were back home in your original country, you may have died?
>
> Participant: I could be die. Maybe today...(I wouldn't be) living...it was just terrible. And they handle me very well, very nice.
>
> Moderator: To say that you might be dead today if you were back in your home country is a big statement. What was the difference?
>
> Participant: The difference was they give me hope. (They would say) "Don't worry. Even if there is a problem, we'll see. So you go and do this and do this and do this." Sometimes they tell me go and take kind of juice, and do this, try this. Different kinds of things which would make me feel better because I used to vomit. Even if I drink water, I vomited. I did every stuff... I never have seen those drugs to stop vomiting, although they are expensive but they told me go and buy these. And I went and bought them, one to two days I just feel fine. And they took my weight so much. I started eating and gaining and now I'm okay. Now my weight is okay.

As a final illustration of this point, several focus group participants commented that the PHN always made a point of inquiring into their well-being, even when their reason for the clinic visit was for services for their children.

> That's what I like about Joanne. Every time I come she says, "How are you doing? Every time she says that, "How are you?" And I'll say something and she'll say you're getting off topic again, "Now how are you doing?" (Laughs.) You know? And it's like wow, how many people do you find that say that to you? You know, it's always the baby not you.

Summary

This section of the report was largely devoted to giving voice to clients' own perspectives and experiences of the NHC clinics. The findings presented were based on three focus groups conducted with 20 NHC clients representing a broad spectrum of clinic users. The characteristics of focus group participants were somewhat more consistent with the intended target population than the group of NHC clients as a whole.

When we asked clients about the specific reasons why the came to a NHC clinic, we found the following. The most common experience was for clients to initially access the NHC clinics though a Well Baby Clinic. A number of those who accessed the program through the Well Baby Clinic were not fully aware of a distinction between the two types of clinics, and were somewhat unaware of the full range of services available to them through the NHC program. About a quarter of the focus group participants came to a NHC clinic seeking some sort of non-urgent medical services. Others mentioned coming specifically for some health information related to a specific concern, such their child's food allergies. The reasons offered by focus group participants for coming to a NHC clinic were generally consistent with reasons for the group of NHC clients as a whole, based on analysis of intake data.

We asked clients at intake what they would have done if the NHC program had not been available? The most common response was that they would have sought out a Well Baby Clinic. This reinforces our finding of how important well baby and breastfeeding support is to the population of NHC clinic users. A substantial proportion indicated they would have done "nothing" (23.4%), or gone to a walk-in clinic or emergency room (15.4%). Taken together with clients' and NHC team members' accounts of the experience of receiving and providing service, these findings suggest that the NHC program does play a significant role in facilitating access to health care before problems escalate, as well as deflect unnecessary use of walk-in clinic and emergency room.

Clients provided vivid accounts of what it was like to receive NHC services from the NHC team in a coordinated, multidisciplinary manner. They expressed appreciation for being able to get so many services in one place at one time. They described how the NCH team helped them access physicians and other resources. Thirty four percent of individual clients received at least one referral to an outside resource. Clients recounted examples of NHC team members consulting and advocating with physicians on their behalf. They described receiving a wide variety of up-to-date health education information, and having team members carefully go over the information to make sure they understood it. One minor complaint that was heard from a few clients was some lack of privacy when clinics were very busy.

We asked NHC clients to discuss the difference between the NHC program and other primary health care services they have received. This question generated a very rich discussion in all three focus groups on the distinction between the approach taken at the NHC clinics and the traditional medical model. Themes that emerged in these discussions include: how the NHC program treats them and their health concerns holistically, appreciation for team members taking time, being able to access the clinics regularly on an as needed basis, the comfortable and friendly atmosphere in the clinics, and the importance of the supportive and relationship-oriented nature of the service.

Section 7: NHC Team Members' Assessment of the Program

This section of the report presents NHC team members' reflections on key aspects of the program. Findings are based on a focus group conducted in November 2005 with the core NHC team, and two PHNs who conducted Well Baby Clinics in conjunction with the NHC program. NHC team participants included the Program Manager, the Administrative Assistant, the Public Health Nurse, the Registered Dietitian and the Early Years Resource Consultant. There was no Nurse Practitioner with the program at that time.

Difference Between Well Baby Clinics and NHC Clinics

As discussed at several points throughout this report, there was a close relationship in several respects between the MLHU Well Baby/Child and Breastfeeding Clinics and the Neighbourhood Health Care Program. Analysis of clinic utilization statistics revealed that NHC clinics operating in conjunction with Well Baby Clinic had the greatest utilization. Many clients did not readily perceive the distinction between Well Baby Clinics and NHC clinics. We asked the NHC team what they thought were the important differences and advantages to the NHC model compared to the Well Baby Clinic model or other clinical models.

The following themes emerged in the discussion as key and in some respects distinct features of the NHC model: the multidisciplinary aspect, the whole family as client, breadth of assessments provided, thoroughness of assessments, importance of consistency of team to build trust with the population, serving a different target population, and inclusion of a community development component.

The Multidisciplinary Aspect

The NHC team was asked to reflect on the specific and concrete objectives of having a multidisciplinary team. In response the Program Manager recalled that one of the key objectives of the program was *early assessment.* In her view,

> In order to do early assessment you need the multidisciplinary approach because a nurse is not a Dietician, she's not a child-care expert. And vice versa, the child-care expert doesn't have that background, or the Dietician... When you look at the objectives or the goal of the entire project, it can't be done with one discipline in a comprehensive way.... We were doing an early assessment, a total assessment on one family, where one discipline can't do that.

NHC team members worked together as an integrated team, with a keen awareness of and ability to address the *interconnectedness* of various determinants that affect a young family's health.

> We go through point A to point Z with the parents, or the families and the child, because everything we find stems from one piece to another. For example, a toddler who is not eating properly, is a very picky eater, so the mother starts getting stressed out because the child is not eating properly and she needs some help with dealing with the stress, and it's just way too much on her plate. And then...the two kids who are having problems -- fighting. And then the toddler who is not eating properly probably isn't meeting his milestones properly because he's not chewing his food properly. Or you know, we look into the parenting part, the Nippissing and the milestones to see if they're meeting that. So everything is all interconnected. And we go through it. If the families have time, they will sit with us and we'll go through each person and they get a thorough assessment in all the areas most of the time.

Another benefit of the multidisciplinary approach was that team members felt that close collaboration enabled them to learn from one another's professional expertise, which expanded their understanding and perspective on the determinants of health, and enriched their own practice.

The Whole Family as Client

Well Baby/Child and Breastfeeding Clinics serve "mother and babe" as one of the PHNs expressed it, as compared with the NHC which is able and willing to focus on the whole family. Any member of a young family household, including caretakers, grandparents, older brothers, etc. was eligible for service.

Breadth of Assessment

The NHC team's PHN characterized the approach to assessment practiced by the NHC team as follows:

> ...We tend to do the whole family assessment. The social assessment, the head-to-toe assessment, in terms of...their physical status, when was their last Pap, when was their last full exam, when were the dental appointments for the kids, the eye appointments, their birth control problems or their access to primary health care. Do they have a doctor, if not then we give them a list of where they can access, where it is. If they're new to the city, some of the different health resources for them. And if we do find that there are -- like in

high-risk populations, we do screen for women abuse if we're doing a one-on-one, or we have the ability to do an in-depth assessment of that family.

Thoroughness of Assessment

One of the PHNs who had conducted a Well Baby Clinic at one of the OEYC sites for some time before the NHC began operating there had a unique perspective on the difference between the two types of clinics. She took leave of her responsibility with the Well Baby Clinic for a period of several weeks, at the point when the NHC began operating there. She returned to operate the Well Baby Clinic in conjunction with the NHC clinic. Her comments on the difference in the assessment process are particularly instructive.

It's amazing...having just started working in the NHC team...there's a difference in how the clinic runs because you do have more time. And it's amazing because assessments are being done by Rose with regards to Nippissings and developmental things which maybe I wouldn't have had time prior to the NHC team being involved.... I might not go into that big of an assessment...how I work as a Public Health Nurse... I wouldn't ask them if they had a Pap. I'd focus on what their initial concern is.... When I was in the clinic on my own, I couldn't have implemented a Beck, which is a screening tool for PPD moms. You wouldn't have that time. And now I have that time. So I do believe that assessments are much more thorough. The pace of the clinic is nicer. We're working again with that multidisciplinary approach. I mean it's wonderful that Teresa is there as dietician. Rose is there. I've got another Public Health Nurse. So we're providing an increased service to the public even without a Nurse Practitioner. I'm able to know that I can deal with this client, knowing that I don't have fifteen other clients behind me.... We're doing a lot of health teaching and we have that time to do that health teaching. And that's a big difference... And again, I would have never been able to do that prior to the NHC team coming in and sitting and doing a Beck, and having that sort of time to implement it with all that emotional support that the mother needed, as opposed to – I couldn't have done it in a clinic. It wouldn't have happened.

Consistency of Team Builds Trust with Vulnerable Population

One NHC team member commented on how important it is especially for vulnerable families to have the same team members, consistently working together and being consistently available at the various sites. She contrasted this with other clinics where the staffing is inconsistent.

You form a trust with the population and they want to know who you are, coming into their community. And I think they need stability and the same people coming into their area. And that makes a big difference for trust issues for these families.

The other thing too that we noticed...we've come across quite a few clients who have come to the different sites...because they've moved....And I think that's a really important point is that we are able to provide continuity of care even though they are moving around. So we know them from before. We know what the concerns were and we can follow up on them. So if you had a different staff at each of those eight different sites, these clients could go to all different ones and sort of fall in the cracks in terms of continuity. Having the same staff in all the vulnerable population, there's that continuity. So we've had clients moving from Limberlost to Boulee, and we knew them, they were comfortable with us, they came and saw us right away.

Different Target Population

The Well Baby Clinics are aimed at a general population, whereas the NHC clinics target a particular population as discussed in the Introduction to this report.

Community Development

As discussed earlier in this report, during the early implementation stages of the program the team realized how crucial various community-based promotion and other community development type efforts were to establishing strong relationship with the target population in under-serviced, high-risk neighbourhoods. Efforts were devoted to this dimension of health promotion work, but this component was under-developed in the original model. NHC team members commented on this during their focus group.

The other thing I think that's different from the other clinics is NHC team members are also members of the community.... There are neighbourhood or community groups within most of the locations and with the exceptions of probably the Early Years Centres... So that is different because we go to their meetings, and participate in their events, they get known. So we become a member of that, which has helped the capacity-building within the community.

Running the NHC Program With and Without a Nurse Practitioner

As discussed earlier in this report the program functioned for the first six months with a part-time, seconded NP. The next eight months the program functioned without the services of a NP. Finally, a full-time NP was secured as a full and integrated team member for the last 7 months of the program. One of the areas of inquiry during the NHC team focus group

(which was held before the NP was finally hired) was what difference it made to operate the program with and without the services of the NP.

As was also discussed earlier, one advantage of functioning without the NP was to open up the service to a wider population, that is, having a family doctor no longer excluded a person from receiving service. Moreover, even when the team consisted of just three members, those members felt they were able to provide an excellent service, conducting multidisciplinary in-depth assessments, providing health education, and linking clients to medical services and other community resources.

They also articulated well what was missing from the program without the NP. Although the team (with or without an NP) was successful in helping clients link with medical services, having an NP on the team made medical services available *right in the neighbourhoods* of vulnerable persons--persons who tend to experience a variety of barriers to services.

> I think there's... that one aspect of accessibility when we're in the vulnerable population. It was nice to have the NP there because for certain medical issues the NP could deal with that issue right away, whereas we'd have to refer to the doctor. And in some cases they wouldn't have a family doctor. So we'd be trying to help them to define, okay...where are you going to go from here. So... (without) that service... it changed the ease of accessibility for the medical service.

Another team member added that there are barriers and challenges regarding accessibility of health care among members of vulnerable populations that *do* have physicians.

> It's nice to at least have accessibility, to have that nurse practitioner there. Even if a client has a family doctor I don't think the nurse practitioner would want to replace that family doctor but can be a support or an addition to. I mean I think that sometimes clients just need -- sort of right there and then, and then she can do what she can with the initial assessment, but also make that referral. So I see it as a support to the health care system, providing that primary health care right in their neighbourhood for the vulnerable population. If they don't have a vehicle to get in the car and go to the doctor, or they don't have the money for the bus. They might have one child in day care or they're going to school, and just the whole logistics. They may not have the support, saying oh well grandma will take care of the two other children, or my husband will take care of the two other children while I take this one to the doctor. That just isn't there for them. So having that medical piece inside their neighbourhood I think increases the accessibility, the universal principle of health care access.

A few specific areas within the NPs scope of practice that were felt to be especially important among the vulnerable population. For example, with respect to preconception, pregnancy and mental health one NHC team member said,

> I think the Nurse Practitioner was seeing a lot of like preconceptions and pregnants and birth control. And women abuse was coming through. So having women being able to access medical care right in their neighbourhood for those specific things I think was pretty popular with them. And mental health. I think those were the ones that we saw a lot of.

One NHC team member discussed the importance of making immunizations more accessible in terms of keeping both children and parents well.

> In terms of service with the NP, one of the big advantages of that we saw was she was able to make sure that the children got immunized while they were well. They're often sick. And if they came and they were well and they were delayed in their immunization, they got immunized right there on the spot. We'd often get the mom's immunization up to date at the same time. So that was a really big plus and ... it was something that pulled them in. Immunization is really big from 0 to 6. And quite often the moms, some of the vulnerable population moms, would not have finished high school or would have come from a different country, so their immunizations weren't up to date and they were at risk for, you know, Hep B (which) was one that we really encouraged and usually got the moms to get.... So not only the children but also the parents...we're helping to keep the parents healthier to take care of the children. So that's the one disadvantage by not having the NP because that may have been the thing to bring them in.

Recommendations with Respect to the Multidisciplinary Team

NHC team members were asked to consider and comment on the adequacy of the particular combination of disciplines that made up the NHC team. It was felt that the four original disciplines comprising the team were definitely appropriate. As the Program Manager stated,

> ...Young families' concerns (are) around parenting, health and nutrition, breastfeeding, intro to solids, toddler feeding, weights, development, and it's all crucial in the first five years before they head off to school. And if there's going to be any intervention, now's the time to do it. Research shows that over and over again. Nutrition affects development,

parenting affects development. Health affects the whole family. So it's all very much interconnected.

Adding a Health Promoter

As discussed earlier, the team also felt that a full-time Health Promoter would be a very important addition to the team. As the Program Manager stated,

> I would think (a Health Promoter) would be a major component...because the clinic people are so devoted to the clinical component for their client that to take them out of that atmosphere or environment to do other things just adds to the workload. So I would add that component to it.... There are other primary health care initiatives going on that have a multidisciplinary approach to it but they do not go to their neighbourhood; the client comes to them. So the uniqueness about this is we're going out to them, whether you see them all or you don't see them all, there is a particular uniqueness about this.

The Health Promoter role was seen as being crucial to be able to make successful linkages within the target population and work on the level of community development and the social determinants of health.

Capacity to Deal with Mental Health and Woman Abuse Concerns

Another recommendation that received general endorsement from the team was to add a worker who could competently address mental health issues among members of the target population, such as a Social Worker or Community Mental Health Worker. As one team member commented.

> I think a Social Worker or Mental Health Worker (should be added) because we have new immigrants that have a lot of social concerns. And if they're low-educated and have...grown up in the housing complexes, you have a couple of generations of families within the complex. And just to try to get them out of that cycle, I think that would be really helpful.

To this comment, another team member responded,

> I would support the social work component.... (Some of our clients) have complex problems when they come in and they're stressed about all of them... (to) just go into a counselor is another thing on their plate and if they had that right there on the spot, they could come in once a week and talk to her about how things are going. You know, we have issues – some of our families have issues with, you know, being physically beaten up, having old boyfriends come in or violence or poverty ongoing.

The preceding comments relate to other comments made by a NHC team member with respect to the sensitivity with which the issue of woman abuse must be handled. As reported in the statistical overview of services provided, one of the least frequently indicated interventions among adults was screening for woman abuse. When asked if woman abuse was being disclosed by clients, one NHC team member responded,

> I think having... the interviewing skills... you would find ways to phrase it so that it just seemed like part of the conversation. You know, 'You've said this....". So I think that's a big part of it. If you want to find out, asking the question, knowing when to ask the question, how to ask the question. You know, is it an appropriate time to ask the question. Is the partner there?... If you're comfortable asking it, you will ask it. If you're not comfortable or you haven't had the training, you won't ask.

These various comments, along with the statistics pertaining to woman abuse screening among all clients suggests that any future multidisciplinary team operating in a similar context could benefit from a professional with the particular expertise to handle mental health and woman abuse concerns.

Training for Collaboration

One final point that was made during the focus group in term of lessons learned about being a multidisciplinary team, was how important the ability to collaborate effectively was for the success of the program. It was suggested that an effective team depends to a large measure on the right mix of people, in terms of both complementary skills and compatible personalities. The NHC program was successful in putting together the right combination of professional roles and individual personalities. It was argued however that most professionals in pubic health are trained to operate as individual practitioners. Therefore, it was recommended that any future such program could benefit from deliberate training in collaboration.

Summary

This section reported the NHC team's assessment of the advantages of NHC approach, and their suggestions to improve on the model. Three broad topics were discussed: the difference between Well Baby Clinics and NHC clinics, what difference it made to run the program with and without a Nurse Practitioner on the team, and recommendations the team would make to improve the multidisciplinary model.

NHC team members described important differences and distinct advantages to the NHC model as compared with the Well Baby Clinics and other similar clinical models. It is important to note that two PHNs who worked Well Baby Clinics in conjunction with NHC clinics contributed to this discussion and concurred with the overall assessment.

The most obvious and significant distinction is the multidisciplinary team. The multidisciplinary team made possible the provision of more complete early assessments for individuals and families. The NHC team worked together as an integrated team, focusing on and addressing the interconnections among various determinants of health. Team members reported learning from each other through consultations and observing one another's practice, thereby expanding their understanding of the determinants of health and enriching their own practice. They saw a difference in the breadth and thoroughness of the assessments they were able to do. As one team member said, "We tend to do the whole family assessment, the social assessment, the head-to-toe assessment..."

Other key differences included a focus on the whole family and the targeting of vulnerable populations. The team felt that the consistency of the personnel from clinic to clinic was an important factor building trust with member of vulnerable populations. They felt the community development component, even though it was underdeveloped, was an important and distinguishing component of the NHC program.

In terms of the experience of running the program both with and without a Nurse Practitioner the following observations were made. The experience of having to run the clinics without a Nurse Practitioner had the unintended benefit of opening up the service to a wider segment of the population. It was recognized that on a population or community level, it pays dividends to not have to restrict the program to those who do not have a family physician. Many clients who had a family physician experienced various barriers at any given time that restricted their access to their physician, such as transportation, child care issues, waiting times, time constraints on visits, and a narrowly focused medical perspective. The NHC program addressed and promoted health on many other levels.

In terms of the objective of increasing access to medical services, the NHC program adapted to the unavailability of a NP, by thinking more in terms of all team members facilitating clients' access to medical services through referral and advocacy. Even though the team was able to link clients with medical services, there was perceived to be a great advantage in having the NP service available right in the neighbourhoods, in terms of overcoming the kinds of barriers referred to above. It was mentioned in particular that the NHC target population benefited especially from preconception, pregnancy, mental health and immunization related services.

The NHC had recommendations as to how the multidisciplinary team could be strengthened if the model was ever to be implemented again. They strongly endorsed the value of each of the original four roles. In addition, they strongly recommended that the team include a full-time Health Promoter to undertake program promotion and community development work. They also recommended incorporating a role to address mental health and woman abuse issues, such as a Social Worker or Community Mental Health Worker.

Finally, in reflecting on the importance of collaboration to the success of the program, and in recognizing that working collaboratively requires skill, it was recommended that any future program invest resources in deliberate training for collaboration.

Conclusion: Lessons Learned from Community Partners

A crucial component of the NHC Program from the beginning was the establishment of community partnerships. Community partnerships were integral to the idea of bringing the clinics right into neighbourhoods, and to the idea of building on relationships that community partners' organizations had already established with members of the target population.

As discussed in the Introduction to this report, two mechanisms were created to foster and maintain these partnerships. First, an Advisory Committee made up of representatives from the community partners was established to provide "high level" guidance and support as the program unfolded. Second, a Site Lead Committee was established to proactively deal with any concerns or issues that might emerge "on the ground" with respect to the weekly operation of the clinics.

As the program was winding down in the Spring of 2006, informal focus groups were held with each of these groups, to invite feedback as to lessons learned from the experience.

Lessons Learned by the Site Lead Committee

The informal focus group with the Site Lead Committee was held during the last scheduled Site Lead Committee meeting in April 2006 at Childreach. Six of the eight sites were represented. The entire NHC team was present. The Program Evaluator presented five topics for the group's consideration. For each topic the group was asked to consider what worked well, what did not work so well, and what recommendations they would make for future implementation of such a project.

The following is a summary of points made during the discussion, based on notes taken by the Program Evaluator.

Establishing the relationship between the NHC program and your organization:

- There was open communication. Designating one representative from each site, and meeting regularly with the NHC team as a whole worked really well.
- From the NHC team perspective, obtaining expertise about the community from within the community, was very important.
- The Site Lead Meetings enabled the NHC team to more readily get to know "who's who" on site and in the neighbourhood.
- Any site-related problems or concerns that were communicated to Site Leads were taken care of.
- From a program management point of view, it was a "culture shift" to have a NHC team members (i.e., staff) designated as liaison responsible to manage communication with each site. At first it was uncomfortable, but it worked very well.
- From the community partners point of view, it was really important to name and honour the partnerships when the program was starting up.

The practicalities of setting up the physical space and getting the clinics running:

- It was very helpful to be able to "meet in the middle" in matching the NHC team's idea of what was needed to run a clinic, with the pragmatic considerations of what would work in a given space.
- From the NHC team perspective, getting establishing in the neighborhoods at times felt "overwhelming". This work involved a lot of time and energy devoted to building relationships, visiting, and marketing. As clinical practitioners they felt they lacked a certain degree of community development expertise. They would recommend hiring a full-time Health Promoter or Community Developer.
- It "meant a great deal" to the community partners to have the NHC team work with in-house staff to do the physical set up of the clinics. As an example, NHC team and in-house staff worked together, brainstorming and figuring out how to create a private space for clinical examinations. They made it fun.
- The NHC team was able to make do with what was available. One Site Lead stated, "when they left, we didn't know they'd been there. They made it cleaner."
- A "cookie cutter" approach cannot be used in setting up the various sites.
- In school settings it is very important to make sure the Principal is fully on board. In the future, space in schools is likely to be in even higher demand.

The establishment and functioning of Site Lead meetings as a feedback and adjustment mechanism:

- It was very useful to have designated a NHC team liaison person to come to staff meetings at the community site. It was important to be physically present, to have informal interactions and to "mingle" at the site.
- Establishing the relationship required a great deal of patience in the start up phase.

The overall viability of the NHC model as a mode of primary health care delivery in your community:

- The idea of siting clinics in neighbourhoods, in partnership with established community-based agencies with well developed relationships among the target population worked really well. For example, building on the Well Baby Clinics, the chaplaincy at the public housing complexes worked really well. Food banks and churches were suggested as another possible type of sites for consideration.
- A program such as the NHC Program should be expected to take three to four years of community development work in order to become well established.
- With one minor exception, the NHC program did not experiment with offering clinics during evenings. Consideration should be given to running evening clinics.
- Avoid changing clinic times and locations around. Clients need predictability.
- In terms of the number and frequency of clinics, it was challenging for the NHC team as constituted to cover their commitments. We would "almost need two teams" in order to allow time for team member to do any professional development.
- Despite the poor utilization, the group generally agreed that schools may well be a viable type of site in the long run. To become established takes time and patience, especially in "a hurting, higher needs community." It takes time to build trust. Members of this population "don't always grasp" or easily embrace the idea of preventative health care. They may have more urgent needs ("want a band aid").
- It would have been interesting to see how well a clinic would have fared in a school with a viable Healthy School Community program in place.
- There are many vulnerable families that do not feel comfortable in or like school settings due to their past experiences (as children) in schools.
- There is a challenge with public housing as a site, due to "inside/outside" boundary issues. There are "unwritten rules" and "boundaries that we don't see". For example, "people don't cross the fence at Boullee".

General lessons learned:

1. Link with community partners
2. Link with those well trusted in the community
3. Need to build more community development into the program from the beginning
4. The program has to be a part of the community; requires involvement, participation, and visibility.

The sustainability of this type of partnership:

- Concern was expressed that community members (clients) are going to be wondering what happened, why program ended. This type of program needs continuity over time. People may lose trust with respect to similar future initiative. Funders are urged to understand this.
- The Ministry is urged to consider carefully how they measure success, i.e., in terms of quantity versus quality. Must understand that the NHC clinic users are complex families. They require different service than they can obtain in a walk-in clinic.
- It was agreed that this is a "wonderful model" that should receive sustained funding.

Lessons Learned by the Advisory Committee

The informal focus group with the Advisory Committee was conducted at their final scheduled meeting held in May 2006 at Middlesex-London Health Unit. Four of the seven community partner representatives were present, as well as the Director, Family Health Services, MLHU and the NHC Program Manager.

A slightly different approach was taken in conducting the session. Participants were asked to develop a list of important topics that should be discussed in order to capture the most important lessons learned from their point of view. The list was prioritized, and the Program Evaluator facilitated a discussion in terms of lessons learned with respect to each topic. Key points from the discussion were recorded by an Administrative Assistant. An edited version of that record is presented below.

How Well Did the Partnership with Community Agencies Work?

- Building on existing relationships worked very well.
- Ongoing recognition of what wasn't working and adapting as needed is critical.
- The Advisory Committee adapted, brought in another partner when needed (e.g., London Intercommunity Health Centre wasn't originally part of model).
    - Helped with recruiting NP
    - Seconded NP on temporary basis; more than just "purchased services"
- There was a recognition that things could be learned and more could be done by involving partners. Partners voices were heard, the model was adapted.
- The partners worked from a vision and adapted the initial proposal.
- Hashed out issues in beginning; got beyond being adversarial.
    - How can we make it work? Find the solution.

- Structure was adapted. "Site Lead Committee was split off from Advisory Committee; more efficient, flexible, and made things happen."
- The Advisory Committee adhered to their terms of reference; this was appreciated.
- Great model and the partners were great partners.
- Build on positive relationships; sets up for success.
- Keep focus on client/families vs. needs of organizations.
- Having a track record of consistently following through on concerns with community partners is important.
- Having a joint accountability agreement between MLHU and partners which was seamless to staff, clearly outlining lines of accountability, was very positive for the staff, removed "cumbersomeness" from frontline staff.

Establishing The NHC Program; Challenges with Staffing:

- Never would have guessed the difficulty in finding a NP.
- Good to have had a primary care provider involved in developing program.
- NP – new role and scope of practice continually changing.
- Challenges to NP being comfortable with this practice setting.
- Would have been good to have had a primary care provider (e.g. Community Health Centre) involved in delivery of program, to help facilitate enactment of NP role, given experience with having NP on staff.
    - Would facilitate establishing physician relationship within CHC.
- Could replicate this model in the province, wherever there is a CHC.
- Very small percentage of NP going into the primary health care field; they're almost as rare as family physicians.
- New grads coming into the field tend to be relatively inexperienced.
- Covering insurance and liability for the NPs; LIHC able to cover .
- NP needs contact with other NPs for peer support.
- A different dynamic would have developed among the NHC team if the NP had been involved at the beginning.
    - Once the NHC team "gave up" on recruiting an NP and employed a determinants of health model, the existing team members found their way.
- The NHC team was still able to do a lot; physical assessment, educate, health promotion, etc. without an NP.
- Do not think of the NP as the dominant team member, think in terms of a holistic team.

Locations

- Bringing services to people overcomes the barrier of transportation, allows a different kind of conversation with clients, shifts program away from the medial model (more prevention).
- Piggybacking on Well Baby Clinics was good strategy, already established clientele and programs. Built on the trust that was already there through PHN and "word of mouth".

Viability of the Model, Relationship with Broader Health Care Issues, Sustainability:

- The time is right for this model, keep it going.
- People are looking at models other than the "physician driven model". People are accessing doulas, midwives; focus on determinants of health is increasing.
- People are more informed through Internet; people more informed, affects the publics attitude toward receiving health care.
- Many people are taking ownership of their health and managing care.
- The program is not currently viable from a funding perspective; there aren't resources out there for "permanent funding". The projects have been incredible successful; hoping that partners will "find" money.
- There is a critical mass about to emerge with respect to recognition of the need for and viability of alternative primary health care models.
- However, many physicians don't think this should be so, and they have power.
- LHINs not funding primary health care.
- Some glimmer of possibilities seem to be emerging:
    - OMA developing initiatives in funding.
    - Family health network will not be picking up complex cases; these may be a framework to be built upon.
- The public is ready for a new model.
- Community agencies are ready to provide services using a client-centred planning model.
- Consider sending a message to Ministry; idea of a team to support physicians will enable them to move from 1200-1800 clients.
- Need a stronger focus on communication with relevant Ministries and others, e.g. United Way:

  - Dissemination, strategic communication – CAPS, Ministry of Health Promotion, locally; educating for systemic change, educating for funding.
  - To change thinking about what is health (determinants of health model).
- Sustainability; build, adapt model, try to access other sources of resources (broader idea of health).
- Try to keep pieces of program in place until longer term funding can be found.
- Don't underestimate the importance of the multidisciplinary team to the success of the model; very critical for the team members.
- The dynamic that arises from team consistency, relationships among team members is critical :
  - Recruit staff members who could work well together as a "team".
  - A multidisciplinary team is more than a collection of services; it's about cohesiveness and integration.
- Challenge; Ministry representatives are constantly changing; not a consistent partner.
- This kind of model brings services to neighbourhoods; keep the focus on meeting the "clients' needs" not the staff's needs.

Summary

Community partners were involved in the development and implementation at two levels. An Advisory Committee made up of MLHU administrators and mostly management level representatives from partner agencies provided "higher level" guidance and advice as the program was implemented. A Site Lead Committee made up of NHC team members was created after program start up to deal with any concerns that developed "on the ground." Both of these groups met as the program was winding down to reflect on lessons learned and offer recommendations.

There were a number of fairly specific operational suggestions offered. Some of the more global lessons learned and recommendations around which there seemed to a high degree of agreement are presented below.

- Strong community partnerships were critical to the success of this program
- Administrative structures were strengthened by clear terms of reference and a joint accountability agreement between partners.
- Administrative structures were flexible and adaptable, as exhibited in the adaptability of the original vision, the creating of a Site Lead Committee, and managing the challenges surrounding the recruitment and support for the Nurse Practitioner.
- It was very valuable to build partnerships and linking with organizations well established of the target population.
- More attention and resources should be devoted to a community development if such a model were to be implemented again.
- The community partners very strongly endorsed the model as a viable alternative approach to primary health care. They articulated a number of developments that suggest the time is right for such a model
- There was recognition that the model is not sustainable without some kind of permanent funding
- The partners strongly believe this model deserves ongoing, permanent funding.

Appendix A: Implementation Logic Model

MIDDLESEX-LONDON HEALTH UNIT

Neighbourhood Health Care

Bringing health services to young families (children 0-6 yrs)

APPENDIX A

MLHU Neighbourhood Health Care Program Logic Model
Phase 1: Formative Evaluation
Last Update: January 24, 2005

Components	HOST AGENCY LIAISON	COMMUNITY-BASED PROGRAM PROMOTION	INTAKE	INTEGRATION[1] OF SERVICES	PROGRAM MANAGEMENT AND EVALUATION
Activities	1. Include "site needs/issues" as regular agenda item for Site Lead meetings—held every ___ weeks (BW) • Also reviewed as needed at Advisory Committee meetings which will be held every ___ weeks 2. Establish and maintain good working relationship with host agency "site leader" (NHC team designate) • Conduct a weekly "check-in" by phone or email during start-up phase (modify as needed after well established). 3. Selectively attend appropriate staff/ agency/ team meetings at host site (NHC team designate) • Inform about NHC Service Plan • Clarify roles and expectations between NCH team and host agency personnel 4. Provide regular feedback about site needs/issues from each site to NHC team on a weekly basis (NHC team designate) 5. Present feedback obtained through various agency/site contacts about "fit" of program and with local community and barriers to service at weekly team meetings	1. Informal Direct Contact • Make informal contact with existing clients at community sites 2. Media • Develop mass media campaign • Consult with Rata Pocius • Execute mass media campaign • Develop print resources for distribution to various local media channels 3. Agency Promotion • Identify agencies and organizations in each target community that serve target population • Identify, establish link with and consult/educate key informants at identified agencies and organizations about NHC service • Attend team/agency meetings to educate wide range of community agency staff members about NHC service • Seek feedback through various agency/site contacts about "fit" of program with local community and barriers to service 4. Targeting Vulnerable Population • Identify agencies, organizations and individuals known to have strong relationships with members of vulnerable populations in target communities • In consultation with those identified,	1. Responding to Phone Inquiries • Train host site reception staff regarding appropriate response to phone inquiries • Conduct quick assessment of whether caller meets criteria • Direct eligible callers to appropriate sites/times • Direct ineligible callers to other services with sensitivity 2. Theme-Based Information Packages • Develop and display at each site a variety of theme or topic-based health information displays, including materials that may be handed out, based on assessment of needs of local community 3. Drop-in/ Sign Up • Post clear, easy-to-read information about available NHC services and clinic times at each site • Post clear, easy-to-read sign-up board/sheet at each site, including means for client to indicate what service they are seeking • See clients attending clinics on triage, then first-come-first-serve basis 4. Intake/Brief Intervention • Available NHC team member takes basic information (e.g., name, presenting need) on "Intake/Brief Intervention Sheet"	1. NHC team meets (daily initially, then as needed) to discuss, problem solve and develop follow-up plans around • Individual client issues (client review) • Group work issues • Site issues 2. Ongoing assessment at weekly team meetings, of adequacy of services and gaps in service for population within each target community, in terms of a broad *determinants of health*[2] perspective *and health promotion strategies*[3] 3. Discuss and look for ways to enhance coordination, cooperation and mutual support among NHC team members in providing service 4. Share information and make suggestions for coordinating with, accessing and/or referral to outside community resources 5. Link with individuals, organizations and agencies representing and/or serving target population in planning and employing appropriate *health promotion strategies* where feasible, in order to address broad determinants of health	1. Conduct collaborative and relationship-centered weekly team meetings 2. Proactively consider feedback from all relevant sources and identify and solve problems, by included the following as standing agenda items to be discussed at weekly NHC team meetings: • Program promotion • Site and facility issues at each site (identified by NHC team or at Site Lead meetings) • "Fit" of service offered at each site • Gaps in service • Barriers to service • Adequacy of service in terms of broad determinants of health and health promotion strategies • Other program issues 3. Review/audit select cases to ensure best practice 4. Obtain updates to keep informed about and learn from other provincial initiatives (through for example, ministry updates and teleconferences, and networking) 5. Identify and take advantage of professional development opportunities

[1] There is overlap between the last two components. What is the difference? It may help to consider the following definitions. Integrate: "To form, coordinate, or blend into a functioning, unified whole." Manage: "To handle or direct with a degree of skill as a: to make or keep compliant, b: to treat with care, c: to exercise executive, administrative and supervisory direction of."

[2] (a) Shah, C.P. (2003). *Public health and preventative medicine in Canada* (5th ed.). Toronto: Elsevier, pp. 4-17, 101-134. (b) Wilkinson, R & Marmot, M (eds). (2003). *Social determinants of health: the solid facts. 2nd edition*. World Health Organization. (http://www.euro.who.int/document/e81384.pdf)

[3] Shah, pp. 20-31.

Components	HOST AGENCY LIAISON	COMMUNITY-BASED PROGRAM PROMOTION	INTAKE	INTEGRATION[1] OF SERVICES	PROGRAM MANAGEMENT AND EVALUATION
Activities (con'd)		identify channels and develop and execute print and word-of-mouth strategies to communicate about NHC service to target population, such as: • PHNs in schools • Daycare centres • Walk-in clinics and emergency rooms • Drug stores • Food banks • Ontario Works • Children's Aid Society • Agencies serving women (e.g., shelters, advocacy groups) 5. Seek feedback from individual members of vulnerable population about "fit" of NHC services with local needs and barriers to service 6. <u>"Pre-launch"</u> • Plan and organize a "pre-launch event" at a selected community site • Invite key informants identified in previous steps	• Assess if client meets NHC criteria • Refer to appropriate NHC team member for *in-depth assessment*, or • Provide informal support and/or information (documentation), or • Refer to other appropriate NHC service such as group • "Suggestion" made when appropriate for client to seek outside service 5. <u>In-Depth Assessment</u> • Relevant NHC team member conducts assessment (documentation) • Refer as appropriate for: • Treatment within NP scope of practice, or • Services of other NHC team members including groups and informal consultations, or • Outside resource		6. Conduct quarterly meetings with site leads to exchange information, discuss and resolve any common concerns pertaining to operation of program across host sites 7. Conduct process and outcome evaluation activities and make use of evidence in ongoing program planning and adaptation
Process Evaluation Method • **Activity Indicators** • **Outputs**	1. % of Advisory Committee meeting agendas that include *site needs/issues* 3. Log: Record kept by each NHC team member including agency name, date of meeting, and topics discussed 4&5 Key discussion points and action items regarding <u>site needs/issues</u> and <u>program fit</u> captured in minutes at each weekly team meeting	2. Track # of print resource items produced by date and description of print resource 3 (all), 4.1 and 4.3 • List of agencies and individuals identified for networking/ program promotion purposes, by "General Community Agencies", "Agencies Linked to Vulnerable Population", and "Member of Vulnerable Population" (Generated by team, maintained by K. Rowland) • Log: Record of meetings attended/contacts made by each NHC team member for networking/program promotion purposes including agency/contact name, date of meeting, and topics discussed, by "General Community Agencies", "Agencies Linked to Vulnerable Population", "Member of Vulnerable Population" • Log: Record of comments/feedback regarding <u>program fit</u> and <u>barriers to service</u> in general and/or for each site.	• <u>Responding to Phone Inquiries</u> • Health Connection staff records # of calls received inquiring about NHC • NHC Admin. Assistant records: • # of inquiries received • How callers heard about NHC (Health connection, other) • How callers were directed in response to inquiry (referred to NHC site, referred to outside resource) • <u>Information Sessions</u> • # of sessions per month by site, topic, # of participants (first time, repeat), collated monthly from *group sign in sheets*. • <u>Intake/Brief Intervention</u> • # of people seeking NP service that meet eligibility criteria per month, by site (indicate whether *no family doctor* or, *experience a legitimate barrier to access*, including nature of barrier in comments section, on Intake/Brief Intervention form)	2. Capture key discussion points and action items regarding adequacy of services and gaps in service in terms of determinants of health and health promotion strategies in minutes at each weekly team meeting 4. Track links and/or partnerships established with other community agencies intended to address broad determinants of health through health promotion strategies, by determinant(s) addressed and health promotion strategies employed.	

Components	HOST AGENCY LIAISON	COMMUNITY-BASED PROGRAM PROMOTION	INTAKE	INTEGRATION[1] OF SERVICES	PROGRAM MANAGEMENT AND EVALUATION
Process Evaluation Method • **Activity Indicators** • **Outputs (con'd)**		by "General Community Agencies", "Linked to Vulnerable Population" and "Member of Vulnerable Population" , captured in minutes at each weekly team meeting 4.2 Log Specific promotional activities aimed directly at members of vulnerable population undertaken by each team member described (what, to whom, where, when) and reported weekly to K. Rowland	• # of people seeking NP service that do not meet eligibility criteria, per month, by site (record *yes family doctor* and *no legitimate barrier access* on Intake/Brief Intervention form, and indicate reason person did not go to family doctor in comments section) • # of new intakes, per month, by site (collated from Intake/Brief Intervention form) • # new intakes receiving brief interventions, resulting in informal support/information and/or internal referral to NHC team for specific non-medical NHC service such as group activity (no file opened), by type of need (nutrition, parenting, health education, other) • # new intakes receiving brief interventions leading to in-depth assessment (result in "opening a file"), by type of NHC service (NP, PHN, Dietician, Parenting) • # of returning clients, per month, by site (collated from Intake/Brief Intervention form) • # of returning clients coming for follow-up for previously identified medical problem (has open file with NP) • # of returning clients coming for follow-up for previously identified health promotion need, by type of need (nutrition, parenting, health education, other) • # of returning clients coming for new problem, by type of need (medical, nutrition, parenting, health education, other) • # of "referrals" to outside resources from per month by site, and type of agency or service suggested • # of "suggestions" to outside resources from per month by site, and type of agency or service suggested		

Components	HOST AGENCY LIAISON	COMMUNITY-BASED PROGRAM PROMOTION	INTAKE	INTEGRATION[1] OF SERVICES	PROGRAM MANAGEMENT AND EVALUATION
Target Group	• Host agency "site leaders" • Other host agency personnel • Advisory Committee members	• General social service and other community opinion leaders • Social service and other community opinion leaders that serve vulnerable populations specifically • Members of vulnerable populations	• Host site reception staff • Members of target population	• NHC team members • Members of target population • Outside community service providers	• NHC team members • Members of target population • Community partners
Short-term Outcomes	1. Appropriate space and resources secured and maintained at each site 2. High quality relationships (effective communication and high level of trust) established and maintained at each site between host agency personnel and NHC team members 3. Host agency personnel clearly understand and strongly endorse intended outcomes of NHC project 4. Minor adjustments made with respect to day-to-day site and facility related aspects of service delivery as needed 5. Feedback loop established between host site and program management in order to assure appropriate response to more significant NHC program issues	1. Relationships developed with current users of host site services 2.1 Appropriate messages developed and channels selected for mass media campaign 2.2 Appropriate print resources developed for various promotion strategies 3.1 Relationships developed with broad social service community in each target community 3.2 Broad social service and other community opinion leaders well informed about NHC service 3.3 Feedback gained from social service and other community opinion leaders in each target community about appropriateness of NHC service for that community and barriers to service identified 4.1 Relationships developed with those known to have strong relationships with members of vulnerable population in each target community 4.2 Those known to have strong relationships with members of vulnerable population in each target community are well informed about NHC service 4.3 Members of vulnerable populations consulted about appropriateness of NHC service and barriers to service identified 4.4 Members of vulnerable populations well informed about NHC service 5. Broad social service and other community opinion leaders well informed about NHC service	1.1 Phone inquires responded to appropriately 1.2 Community members eligible for service directed to appropriate NHC service 1.3 Community members ineligible for service directed to appropriate outside service with sensitivity 2.1 Community members who may be reluctant are introduced to nature of NHC service in non-threatening way 2.2 NHC begins to establish relationships with community members 2.3 Drop-in or casual visitors encouraged to come back for more in-depth service 3.1 Clients understand and utilize drop-in, sign-up system 3.2 Clients triaged appropriately 4.1 Determination made whether those presenting for service are eligible 4.2 Community members eligible for service directed to appropriate NHC service 4.3 Community members ineligible for service directed to appropriate outside service with sensitivity 4.4 Community members eligible for service screened and directed as appropriate for in-depth assessment or other NHC service 4.5 Intake/brief intervention documented appropriately 5.1 Community members eligible for service *assessed* and referred as appropriate for NP treatment, other NHS service, or outside services 5.2 In-depth assessment and referral documented appropriately	1.1 All NHC team members kept up-to-date about concerns throughout program 1.2 Service to individual clients enhanced 1.3 Group work enhanced 1.4 Site issues identified 2.1 Minor gaps in services identified 2.2 Minor adjustments in service plan made as needed 2.3 NHC team develops increased understanding between health status of target population and broad determinants of health 2.4 Determinants of health that most influence health outcomes in each host community identified 2.5 Possible major gaps in service plan in terms of determinants of health identified to be brought forward to management 3.1 Coordination of service within NHC team optimized 3.2 Strong sense of mutual support and trust among NHC team members 4.1 Service coordination between NHC team and outside community resources 4.2 Unnecessary duplication of services avoided 4.3 Clients connected with needed services not available through NHC team 5. Empowering relationships built with advocates for and members of target population	1.1 Effective meetings 1.2 Trust, support, safety, reassurance, cohesion experienced within NHC team 2.1 Problems, concerns and/or issues identified and addressed 2.2 Services adjusted as needed and feasible to fit needs of each target community 2.3 Barriers to service reduced 3.1 NHC team members assisted in meeting best practice standards 3.2 Clients receive effective and safe services 4. NHC team learns about and applies promising approaches from other provincial initiatives as adapted and deemed appropriate for local settings 5. NHC team members' professional practice enhanced 6.1 Common concerns across sites identified and addressed 6.2 Partnerships with host sites well maintained 7.1 NHC program activities appropriately tracked, evaluated, and adjustments to program processes implemented 7.2 Evidence obtained about select program outcomes, sustainability of program, and report written with recommendations for future of program

Components	HOST AGENCY LIAISON	COMMUNITY-BASED PROGRAM PROMOTION	INTAKE	INTEGRATION[1] OF SERVICES	PROGRAM MANAGEMENT AND EVALUATION
Short-term Outcome Indicators	2, 3, & 4. Brief questionnaire administered to site personnel, site leads	3.2 & 4.2 Brief telephone interviews		1.4, 2.1, 2.2, 2.5 Tracked regularly via team minutes 2.3, 2.4 Conduct focus group with NHC team	
Intermediate Outcomes		• High degree of utilization of NHC services by target population	• Target population receives available NHC services appropriate to their needs • Increased access and receptivity to prevention, health promotion and early intervention health care services by target population	• High level of integration between NHC team and other community resources • NHC clients experience integrated, coordinated, holistic care • NHC team and clients increase understanding of and sense of empowerment with respect to determinants of health	• NHC Program continually adapted to meet needs of target population • Service providers are highly competent in provision of services
Long-term Outcomes	• Reduced incidence of unnecessary complications and escalation of illness • Decreased inappropriate use of emergency rooms • Increased control over determinants of health • Increased understanding of the relationship between health and health promoting behaviours among target population • Increase in health promoting behaviours among target population • Decreased costs to health care system				

Appendix B: Clinic Intake Form

Neighbourhood Health Care

Intake/Brief Intervention Form

Notice of Collection:	Y N
Date/Initial:	

What would client have done if the NHC clinic was not available?

How Heard About NHC (check one)

1. Family/friend
2. Media
3. Brochure/flyer
4. Community resource person
5. PHN
6. Other ______

Clinic Location (check one)

1. Limberlost
2. Southdale
3. OEYC-London Fanshawe
4. Childreach
5. CC Carrothers
6. Boulee Street
7. Families First

Client/Family Information

	Gender	D.O.B.	File I.D. #
Adult 1 Name (last/first):	M F		
Adult 2 Name (last/first):	M F		
Postal Code:		yyyy/mm/dd	
Telephone:			

Possible Barrier to Service		Childrens' Names (last/first)	Gender	D.O.B.
Language barrier?	Y N		M F	
If yes, primary language:			M F	
			M F	
Immigrant/Refugee < 5 yrs	Y N		M F	
Literacy Barrier:	Y N		M F	

Clinic History

Date	Name of Client	Confirm Eligibility		Reason for Visit	Intake Intials:
		Doctor:	Y N		Describe barrier(s) to access
		Barrier to Access*:	Y N		
		Children or Pregnant:	Y N		
New or Returning?	N R	Eligible?	Y N		
Team Members Seen Today (check)	NP	PHN / Dietician	EYRC	Follow-up or New Problem	FU NP

CHILD WELL BEING							ADULT WELL BEING											REFER'L/ SUGGST'N					INDEPTHSRV (Entry to File)			
Dental	Development	Growth/Weight	Immunization	Nutrition	Physical Well Being	Safety	Breastfeeding	Immunization	Mental Health	PPD	Nutrition	Parenting	Physical Well Being	Prenatal	RUCS	Sexual Health	Smoking	MLHU Resources	OEYC	Othr Communty Resrces*	Formal Referral	FILE STATUS	Nurse Practitioner	Public Health Nurse	Registered Dietician	E.Y.R.C.
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

Comments:

Date	Name of Client	Confirm Eligibility		Reason for Visit	Intake Intials:
		Doctor:	Y N		Describe barrier(s) to access
		Barrier to Access*:	Y N		
		Children or Pregnant:	Y N		
New or Returning?	N R	Eligible?	Y N		
Team Members Seen Today (check)	NP	PHN / Dietician	EYRC	Follow-up or New Problem	FU NP

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

Comments:

Date	Name of Client	Confirm Eligibility		Reason for Visit	Intake Intials:
		Doctor:	Y N		Describe barrier(s) to access
		Barrier to Access*:	Y N		
		Children or Pregnant:	Y N		
New or Returning?	N R	Eligible?	Y N		
Team Members Seen Today (check)	NP	PHN / Dietician	EYRC	Follow-up or New Problem	FU NP

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

Comments:

*If yes, specify in box provided

MIDDLESEX-LONDON HEALTH UNIT

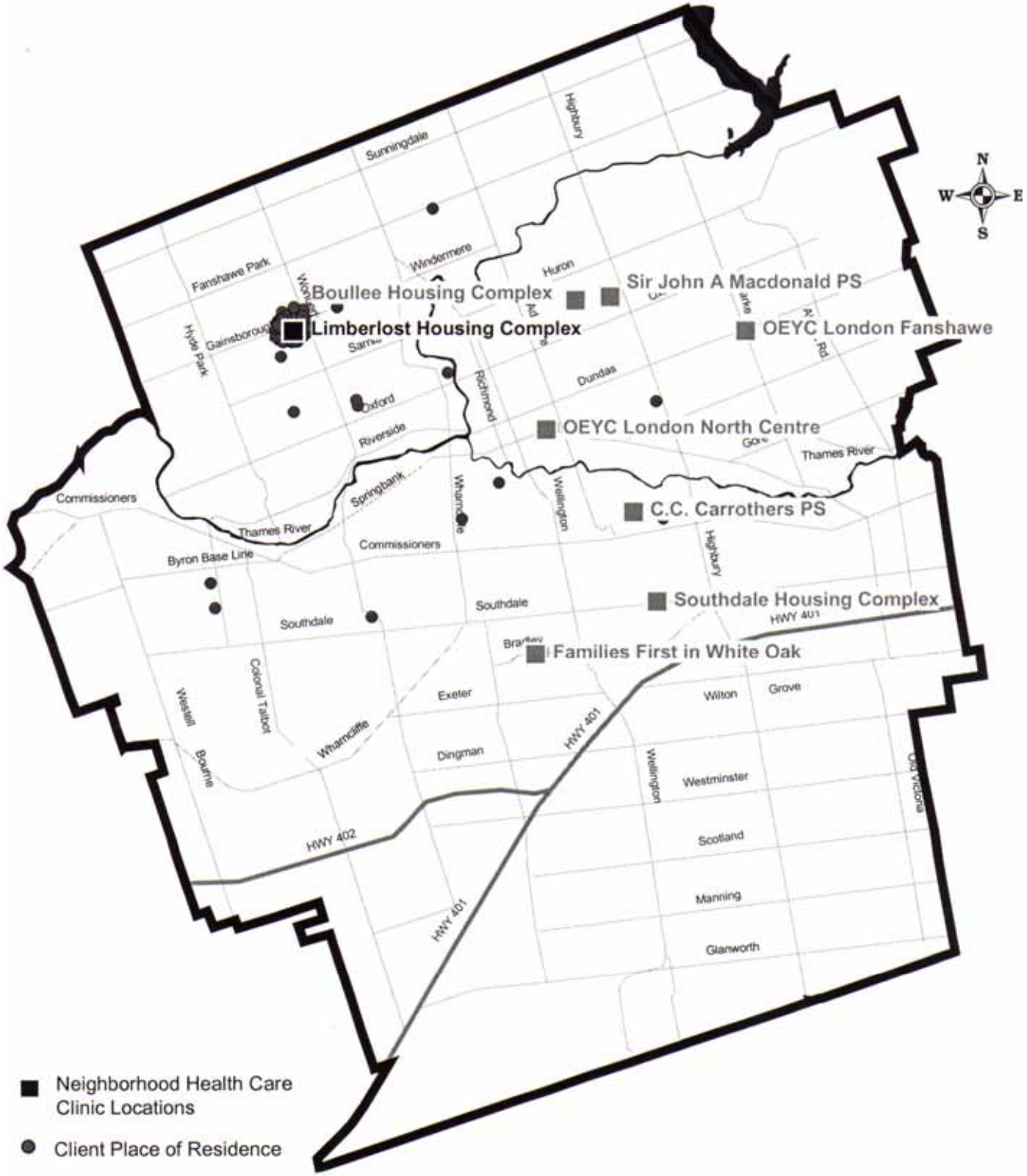
Ontario Early Years / Petite enfance

No file - X	New file - N
Open file - O	Closed file - C

9/22/2006

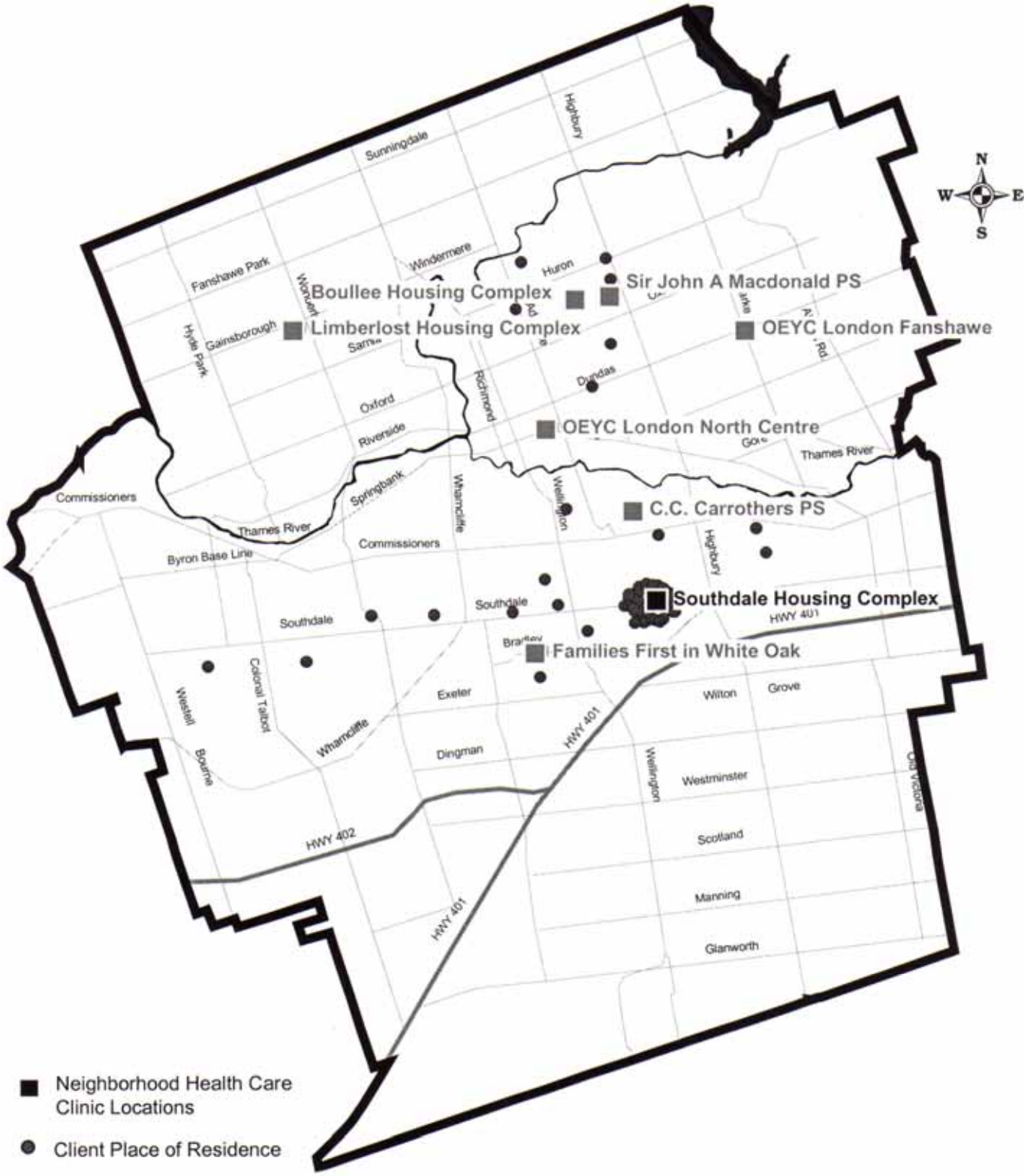
Appendix C: Map Analysis, Clients Place of Residence by Clinic Site Visited

Appendix C1: Place of Residence for Clients of NHC Clinic at Limberlost Housing Complex- 2004 to 2006



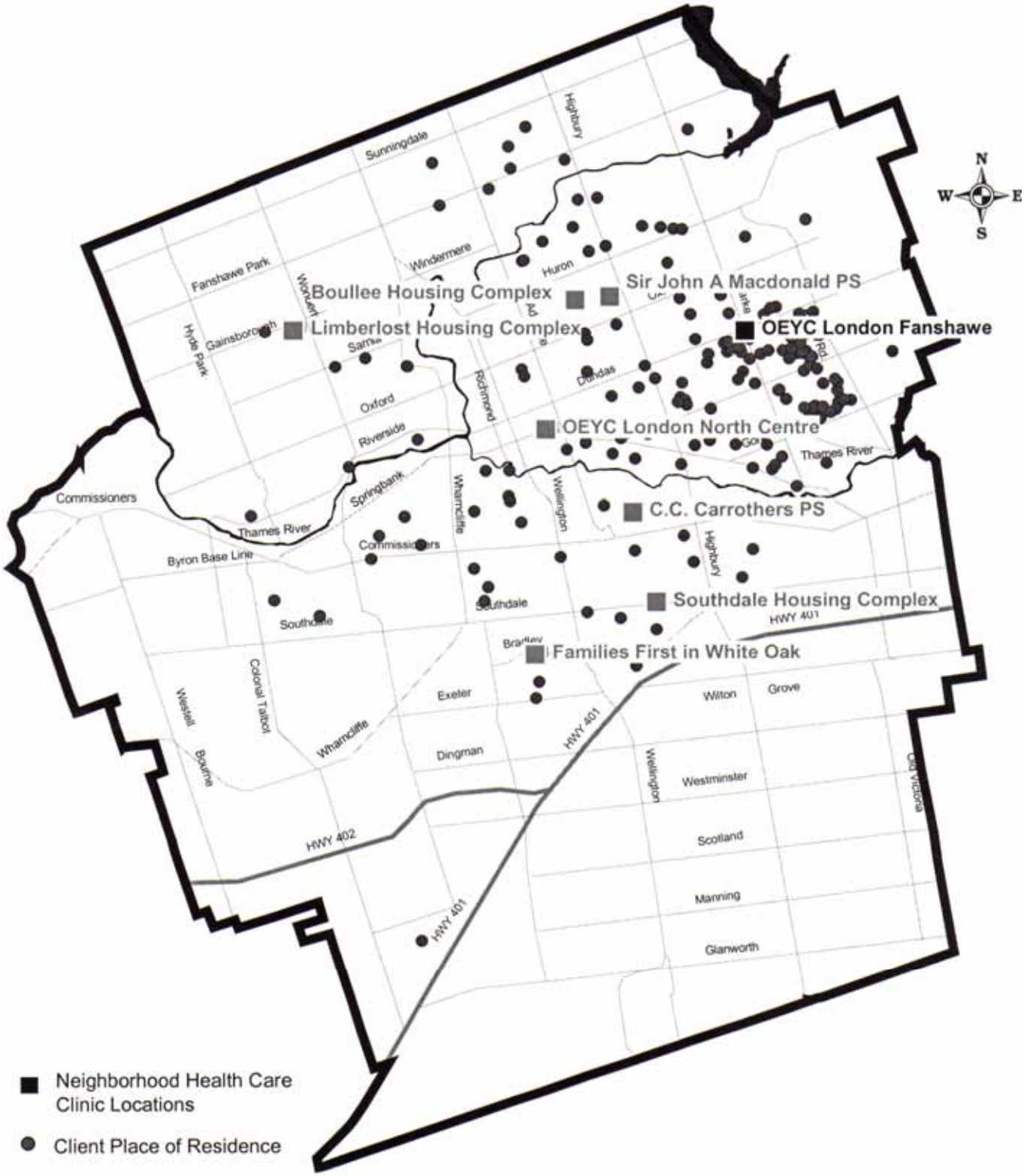
Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Appendix C2: Place of Residence for Clients of NHC Clinic at Southdale Housing Complex - 2004 to 2006



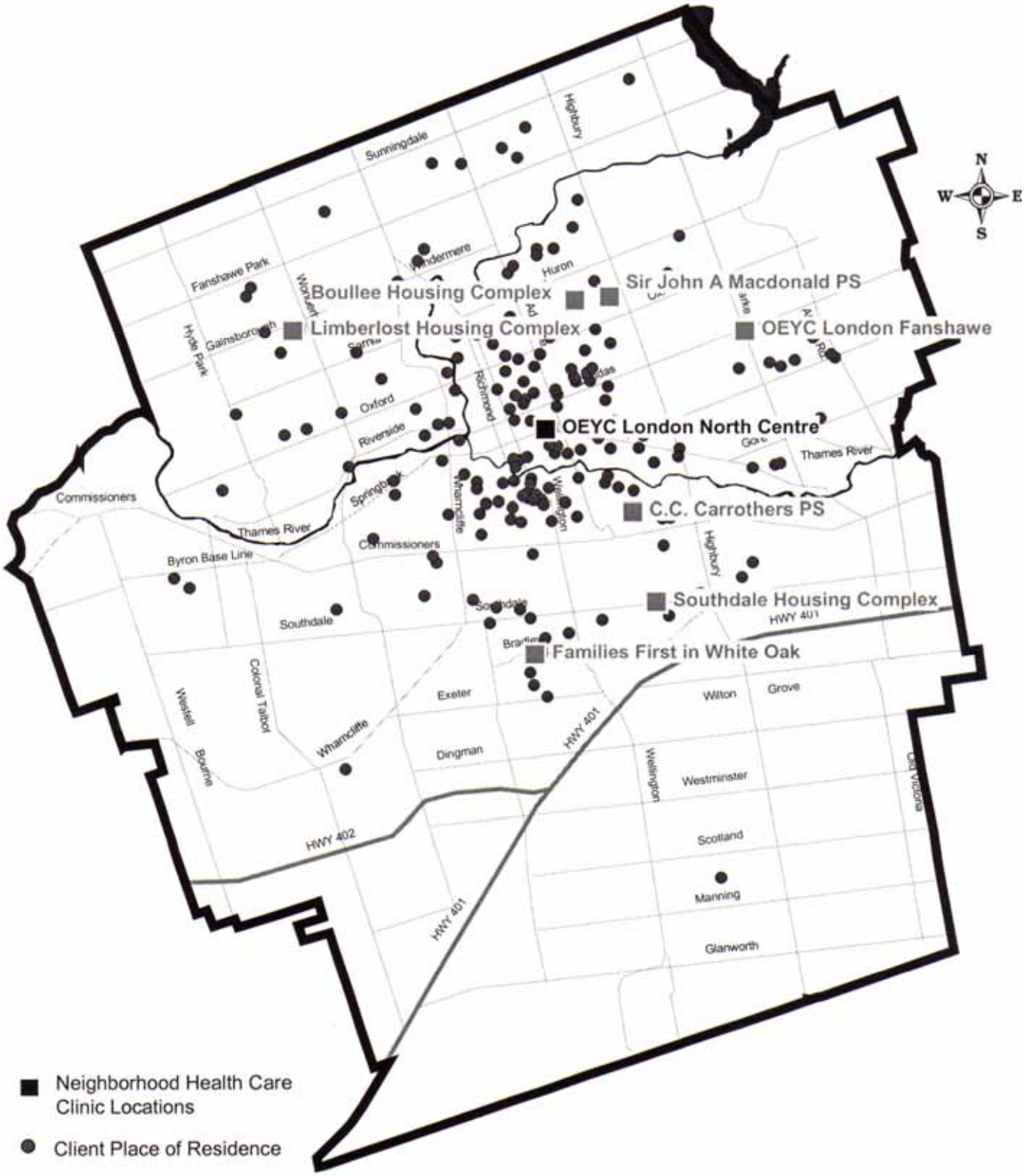
Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Appendix C3: Place of Residence for Clients of NHC Clinic at OEYC London Fanshawe - 2004 to 2006



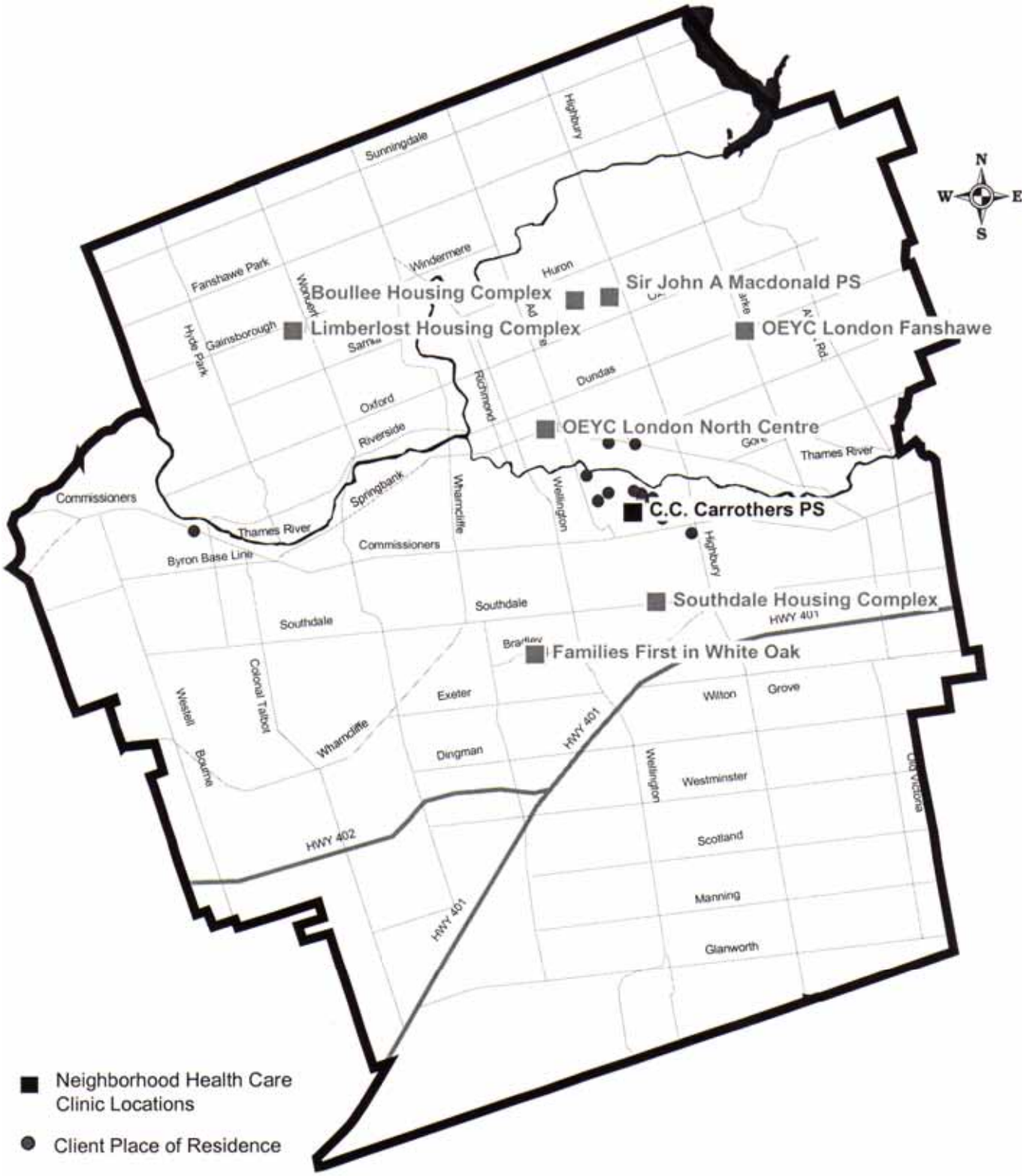
Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Appendix C4: Place of Residence for Clients of NHC Clinic at OEYC London North Centre- 2004 to 2006



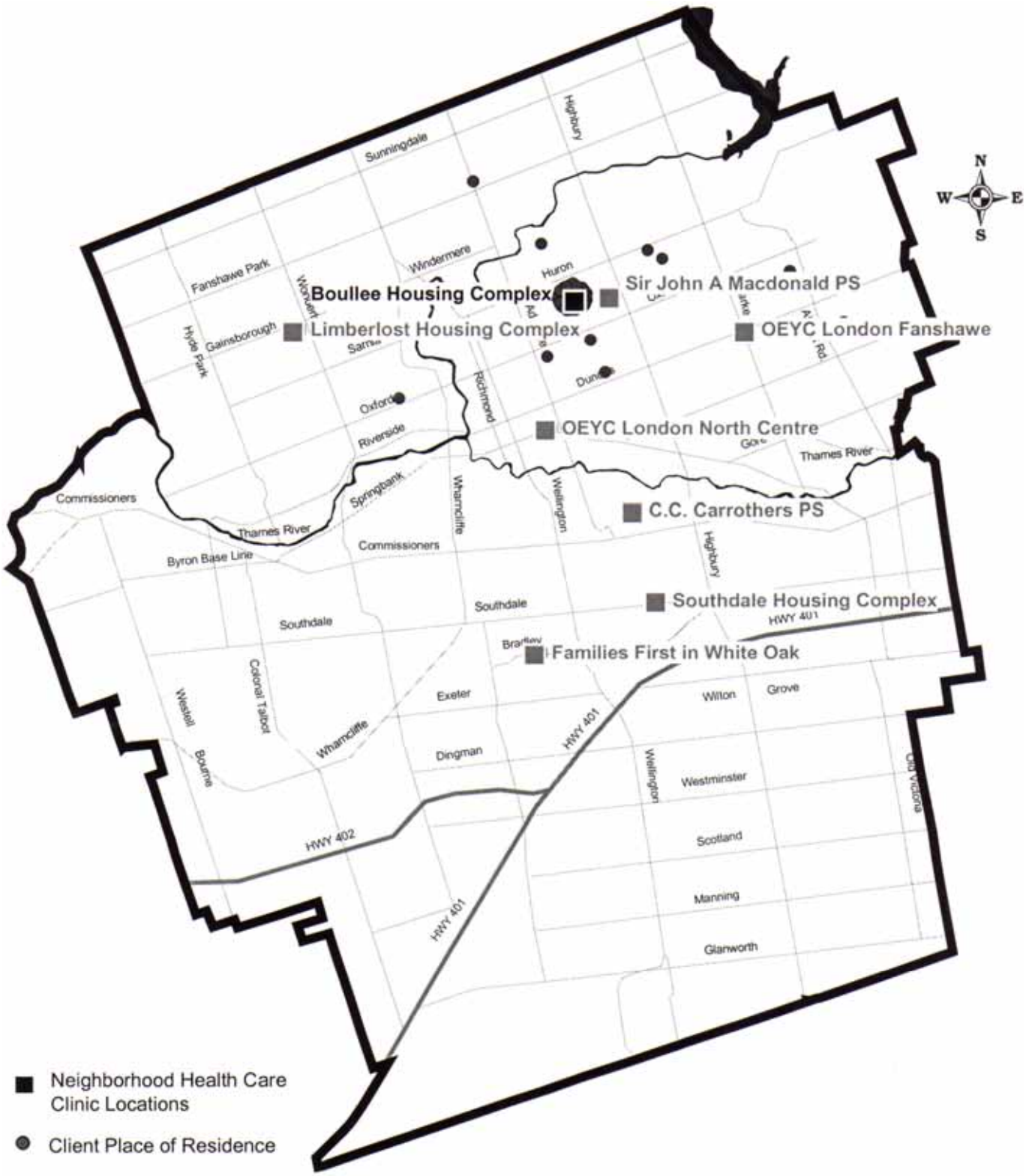
Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Appendix C5: Place of Residence for Clients of NHC Clinic at C. C. Carrothers Public School - 2004 to 2006



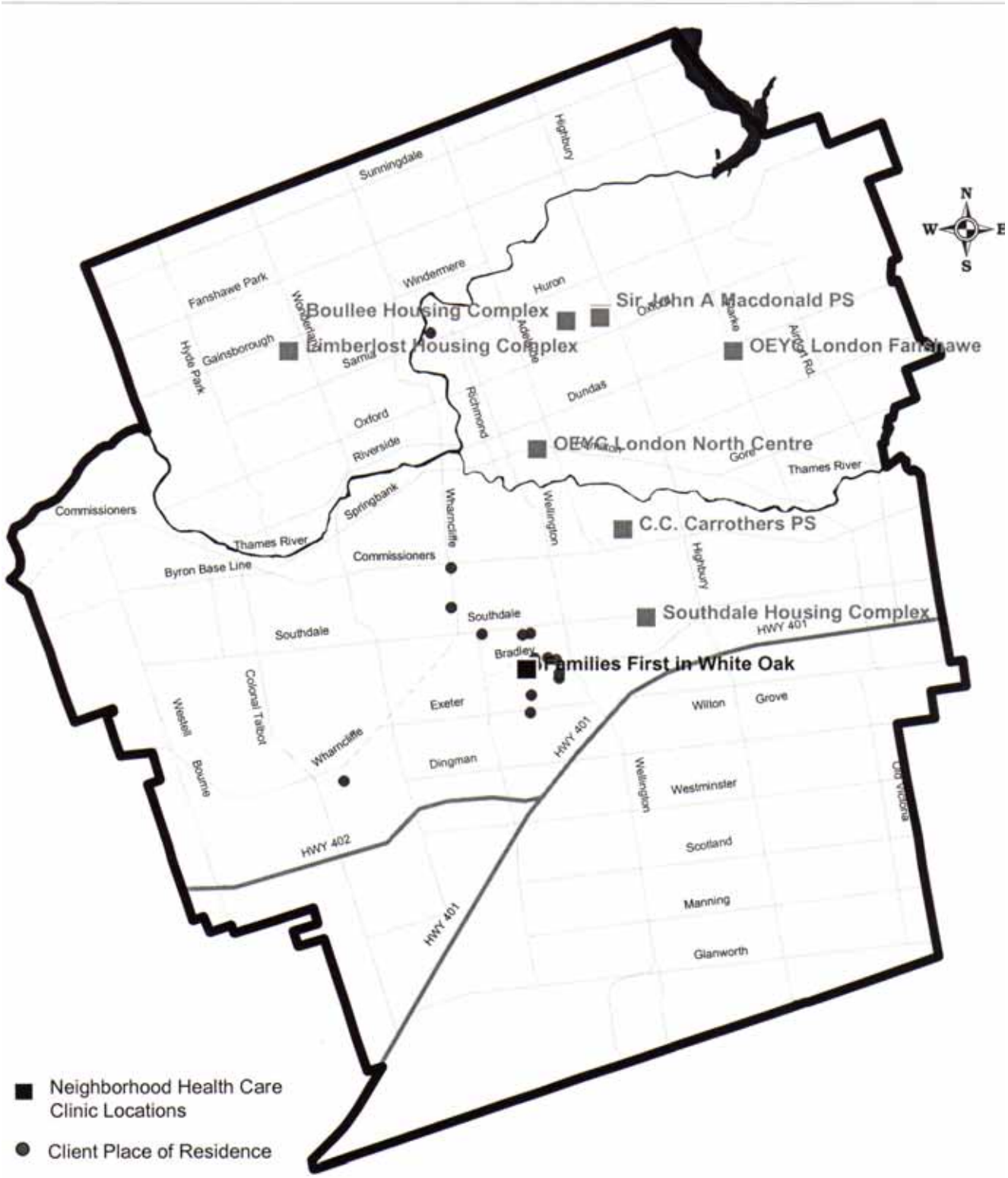
Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Appendix C6: Place of Residence for Clients of NHC Clinic at Boullee Housing Complex - 2004 to 2006



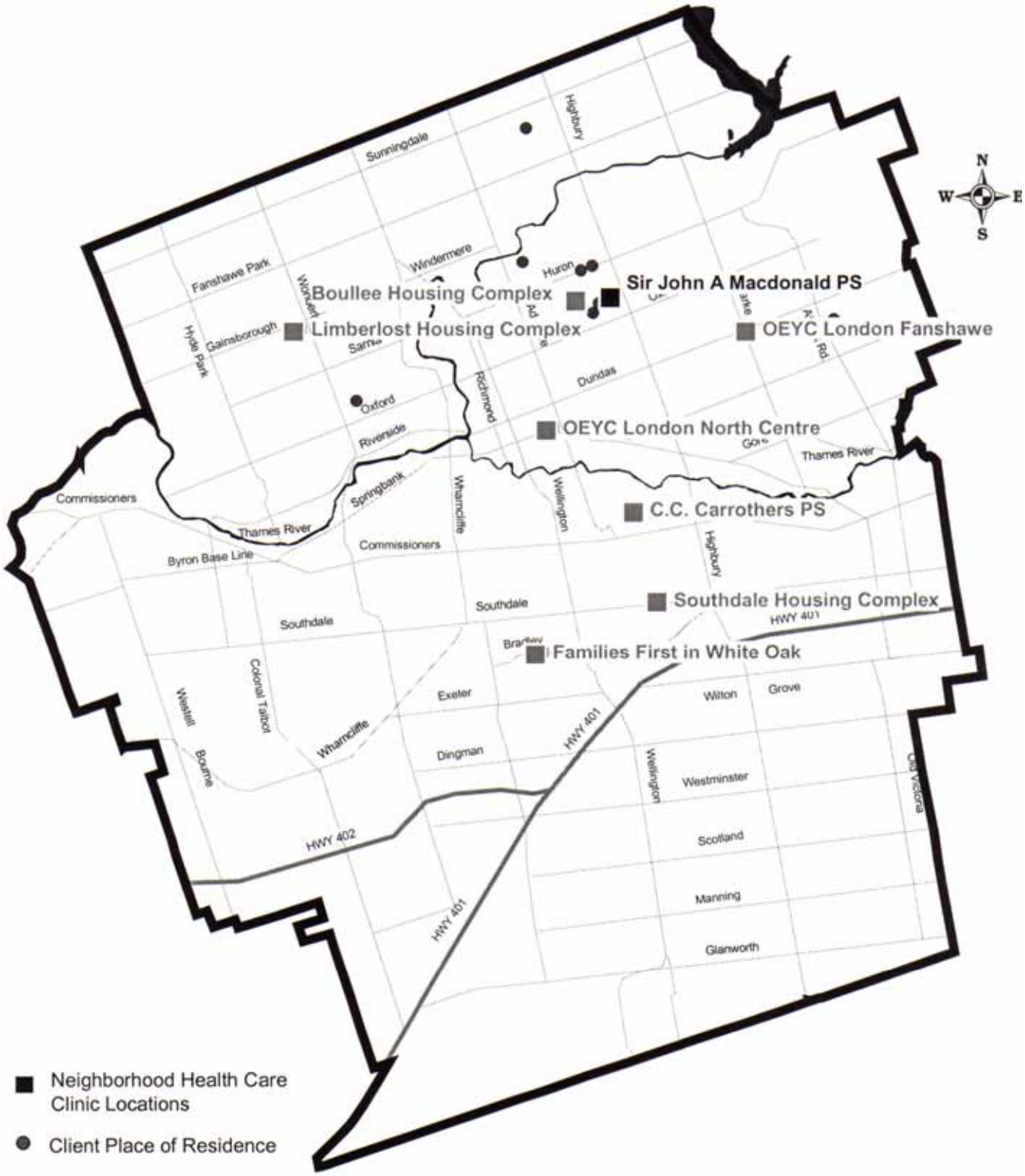
Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Appendix C7: Place of Residence for Clients of NHC Clinic at Families First in White Oak - 2004 to 2006



Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Appendix C8: Place of Residence for Clients of NHC Clinic at Sir John A. Macdonald Public School - 2004 to 2006



Source: REED Services (Research, Education, Evaluation, & Development Services). Middlesex-London Health Unit.

Appendix D: Reason for Visit Listed on Intake Form for Children Identified as Receiving Physical Well-being Services (N=149)

Has had the flu since 05/04/10. Vomiting, sore throat, giving apple juice.
"Listen to lungs" ?rattle. Completed Abtx few weeks ago.
? Bronchitis. Vomits after meals, in car ?motion sickness x4 days.
? Ear infection. Appetite slightly decreased, sleep ++ awake. Cold symptoms X 5days, cough - dry, Tx decongestant/cough syrup effective X3 days, nasal discharge. Temp 101.9F Tx = Tylenol Adult. Similac Adv. 6 0z X3, 8 oz hs, cereal, fruit and veggies
? Thrush (po) x 2days.
?Thrush.
c/o urinary frequency x 5 days. S/A pain with urination hx bladder infection f/u with pediatrician
1) Rash face, 3 raised blanched area L lower cheek approx 1/2" ea and surrounded by 1/2" reddened area, +++ itchiness x 24hr. Hx n&v 2 days ago. ?hives.
BF, wt check, flat head, cold symptoms. 20 BF? Mastitis yesterday febrile, pain aches, much better today, small ump on (R) upper breast (improved but remains. 3) 1 & 2 month Nippissing checklist.
1. Fever x 24hr temp 102F Ax. Advil x 2 given. 2.?boil (s/a purulent fluid) on buttock. 3.Constipation.
16 weeks - bloody diarrhea X 7 weeks - 19.11.05. Emergency visit: 21.11.05. Urine and stool sample sent.
5 day old male. Well child. Assessment and weight
Allergy? Flu like symptoms. Height and weight check. 12 month Nippissing and Tyke Talk checklist.
Assess re cold.
Belly button check. Weight check up 2.5 wks old.
BF and Wt check.
Bf excl. Last F.P. Feb 14. Rash times 4 days. Patchy, dry on abdomen and cheeks. Change laundry soap. No signs infection. Happy. No fever. Spoke to Mom intro to solids.
BF Novish declined
Bites on her arm "itchy" x1 day.
Bladder infection. ++ frequency x 2 days, no pain, no fever, no burning.
BM ?? BF excl.
Body rash
Breastfeeding
C/o fever, cold symptoms, no nasal d/c, dry cough, sore throat x 4 days. Awaiting f/u with ENT re throat problem.
C/o itchiness body.
C/o vomiting , low appetite, fever x 36hrs. Tx Tylenol (approp dose effective).
CAS referral for physical exam
CAS referral for physical exam. Check development, check speech/hearing - high-risk
Check head lice. Grade 7 student
check incision (appendectomy 2 days ago). F/u with Dr 1 month.
Check large toenail R foot (injury last eve large water gun fell on toe).
Check R elbow, hx fallen on elbow yesterday.
Check skin condition. BF q1h, 30-50 mins. Formula 1oz after each BF. PHN home visit today, plan home visit ? Week
Check skin rash. R abd x 2wks. Tx with Polysporin
-check up for baby
-questions gassy, formula 5 oz q 4 hr
check weight, BF excl, cleft lip, no palate involved, ? Surgery at 3 mos. Followup with FP Monday March 66/06. BWT 6.3 lb at 36.5 weeks, D/C 5.13 lb.
Check weight. N - Similac with Iron Con. 2-4 ox q304 hr. No PHN ed, no 48 hr PHN Pv or HV - declined. Well child assessment at 9 days old.
Checkup with eyes - has been using since birth, physical exam
Cold and belly button check (sticks out). Wt check.
Cold for last four days with fever.
Cold symptoms,? F/u with Dr. X2days, sister has cold. Fever, Tyl use effective, cough clear phlegm. N&V x 1 yesterday.
Eye infect, ax and tx with ab drops/cream. 30 Mo Nippissing and tykeTALK info.

cold symptoms with "loose cough" afebrile, clear phlegm. Fluid ok, output ok. Sleep inc, no hx ear infection. Bf excl, refusal solids, pale. R ear lg, floppy Dr in BC reccom hearing test. Unsure immun status. 9 Mo Nippissing.

Cold symptoms x <24hrs. Temp 104F, 101F today no meds. Tyl 1ml every 3hrs effective. Intake good, urine down slightly.

Cold symptoms x 24hr. No nals d/c, no cough, good appetite, good sleep. C/o headache >1 day, good eyesight, no neck stiffness, no diarrhea, no dizziness.

Cold symptoms x 2days. Tx with Tylenol. ?Thrush (tongue), noted today (hx of Thrush),. Sore throat. Nasal d/c thick green/yelow, no cough. Good appetite, good sleep.

Cold symptoms fever.

Cold/cough x 1wk. No f/u with Dr since 2yrs. No dentist first app. No optometrist. Hx speech/lang delay - "Lost phone # tykeTALK. 2nd hand smoke.

Concerns re umbilical area

cough - no prod x 1wk, no fever. Bil swollen neck glands. "sore throat". Head lice. EDD May 06

cough x 1mo. Prod green and yellow, reduced appetite, good sleep, no fever. R > L swollen neck glands. Head Lice.

Cough, diarrhea x 1.5 day. 4-6/24hr yellow, x3 days.

Cough/cold. ?re: immunization. 1 & 2mo Nippissing.

Coughing at night nd morning/not sleeping well. Well baby check.

diarrhea 0 oval use. Heat rash. Well baby.

Diarrhea.

Dr., 40 mos immunizations

Fever

flu (7 days old). Ht and we. BF excl and vit D. F/u with Dr Oct 21/05. PHN HV Oct 21. Newborn hearing Pass.

Food sensitivity, requesting assessment intake. Head lice check. Hx speech/language concern, tx with tykeTALK.

Head cold. Vomiting x 1 this morning, no diarrhea, afebrile. Head lice.

Head l ice

Head Lice

Head lice check requested by school social worker

Head lice check requested by school social worker

Head lice check.

Head lice check. Hx s/l concern tx with tykeTALK D/C

Head lice gestation 2 weeks off school. Hx R & C times 2 last week, tea tree oil, baby oil

Head lice. Dental.

Headache x 24hrs, no other family member ill, or schoolmates. Check immunization status, no N&V. Inc sleep, no appetite, c/o sore throat.

Head lice, hx R&C 2-3 wks ago.

Inhalers not effective n&v, SOB with exercise". Last seen by Dr >5 mos, no f/u. No Dr however regular f/u with same Dr at med clinic.

Itchy rash on body, becoming more and more prominent on face and back.

jaundice, check up -circumcision site

L eye ?infection, s/a green d/c X 24hr. Wt check.

No BM x5 days. Check weight. BF exclusively. ?Constipation

Nutrition concerns.

On meds for "worms" bum x1. Neck "tick" no hx illness, meds.

One week visit for, Info on vaccination.

Penis ? Circumcise. Never seen a doctor unless ill. Hx 10 cavities f/u with dentist - no coverage. Questions - immunizations child and adult.

Persistent cough post Chickenpox Nov 2004.

PHONE VISIT. cold symptoms, f/u with Trafalgar Med clinic, sugg f/u with hosp or pead after hr clinic (unknown). No fever, all members family ill with cold. BF - yes, Urine - yes, BM - yes.

Physical assessment. 4 year old Nippissing and 4 year old tykeTALK checklist

Physical assessment. 5 year Nippissing checklist

Physical assessment. Bed wetting. 5 year Nippissing

Questions regarding: solids, sleep, BF.

Rash buttocks x > 2months; pain with sitting; zero tx. NKA Risperidone dx: aspergers restarted this week.

Rash on body x 4days, attends day care. No fever, good appetite, good beh/activity, pin size red raised chest, arm, legs.

Rash x 1 mo – face and chest. Speech concerns. Nutrition - 3 cups of juice.
Request from HRS (teacher) to check head lice, verbal consent via phone from (Mom)
Review meds Cab tx - cold, ear inf. Behind with immunizations. +++ juice/day - 2 bottles per day.
Sick on and off for 6 weeks - throwing up lunch. Cold symptoms.
Since June 7 one round spot on her arm and 2 on her belly. 5yr Nippissing.
Sore R foot x couple days. Questions immunization status, re: entry to school.
Sore throat x 12hrs, afebrile. Bus tickets.
Sore throat.
Spots on body
To clinic with principal with concerns re: rash
Visiting from Taiwan -Baby check-up -? Re: immunization for baby & mom
Vomiting when eating sweet foods x 2mos.
Vomiting x 4 yesterday, Diarrhea x 8 today. Diaper rash. Fever yesterday tx with Tylenol, effective. 6 month Nippissing and SLP checklist.
Vomiting, fever, coughing. Tylenol 1tsp every 4hrs.
vwt.
WB check. Check skin rash on knees.
weight and height check + teething
Weight check
Weight check
weight check + heights + cradle cap
Weight check at 7 months and 21 days. N - breastfeeding q3h times 20 minutes and formula. Poor intake cereal.
Weight check, check diaper rash, Breastfeeding/formula
Weight check. 4 month Nippissing, 3 month Tyke Talk checklists. Sleeping difficulties (baby)
Weight check. BWT 8 lb 8 oz.
Weight check. Dec. 21 at 8.2 lbs. BF excl, and Vitamin D, PP booklet. Questions umbilical hernia followup with Dr.
weight gain + height ? Yeast
Weight. Vein on groin area near penis
Well baby and breastfeeding questions - Thrush.
Well baby check up-last check up at 9 months.
Well baby check, last seen by MD at one week old.
Well baby check.
Well baby check.
Well baby check.
Well baby check. BF + suppl with Similac - 3oz.
Well baby check. Immunization.
Well baby check. Umbilical cord care. Cry at night.
Well baby, discuss stools, many questions.
Well baby. BF - pain breast bil x 1wk. R eye - d/c, s/a yellow fluid.
Well child check
Well child exam at 8 days old
Well child visit - concerns re weight and height. poor vegetable intake and high milk intake. 30 Month Nippissing checklist.
White BM x 2, s/a irritable.
Weight and height. Sore finger.
Wt and height. Nippissing check list, Sids.
Wt and Ht check. Concern re wt gain, feeding patterns.
Wt and Ht. Dry skin. Bathes daily, uses Tide laundry soap, already discussed with Dr. no tx.
Wt and Ht. Nippissing checklist, and what to do with baby at this age. Rash - perineum focus rectal area, red, raised irreg on lower buttocks, no labia, no inner thigh. Tx with Zin cream ++.
Wt and Ht. Stuffy nose during BF, no other symptoms. Mom hx asthma.
WT check at 2mos. Delay 2 mo immunization, r/l absent Dr and mom travel. Taking Vt D, BF excl. S/A D/C R eye.

Wt check.
Wt check.
Wt check.
Wt check.

Wt check.
Wt check.
WT check. ? West Nile.
Wt check. BF excl,?Vit D. Red rash diaper area x 24hr.
Wt check. Bf excl. Flat head. 4 mo Nippissing and 3 mo tykeTALK checklist.
Wt check. Check diaper rash. Milestone check. Nippissings and tykeTALK.
Wt check. Immuniz up to date. Cold symptoms x24hrs, ?fever. Irritable, Nippissing no concern done with PHN HV. Wt >10%ile.
Wt check. Nail on fingers
Wt check. Sun safety. Teething.

Appendix E: Reason for Visit Listed on Intake Form for Adults Identified as Receiving Physical Well-being Services (N=73)

? Freq of well baby check. BW = 8.11lb. D/C = 8.2lb. BF excl. Occ suppl.
? Head lice. Basic needs - bus tickets. Toothache.
? Re weaning, BF while preg.
?pregnant planned. Last Menses Feb 05. REQUIRES PN CARE. Folic acid daily. HX: miscarriage Oct 04 @ 11 weeks.
1) Head Lice shampoo. 2) questions re: IUD
2 days pain, fever Wednesday, chills and aches, little redness. ? Blocked duct, no mastitis, baby difficult to latch, occ. Pumping.
5 to 6 weeks pregnant. Dx at medical walk in cliic. Bld wk required and given. ? where to go? Prenatal nutrition.
Abd pain r/l hx miscarriage? Mental health issues. No Dr., Finances - OW. Single mom. (9yr old daughter) not listening and showing inappropriate sexual behaviour.
Beginning of 2nd trimester. Loss of blood on January 22/05. Spotting today.
BF - latch, engorgement, ? need suppl, goal BF excl. Pain incision analgesic.
Birth control options. Nutrition info re BF.
Blood work (glucose)
BP check, assistance with re-connecting with Dr.
Breast examination questions. Last PAP 1 yr ago.
Breastfeeding concerns
Breastfeeding questions – latch
Bumps on lower legs x 2-3wks. Inc numbers, size and inc thigh area.
Bus tickets.
Bus tickets. Coping with stress. Info on dental care.
c/o cold symptoms. Difficulty breathing, nausea, vomiting x 4 days. Treated with Gravol and Tylenol. Wondering if need to f/u with own Doctor.
C/o dizziness, headache since yesterday.
C/o heat rash to breasts.
Check abdominal dressing. Hernia repair Jan 10/06. Followup appointment Feb 8/06
Check BP. Hx stroke May 2004. Hx migraines, f/u with Neurologist Nov 05.
Check R ear.
Condoms for daughter hysterectomy - May/05 stress depression. Query re: Calcium.
Condoms, R&C. Info to get diapers and fmla.
Coping
Cough in chest, not getting better, on Ab.
Declined PHN services
Diet for gall stones.
Dizzy x 1 week. EDD Sept 23/05. St Joe's apt July 13pm "check heart". Last seen Dr July 1.
Dr. (immigration TB testing only). "Lost voice". Hx TB + tx with meds.
Feels depressed "would like to discuss birth control options
get blood pressure check.
Get info on meds prescribed for nausea. 8 weeks pregnant. Nausea, prenatal nutrition.
Hbg 87 apr 8/05. Tx Iron 105mg/day, no constipation no hx. P Partum (5 days). Low FE
head lice
Head lice (9 year old son). Wanting to know info on ADHD meds and what to do (child is off meds totally)
Head lice check and info.
Head lice check.
head lice, need shampoo - self and 3 yr old daughter.
Headache x 5 days, tx with Ibuprofen, effective. ++ stress (situational).
Home preg test +. LMP Feb 14/05. Unplanned, unprotected. No PN vit.
Ht and wt for passport.
Impetigo
Info on childcare centres in the city, and outdoor/indoor resources as well.
Information on where to get a Pap test. No doctor.

L hand 2rd-4th fingers dry/scaly/itchy was blistered d/t "fake" ring. Recommended 1% steroid cr bid sparingly, showed improve in 2 days.
Left foot swollen, pain x 4 days. History: diabetes newly diagnosed, no follow up, "in denial".
LLQ Pain. Hx of hernia
Mastitis. Breast pump inquiry
Needed head lice info and R&C shampoo.
Needed R&C shampoo for head lice for himself, girlfriend and children.
New to Canada; health concerns; mental; physical
New to country. Dx pregnancy in China EDD Sept 20/05. Pre-natal nutrition.
No Doctor, new to city from Quebec. No OHIP. Hx Arthritis requires f/u with Dr for meds.
No Dr, where to go? Drug info - stomach pain. Condom request.
Non-prod cough.
Numbness across Left breast to shoulder blade.
Pain in R breast x 2 days.
Pain, swelling of R side of face, with swelling upper gums with pustules x 3 days. No dental plan, OW already used emerg funding. Bus ticket provided.
Post partum adjustment
Pregnancy test.
R upper arm swollen and pain.
Recurrent wart on R index finger. No Dr. No phys exam x 4 years.
Sore ankle x 24hr. Sore jaw jt - 2-3days. Access to Dr. ? Fungus L large toe nail.
Sore ear. Doctor availability. Walk in clinics.
sore throat, hx cold/cough x 1wk. No tx, occasional Tylenol effective.
Stop smoking info for husband. Back and upper leg pain since birth of son.
-sts bladder infection. hx catheter(urinary) with delivery. -B.C. option questions
Support re physical assault Fri April 7 X1 - Tx at hospital. Police involved, assailants girls Grade 8/9 from housing complex, charged by police. "Girls who attacked me Friday are outside my house waiting for me & they know I'm here. Now they are coming
Thinks pregnant, no period 2 months.