

ALBERTA PERINATAL HEALTH PROGRAM

Second Interim Evaluation Report

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Prepared by:

Margaret Wanke, BSc, MHSA

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Introduction

Background

The Alberta Perinatal Health Program (APHP) formally commenced operation as a single entity on July 1, 2004, replacing and expanding on the work previously undertaken by three independent organizations – the Alberta Medical Association (AMA)'s Reproductive Care Committee, Northern and Central Alberta Perinatal Outreach Program (NCAPOP) and Southern Alberta Perinatal Outreach Program (SAPOP). Under a tripartite partnership arrangement among the AMA, Calgary Health Region (CHR) and Capital Health (CH), this program provides services on behalf of the nine regional health authorities (RHAs) with a mission to:

Promote maternal health, positive birth outcomes and healthy infancy by providing leadership and support to health regions, health professionals, Alberta Health and Wellness (AHW) and other stakeholders.

The work of the program is organized under four functional areas, as follows:

- **Leadership and coordination** – to provide provincial leadership and coordination for perinatal health including implementation of relevant strategies and activities.
- **Education and consultation** – to facilitate and develop the capacity of health regions, health professionals, AHW and other stakeholders to achieve optimal perinatal practice.
- **Information management and research** – to collaborate with health regions, health professionals, AHW and other stakeholders on activities to monitor and assess the health status of mother and infants in Alberta.
- **Quality and innovation** – to facilitate and develop the capacity of health regions, health professionals, AHW and other stakeholders to achieve optimal perinatal practice.

Detailed information about the program and its mandate, structure and implementation is available in the first Interim Evaluation Report (Charis Management Consulting 2006) and on the APHP website.

First Interim Evaluation Report

The general APHP program grant received from AHW includes funding for evaluation activity. This report is the second interim report provided to the program. The first interim evaluation report, submitted in February 2006, provided a description of the program from inception in July 2004 through December 2005, a logic model and evaluation framework, and results from a qualitative review of stakeholder perceptions about the program implementation process, current operations and suggestions for the future.

The findings from the first qualitative evaluation revealed that staff and leadership of the APHP had experienced a successful first 18 months of implementation despite significant challenges. Stakeholders perceived that a cohesive single program had been established with considerable potential to positively impact perinatal health in Alberta. Stakeholders were generally satisfied with the program and its accomplishments, recognizing that outstanding implementation items remained. They identified a long list of tangible benefits that were made possible because of the formation of the APHP as a single entity. Regional health authorities (RHAs) were enthusiastic about their involvement and highly complimentary about the services they receive from the program.



Stakeholders were unanimous in endorsing the broad mandate of the program and suggested this breadth, while necessary, will prove to be a challenge for the program within its current resources. The need for the APHP to clearly define its role and priorities was noted.

The most important outstanding issues that faced the program at the end of the calendar year 2005 were:

- Lack of a distinct legal entity for the program – which affects the ability of the program director to manage human resources effectively and fairly, and limits the ability to efficiently address the program’s legal issues. As well, there was a need to address the need for the director to have access to accurate program financial data on a timely basis.
- Legal issues – which presented as barriers to the efficient and timely achievement of objectives identified in the quality improvement, information management and educational functional areas.
- A need for clarification of the role of the Advisory Committee vis-à-vis the APHP, especially in regard to a mutually satisfactory method of identifying, prioritizing and managing perinatal issues.
- A need for a clear strategic program agenda for achieving full implementation of the program’s mandate with available resources.

Nine recommendations were offered for consideration by the APHP Coordinating Committee and Program Director.



Second Interim Evaluation – Purpose and Methods

Purpose

The year 2006 represented continued program enhancement and development. A second formative evaluation was requested to determine regional health authority stakeholders' satisfaction with the program and suggestions for enhancement. In addition, an update of program highlights from 2006 and progress on the recommendations from the first Interim Evaluation were desired.

A program logic model and associated high level evaluation questions are presented in Appendix A. This evaluation addresses the following questions from the evaluation framework:

Short-term outcomes:

- How satisfied are key partners?

Outputs:

- What has been accomplished?

Function/activities:

- What is working well?
- What adjustments to program functions and activities are needed?

Inputs/structures:

- Were committee structures adequate?
- What adjustments to program inputs/structures are recommended?

In addition to general questions about satisfaction and program enhancements, the program director requested information about priority perinatal health issues faced in each region.

Methods

This second interim evaluation, like the first, is formative in nature with an intention to provide feedback to further strengthen the program. The aim of a formative evaluation is to strive for optimal program processes and structures before attention is directed to outcome evaluation.

Data Sources

Data sources to guide the evaluation were:

- Program documentation, including quarterly reports, strategic planning documents, meeting minutes and other documents as they were developed;
- Observation through attendance at staff, Standing, Coordinating and Advisory Committee meetings;
- Telephone interviews with 25 RHA representatives; and
- In-person interview with the program director.



Timeframe

The general timeframe for this second interim evaluation is January 1, 2006 through February 28, 2007. It includes program activity information reported to the end of the third fiscal quarter (i.e., December 31, 2006).

RHA Interviews

The sample frame involved obtaining at least three interviews from each of the nine regions, specifically the:

- Primary women's health program director/manager;
- Primary public health representative responsible for prenatal, post-partum and newborn programs, and
- Medical director responsible for the quality of maternity services.

In Appendix B, letters introducing the evaluation and the interview questions are presented. The program director issued a letter to each member of the Partnership Accord to invite participation in the evaluation and request the names of the most suitable public/community health and medical representative in the region. Eleven questions guided the telephone interviews. After they were provided with information about the evaluation purpose, data collection and analysis methods, each individuals contacted was asked for their consent to participate. Detailed notes were taken during the telephone interviews, then compiled and analyzed by theme according to each question.



Findings

This chapter of the report is divided into three sections. First, the highlights of program activity in 2006 are presented. Second, progress on the recommendations in the first Interim Evaluation Report is discussed. Third, the methods and findings from the RHA interviews are presented.

2006 Program Highlights

Program staff engaged in an extensive array of activities during the course of the year. These will be described in their 2006/07 Annual Report. A summary of the key milestones and accomplishments are presented in Table 1. A brief description of the most significant of the milestones follows after the table.

Table 1. Milestones and Key Activities by Functional Area

Functional Area	Milestones and Key Activities
Leadership and Coordination	<ul style="list-style-type: none"> ▪ Organizational retreat “Taking the Next Steps” in March 2006. ▪ All RHAs sign the Partnership Accord Letter of Agreement. ▪ APHP Strategic Plan for 2007/08 – 2009/10 Strategic Plan developed along with three-year grant proposal. ▪ Preconception health strategy drafted and shared with Partnership Accord and Advisory Committee for feedback. ▪ Planning for a Healthy Mothers / Healthy Babies (low birth weight) Consensus Conference in May 2007 underway, in partnership with the Institute of Health Economics, Alberta Heritage Foundation for Medical Research, Calgary Health Region, Capital Health. Additional sponsors are supporting this conference. ▪ Commissioned a Scientific Review of the literature regarding low birth weight (LBW) in preparation for the Consensus Conference. ▪ Ad hoc prioritization committee submitted the following issues for consideration by the Alberta Health Technology Decision Process Advisory Committee: <ul style="list-style-type: none"> · Fetal fibronectin screening (in 2005) · Newborn metabolic screening including screening for cystic fibrosis · Newborn hearing screening · Assisted reproductive technologies · Early Risk Assessment (ERA) including maternal serum screening and nuchal translucency ▪ To date, the Minister of Health and Wellness (AHW) has made a decision to require fetal fibronectin testing through all health regions by April 2008, and funded the enhancement of Alberta’s Newborn Metabolic Screening Program to screen for an additional 13 conditions (in addition to three conditions currently included). The AHW process is currently underway for newborn hearing screening and assisted reproductive technologies. The ERA proposal was submitted in March 2007. ▪ Production of first APHP Annual Report.



Functional Area	Milestones and Key Activities
Education and Consultation	<ul style="list-style-type: none"> ▪ MORE^{OB} implemented in 62 sites in 9 regions. ▪ Completed and distributed Strategies for Teaching Obstetrics to Rural and urban Caregivers (STORC), an education program for health professionals interested in learning about clinical obstetrical practice. Prepared and distributed evaluation forms for learners and mentors using the program. Planned for the development of an electronic version of STORC. ▪ Continued work with the Heart and Stroke Foundation of Alberta, NWT and Nunavut to plan for the provincial roll out of the new Canadian Neonatal Resuscitation Program (NRP) guidelines. ▪ 120 professionals successfully completed the requirements for their NRP instructor registration and are prepared to teach NRP to health professionals in Alberta. By March 31, 2007, all current NRP instructors will have had an opportunity to attend an Update course. ▪ Baseline rural strategies evaluation completed. ▪ Developed draft education materials for RHAs to support the implementation of fetal fibronectin testing. ▪ Education strategic plan for substance abuse during pregnancy developed. Have determined the extent of guidelines and protocols already in use throughout the province regarding illicit drug use in pregnancy. Completed a literature search on marijuana, cocaine, crystal methamphetamine and opioids and their use in the perinatal period.
Information Management and Research	<ul style="list-style-type: none"> ▪ Letter of support received from the Health Boards of Alberta to indicate Council of CEO support to publish an annual comparative report. ▪ First Provincial Perinatal Report (2000-2004 data) produced and presented in March 2006. ▪ Completed migration of data from the old PARADOX data to the new data repository. The new repository contains all historical data on births and mortalities for the years 1992 to 2004 – taken from the delivery record and mortality data. The year 2005 data are being migrated from PARADOX. ▪ Changes to the Alberta Prenatal Record (APR) have been completed and validated. They will be incorporated into the data repository by the end of March 2007. Implementation of the new APR is scheduled for early 2007, in collaboration with Toward Optimized Practice (TOP). ▪ A new Antenatal Risk Profile tool has been developed and will be introduced as part of the implementation of the new APR. ▪ A maternal screening tool, the Healthy Mother, Health Baby (HMHB) questionnaire, has been finalized along with guidelines for its use. This will be included as part the implementation of the APR. ▪ The data dictionary is being expanded to support the full mandate of the APHP. By March 2007, it will include data definitions for breast feeding and post partum depression. ▪ Second APHP Provincial Perinatal Report (2005) production underway with release scheduled for May 16, 2007. New software tools are being used to prepare the various analyses. ▪ Existing APHP perinatal data elements have been formatted according to Health Information Standards Council of Alberta (HISCA). Mortality data definitions are complete and are to be tabled with HISCA in early 2007. ▪ Program staff have explored messaging standards and drafted the first example of interface specifications for health service partners with a view to ultimately including APHP messaging specifications in the province wide electronic health record. By March 2007, the program plans to have interface specifications available for the Delivery Record and Notice of Birth. ▪ A new APHP server has been installed in Calgary with secure access by a limited number of users.



Functional Area	Milestones and Key Activities
Quality and Innovation	<ul style="list-style-type: none"> ▪ 100 percent (n = 538) of 2005 mortality cases were received and triaged. 2005 data entry complete into mortality database. As of year end, 212 cases had been received for 2006. ▪ A total of 41 cases were reviewed by the Alberta Medical Association's Committee on Reproductive Care. ▪ The QI Committee met on three occasions in the year to follow up on issues identified through the QA review process, resulting in communication and collaboration with key stakeholders for issue resolution or further investigation of issues. ▪ Visits have occurred with six of nine health regions to discuss their QA and QI processes. Two regions have determined to establish a regional review process. ▪ Draft recommendations for guidelines re: stillbirth and livebirth definitions were presented to the Canadian Perinatal Surveillance System Steering Committee. The recommendations were approved in principle. ▪ A new Antenatal Risk Profile tool has been developed and will be introduced as part of the implementation of the new APR. ▪ A maternal screening tool, the Healthy Mother, Health Baby (HMHB) questionnaire, has been finalized along with guidelines for its use. This will be included as part the implementation of the ARP.

Perhaps the most significant accomplishment in 2006 was the signing of a Partnership Accord Letter of Agreement by the Chief Executive Officers (CEOs) of the nine health regions and the Tripartite Partnership (senior executives from the AMA, Calgary and Capital health regions accountable for the APHP). This document formalizes the reciprocal relationship between the APHP and regions who have chosen to participate in the relationship. The fact that the agreement was signed by all CEOs is a testament to the support this program has achieved from its key partners.

Under the agreement, the Tripartite Partnership offers “Regional Participants an opportunity to access additional resources, to enhance communication, to reduce duplication in activities and reporting and to achieve operating efficiencies through participation in the APHP”. While the document does not constitute a legal partnership, it does specify the roles and responsibilities for the Tripartite Partnership and regional partners, specifically in the area of leadership and coordination; data collection, compilation and monitoring; quality assurance; and learning needs.

The APHP embarked on two relatively large initiatives that significantly extended the scope of their work beyond the traditional prenatal through neonatal service period. First, the program was successful in retaining unexpended 2004/05 dollars to hire a Preconception Health Coordinator to undertake the development of a preconception health strategy and action plan. In collaboration with advisors from RHAs and APHP committees, the Coordinator reviewed the literature and proposed a three-point strategy, largely based on a population health approach. The final report was completed by March 31, 2007.

In addition to the preconception health strategy, the program has undertaken to host a large-scale consensus conference on the topic of low birth weight (LBW), in partnership with a number of health regions and agencies. This conference is scheduled for May 2007 and is intended to focus current scientific knowledge and expert opinion toward the development of a consensus on how this long standing issue might best be addressed.

Staff in the Information Management and Research functional area were successful in generating the first Provincial Perinatal Report using a consolidated database. Previously, two reports were generated, one by SAPOP and one by NCAPOP. The primary issue with the two reports was that the data elements and definitions did not coincide between the two data sets, making it impossible to generate a single provincial report.



Key milestones in the Education and Consultation functional area were that:

- As of March 31, 2007, all RHAs and 60 Alberta facilities were participating in the MORE^{OB} program and an additional two were expected to start the program in early 2007. The regions are moving through the modules as evidenced by the fact that at the end of the fiscal year 2006/07, with two years to go in provincial implementation, six hospitals were engaged in Module 3 training, 39 in Module 2, and 15 in Module 1 training.
- STORC workbooks had been distributed to all nine health regions and the North West Territories. This initiative is intended to make obstetrical orientation readily accessible to the local sites. A proposal for the creation of an electronic version of STORC has been submitted to AHW for ultimate submission to Health Canada Infoway funding.
- 120 health professionals have completed NRP requirements for their instructor registration.
- Acute Care of the at-Risk Newborn (ACoRN) program pilots were completed in two Level I facilities and in one Level II facility in rural Alberta. In the metro health regions, four ACoRN workshops were conducted.
- A baseline evaluation of rural perinatal health capacity was completed. This will inform the development of a rural strategy to address identified issues.

Staff in the Quality and Innovation functional area achieved 100 percent data entry for 2005 perinatal cases and supported the review of 41 cases by the Reproductive Care Committee. A key objective for the year was the development of a draft framework for a network of quality assurance (QA)/quality improvement (QI) processes throughout the province. Staff made on-site visits to six of nine health regions to discuss their regional and local QA and QI processes and structures, and offered to support the development or enhancement of these processes. Working relationships have been established with Toward Optimized Practice (TOP) and the Health Quality Council of Alberta to allow for best possible quality improvement processes and structures.

Progress was noted related to the work of an ad hoc prioritization group to prepare and submit new technologies to Alberta Health and Wellness for consideration under the Alberta Health Technologies Decision Process. Proposals submitted on fetal fibronectin testing and enhanced newborn metabolic screening ultimately resulted in an announcement by the Minister of Health and Wellness that all regions should make fetal fibronectin testing available to eligible patients by April 1, 2008, and that the Newborn Metabolic Screening Program will be enhanced by the addition of 13 conditions, including cystic fibrosis. Additional proposals submitted on the topics of newborn hearing screening and assisted reproductive technologies were approved for review by the provincial process and these reviews are currently underway. Finally, a proposal for early risk assessment, including maternal serum screening and nuchal translucency, was submitted to AHW near the end of the fiscal year 2006/07.

Progress on First Interim Evaluation Recommendations

Nine recommendations were offered to the APHP in the first formative evaluation, completed in February 2006 (see APHP Interim Evaluation Report (February 2006) for background to these recommendations). Progress or decisions made on each of these recommendations will be discussed in turn. It is noted that the program was already engaged in addressing most of the issues raised in the first evaluation by the time the report was produced.

1. *The Tripartite Partnership explore mechanisms for establishing a single legal entity for the APHP under the continued governance of the AMA, Calgary Health Region and Capital Health.*

This recommendation was discussed and deliberated among members of the Coordinating Committee and Tripartite Executive. A decision was made to not explore this recommendation at the



present time as the program is still in development mode, although members indicated they may wish to revisit the possibility at a later time.

2. *The Coordinating Committee renew efforts to resolve the legal issues presenting as barriers to the full implementation of the program as designed.*

Progress on this recommendation is as follows:

- The formal signing of the Partnership Accord Letter of Agreement signified an agreement among all key players of their roles and responsibilities. While not a legal document, the endorsement affords the program the assurance that all health regions are supportive of their work and have agreed to coordinate and collaborate on perinatal health issues. Without such agreement, the program was hesitant about its authority to request and use data in both the Information Management and Quality and Innovation functional areas. The Letter of Agreement did not specifically address the issue of sharing of identifiable facility-level data; however, the program has worked with the Health Boards of Alberta to obtain support from the Council of CEOs for the presentation of provincial hospital comparative data.
- The program lacked the authority to access confidential information necessary to conduct mortality case reviews as had been afforded the AMA Committee on Reproductive Care under a Ministerial Order. The program sent a letter to the Minister of Health and Wellness requesting designation of the Quality Assurance Standing Committee as the QA committee with protection under Section 9 of the Alberta Evidence Act. This action is pending. In the meantime, the program continues to undertake reviews through the AMA Committee on Reproductive Care.
- The first evaluation identified a need for a mechanism to indemnify physicians who sit on various APHP committees. It was noted that the Canadian Medical Protective Association will cover physicians for clinical but not administrative activities. To address this issue, the APHP is striving to have lawyers representing the tripartite members agree on a standard contract for physicians. APHP would then contract with physicians directly using this standard contract, and Schedule A of such a contract would define the role of the contract physicians. Within the standard contract, there would be provision for mutual indemnification. At the time of this evaluation, the lawyers had not yet come to agreement on a single contract. In the interim, physicians continue to provide consultation to the program and are offered honoraria for their work.
- Finally, the program had identified privacy concerns regarding the submission of potentially identifiable information to an agency located out of province, i.e., the SOGC. Such transfer of data had been contemplated as part of the MORE^{OB} program in the module(s) involving adverse event and near miss tracking. After consultation with lawyers, it was determined that such transfer of data outside the province would be a breach of privacy legislation and this component of the MORE^{OB} program was altered. Each region was left to determine how they would best accomplish the event tracking component of the program. Ultimately, there was not a comfort on the part of either the RHAs or the APHP for regions to submit event data directly to the program. The program has, however, built in the capacity in the data system to be alerted to events if there is an interest to activate this function in the future. The major concern is that because of the relatively few adverse events in the province, it is possible that they could be backtracked to identify individual physicians and/or nurses.

3. *Alberta Health and Wellness review the role of the Advisory Committee as relating to the APHP with an emphasis on developing an effective issues management process that will meet the needs of all parties.*

At the time of the first Interim Evaluation Report, AHW was in the process of reconstituting the membership of the committee. Members are appointed for a three-year term. The terms are staged so that not all members change at once. At the first meeting of the new membership in September



2006, committee members received and reviewed a revised Terms of Reference (effective June 2006). The role of the Advisory Committee and relationship with the APHP Coordinating Committee was explained. Committee membership, as stated in the June 2006 Terms of Reference, suggest involvement by a broad range of stakeholders and disciplines, with representation across the continuum of care.

4. The APHP Program Director, in consultation with the Coordinating Committee and staff, lead a process to revisit and update the existing business plan and logic model, and establish a multi-year strategic plan for implementing the full scope of the program. As part of this review, the Director, in consultation with the Coordinating Committee and staff, revisit the program's current organizational structure to determine its adequacy for meeting the program's long term needs.

Respondents interviewed as part of the first interim evaluation advocated the need for the program to clearly establish their focus and priorities, as well as to expand their work to include the full program mandate.

The program has expended considerable energy in the past year to develop a long term strategic plan for the program that would accomplish two objectives: to guide the work in each of the functional areas, and to expand the scope of the work to achieve the full mandate of the program without overloading the current staff. The program completed a three year plan from 2007/08 through 2009/10. The plan is organized by perinatal stage – preconception, pregnancy, labour and birth, neonatal and post-partum, and infancy to one year of age – and includes a section that overarches the phases. The specific milestones and activities for each functional area are specified under each perinatal phase, and timelines are proposed.

While preparing this APHP strategic plan, staff realized that while they could establish milestone and activities, they were not comfortable with independently developing outcome goals for the program. There was consensus that perinatal outcome goals should be developed as a collaborative effort with key stakeholders, most specifically with the health regions. Thus, the initiative was divided into two streams of activity. One was to complete a provision strategic plan for the APHP to guide their work. The second was to propose the development of a provincial perinatal framework that could serve to guide the APHP and the regions towards commonly defined goals. Some action to define a potential process for the development of a provincial perinatal health framework or strategy was undertaken in early 2007.

Also as part of the APHP strategic planning activity, the program determined to revise the names of the functional areas, as follows:

- “Information Management” became “Information Management and Research”, and
- “Quality Assurance and Quality Improvement” became “Quality and Innovation”.

A business plan and grant proposal to support the activities in the APHP Strategic Plan were prepared and submitted to AHW in October 2006.

The program is a relatively small one, thus a formal reorganization was not undertaken. The Education and Consultation, Information Management and Research, and Quality and Innovation functions each have a designated lead responsible for coordinating the activities under the function. All professional staff report directly to the program director. In the current year, only one staff member did not align naturally with any of these three functional areas – the Preconception Health Coordinator (a term position). For support, this coordinator was linked with the Education and Consultation team. The program coordinators determined that innovative initiatives such as preconception health and LBW would naturally fit and could be reported under the Leadership and Coordination function while the initiative was still in the development phase.



The work of the Rural Strategies Coordinator is reported under the Education and Consultation function, although the scope of the activities crosses all functions. Because the funding comes from the MOR grant, it has been convenient to include and report this position under the Education and Consultation function.

5. *The APHP Program Director and Coordinating Committee establish a formal mechanism for identifying emerging issues, prioritizing the issues and introducing priority issues into the program's action plans using a measured approach that recognizes existing priorities.*

This issue was of concern to respondents in the previous evaluation, who noted that the program staff were subject to innumerable demands for their limited time. The establishment of a system to prioritize and focus effort was recommended. The program has addressed this recommendation in a number of ways. The Program Director established and distributed to staff a Decision Making Framework for Setting Priorities. This document, adapted from the Ontario Public Health Association (1996), specifies nine considerations and offers a checklist for analyzing a health issue. The Program Director reports she uses this as a guide when multiple issues arise at the same time; however, also notes that the need for the framework has diminished as other processes and systems are in place. For example, issues arising from the quality assurance review process are forwarded to the QI Standing Committee for review and recommendation. Issues pertaining to new technologies are referred to the Ad hoc Prioritization Committee. More immediate issues are brought forward to the Coordinating Committee at their regular monthly meetings.

Program staff are subject to requests that they perceive they cannot refuse. For example, government's decision to require the introduction of fetal fibronectin testing necessitated some form of provincial guideline. Similarly, in response to an identified issue of substance abuse in pregnancy, staff determined the need to investigate this issue in some depth. The Education and Consultation staff, recognizing that emerging issues are inevitable, have created a strategic plan that is flexible and dynamic to address currently unknown but anticipated emergent issues.

6. *The APHP Program Director continue her efforts towards full program integration and staff team building.*

An initial staff retreat and follow up retreat were held in 2005 with an aim of team building. The first Interim Evaluation found that, while external stakeholders perceived the APHP as a cohesive and well-functioning identity, internal stakeholders noted room for improvement in team building and greater entity as a single program. The north / south split in offices was a noted barrier to facilitating such team building.

A third organizational retreat – *Taking the Next Steps* – was organized in March 2006 with a stated goal to “collaboratively identify practices that would support APHP in its journey of becoming a highly functioning team and take the next steps in creating a system that could focus on its purpose of improving the health of babies and mothers.” The retreat was almost exclusively planned by staff in the north office. Retreat participants identified six “next steps” and specific practices to support these objectives.

While not specifically studied in this second evaluation, the external evaluator has subjectively evidenced courteous, respectful, thoughtful and effective communication interchanges and productive staff meetings. The Program Director indicates another team-building exercise is desirable; however, all staff are extremely busy, particularly as they are preparing for the provincial report meeting and LBW conference in May.



- 7. The Coordinating Committee, along with the Program Director, identify a mechanism to ensure the Program Director has financial management support in order to manage her budget on-site.**

The program has continued its arrangement with Capital Health for financial management support. Given the size of the program and without the creation of a separate legal entity, this arrangement has been deemed by the Coordinating Committee to be the best alternative. To accommodate the need for financial information “at her fingertips”, the Program Director has created a parallel system in-house in Calgary, managed by her administrative assistant. While time consuming and still not ideal, this system appears to be working better than the processes that were in place a year ago.

- 8. The Coordinating Committee, Program Director and staff continue to build on the positive relationships and momentum that has been built with regional health authorities and other partners, by maintaining their visibility and modus operandi of inclusivity.**

The program has easily met this recommendation as evidenced by the results of the interviews conducted for this second evaluation. During the year, program staff made an effort to spend time in the health regions. Educational staff who had previously been most visible to field staff continued to consult with and, when needed, make on site visits to regions. In addition, six regions were visited by the QA/QI coordinator with an objective to discuss their current and future QA/QI processes and structures. The Rural Strategies Coordinator traveled to seven sites with the program evaluator as part of the baseline rural strategies evaluation. Consultation support by telephone, videoconference, or in person, when warranted, is evident.

The primary vehicle for communicating with RHAs is through the Partnership Accord meeting (scheduled two or three times per year), and the Standing Committee meetings. These are generally conducted via videoconference to allow maximum participation. Both acute care and community health representatives are encouraged to participate in the Partnership Accord meetings.

- 9. The APHP Program Director and staff consider the possibility of hosting one in-person provincial meeting with the Partnership Accord and Standing Committee members at least once a year.**

Program staff considered this recommendation and chose not to host such a meeting in 2006 or 2007, mainly due to the level of effort and cost involved. While this recommendation has not been met as proposed, there have been a number of in-person meetings, conducted or planned. The program organized a one-day in-person meeting in March 2006 to coincide with the release of the first Provincial Perinatal Report. The number of people represented by RHA varied, largely related to travel distance and cost. To enable greater participation in 2007, program staff have opted to host the 2007 Provincial Perinatal Report release meeting via videoconference. In 2007, the program is organizing the LBW consensus conference which is expected to draw people from across the province. While these provide valuable networking opportunities, they do not represent formal in-person meetings of established committees.

RHA Interviews

A total of 25 individuals participated in the telephone interviews as follows:

- 12 women’s health directors, managers or educators in nine health regions;
- Eight community health or public health representatives in six health regions, including Medical Officers of Health and community health nursing leaders; and
- Five medical directors responsible for the quality of obstetrical services in five health regions.



The number of individuals participating per region ranged from one to four. Fifteen of the 25 interviewees, mainly women's health directors/educators, were members of the Partnership Accord. Seven reported being members of the Education Standing Committee, four indicated membership of the Quality Improvement Standing Committee, three were members of the Information Management Standing Committee, and three were members of the Alberta Perinatal Health Advisory Committee.

While community health and medical directors are underrepresented when compared with women's health administrators, the results represent the perspectives of a considerable number of key individuals involved in perinatal health service delivery in the health regions.

Responses to each question were themed and are presented below in general descending order of how many respondents mentioned the theme. Differences in responses across stakeholder groupings (women's health, community health and medical) are highlighted when substantial variations were evident. Items are identified as themes when more than one respondent commented on the item. Numbers in brackets represent the number of times the item was noted. Sample comments are offered to provide the reader with additional information and a flavour of how the feedback was presented.

1. What are your greatest needs of the APHP at the present time?

The themes determined from responses to this question are listed below in descending order of how frequently they were mentioned. The most predominant themes centred around the need for guidelines, education, data and expansion of program focus, especially to the first year of life.

▪ Guidelines, protocols or standards [13]

The needs varied and included comments related to:

- Provincial coordination of standards and best practice (e.g., for preconception health, early maternal discharge);
- Guidelines/protocols regarding patient transfers, resource levels, new technologies (e.g., fetal fibronectin), medical maternity leave, induction of labour, hypertension, mothers not treated for group B strep;
- Screening criteria for identifying high-risk women and tools to identify at-risk pregnancies;
- Definition and scope of preconception health;
- Standardization of maternal newborn standards that can be applied to rural facilities;
- Policy and procedure development; and
- Standards of care or practice guidelines for rural maternal nursing.

Sample comments:

We need a role and information regarding best practice. There are a number of guidelines available for people to resource on but I think this falls on the role of the program (e.g., fetal fibronectin, guidelines regarding patient transfers, particularly to tertiary level units to ensure that there are beds and resources available).

We are in great need of guidelines – policy and procedure development, but what happens is that each region develops their own and it is time consuming. I know that some things are specific, but even if they had guidelines.

We are so compressed here – so anything that can take pressures off – for example, guidelines for maternity, induction of labour, endorsement then dissemination of SOGC guidelines, developing or propagating guidelines.



- **Education [9]**

Educational opportunities provided or coordinated by the APHP was the second most frequently mentioned need and was predominantly a theme of the women's health administrators/educators. They most frequently mentioned education programs for nursing staff with limited obstetrical experience (i.e., STORC) and the MORE^{OB} program. Additional education initiatives mentioned were NRP, education associated with the fetal fibronectin health technology, and provincial education around best practices.

The development of education programs are very good for us (STORC, NRP, etc.). Our education person has a connection to an APHP education committee and a network to draw on. We don't have this [network] in a rural region.

Continuation of support for MORE^{OB} and STORC in particular. There are of greatest importance to our region. Both are positively received and much needed.

When they implement new programs or technologies it is useful to develop the education that goes with it (e.g., fetal fibronectin) so that we don't have to do that here.

- **Data/statistics [8]**

Respondents from all categories mentioned the importance of perinatal health data and statistics, with an emphasis on the need for timely, comparative data across regions and sites. Additionally, the need for an electronic prenatal record was identified, as was greater linkage with community health related to perinatal health data.

[We need] timely data collection to our specific hospitals and regions with comparative data.

The database, because she [N Bott] has the most validated data around the province, so it gives [our region] the opportunity to see trends, see where we are at, and delve down into a deeper level. If I get data at the regional level, it isn't ever as clean as hers. We can look across the province and country and can see where to go from a quality perspective.

I appreciate the work that is happening related to data elements, particularly the postnatal work, and standardization of the data process that impacts public health (e.g., postpartum mood disorders).

I need to be assured that there isn't going to be duplication – that they do not reinvent the wheel. There are public health nurses who have been working on the same issues for years and years and years – let's use them. Nancy Bott has sat on our committees (RSHIP and Meditech) and she has been a good link. I see the need for this kind of communication.

- **Expansion in focus of program [7]**

A theme predominant among community health representatives and to a lesser extent, women's health administrators/educators, was the need for the program to focus more effort beyond the work in the hospitals and, more specifically, in the first year of life. Other comments related to the need for a greater focus in the rural areas.

We would like to see the birth to first year addressed. This seems to be the weakest component. This is a huge, huge gap. What we have for obstetrics for MORE^{OB} and STORC – wouldn't it be great to see this for the neonatal population.



There is an education group for nurses and doctors, but it would be helpful to look at standardization of education for postpartum education (nutrition guidelines) and prenatal care outside of the physician offices – a focus on work outside of hospitals.

I believe standardizing the data elements needs to continue and expand into other areas. The outcome will be provincial standards around breastfeeding, mood disorder screening that we haven't had for a long time. Indicators of optimal growth and development could be looked at as well. Weight and growth and some of the other elements that are predictors of infant health.

My colleagues in acute care are responsible for the labour and delivery piece but that is such a short part of the piece.

We recognize the number of factors that address birth outcomes [but] how does one address these factors in the rural setting? There is less available for the rural areas. Opportunities like the LBW conference are good but they won't benefit the rural regions [as much as the urban regions].

▪ **Information and support [4]**

This theme was mentioned by both women's health administration and community health respondents, who expressed a need for provincial expertise and support (e.g., to the clinical educator and maternal/child manager). Program responsiveness to requests was mentioned.

We depend on the program for a variety of resources, including people, protocols, information. Because we are a small region, we have limited resources. It is nice to have something like the program to provide information when we request it.

I'm involved in most of the committees and have access to coordinators. If I need anything, I call one of them to get what I need.

▪ **Leadership [4]**

A number of women's health administrators noted the need for provincial leadership to address issues of concern to all regions. Leadership with respect to new technologies, LBW and mortality reviews was specifically highlighted.

There are many issues we have identified (e.g., LBW) so we look to the program to tackle the issue provincially. It makes no sense to tackle this regionally. We look for leadership in rolling out new technologies (e.g., fetal fibronectin, recommendations for funding for in-vitro fertilization, MORE^{OB}).

The phenomenal provincial direction towards the same goals is beneficial.

▪ **Communication/networking [3]**

This theme was raised by community health and women's health administration respondents.

Communication and networking – it saves me a lot of time because in the past I'd have to phone people in the other regions. I know who to contact to get the information.

I see the participation of community health at the Partnership Accord as vital. We need a better connection. It is not just acute care that needs them. The public health staff I work with need to be front and centre – as they do preconception health counseling and prenatal health. The women's health director may get two copies of a document [from the APHP] but she may not think to give one to me. The APHP may



not want to have tons of people to send documents to, but we need to be seen as key partners. Perhaps there should be two representatives on the Partnership Accord – one acute care and one public health.

▪ **Resources – funding [3]**

A few respondents advocated that APHP champion causes for funding, specifically for continued support for MORE^{OB}, in-vitro fertilization and for research funding for further studies in the area of tobacco use reduction among pregnant women.

▪ **Resources – staff [3]**

Three respondents noted a critical concern for nursing and/or physician shortages, which at least one person mentioned lies at the heart of many of their other issues.

▪ **Quality assurance [2]**

Two medical directors noted the need for program leadership in the area of quality assurance, specifically in:

- having the resources to conduct perinatal mortality reviews (even if regions have processes in place, there are times when program guidance is needed); and
- ensuring early risk assessment and fetal fibronectin programs have adequate support to ensure quality assurance. *When fully implemented, these require a very robust quality assurance component. When a new program is introduced, the program addresses education, then time goes by and quality assurance gets lost. It needs to be done. It can't be done randomly.*

A summary of the rank ordering of the themes by respondent category is provided in Table 2. Only those themes mentioned by more than one respondent are reported.

Table 2. Needs of APHP by Respondent Category

Theme [Number of respondents reporting theme overall]	Themes rank ordered (based on number of respondents mentioning theme) by respondent category*		
	Women's health administrators/educators	Community health	Medical directors
Guidelines/standards/protocols [13]	1	2	1
Education [9]	1	-	-
Data/statistics [8]	3	2	2
Expansion [7]	4	1	-
Information/expertise/support [4]	4	3	-
Provincial leadership	2	-	-
Communication/networking	-	3	-
Quality assurance	-	-	2
Resources – funding	-	-	2
Resources – staffing	4	-	-

* The same rank order was given when the same number of respondents mentioned more than one theme.



2. *Is the program meeting your expectations? [Yes, no, partially]*

Eleven of 12 women's health administrators/educators answered this question in the affirmative. The twelfth respondent was new to their position and did not have an expectation; however, noted the program has been *very supportive to us and we won't hesitate to ask for help and support.*

Positive comments included:

They are relatively new but they have gone above and beyond what I have expected up to this point – for example, the new fetal fibronectin guidelines. One of the requests that had gone to Edmonton was that it would be helpful to have educational materials available, and they have done that for us.

It is a great program that has a lot of potential to address our issues.

Despite a positive answer to the question, a few in the women's health category of respondents noted items for consideration, including:

They are going so fast I can't keep up with them. All is being [focused] on labour and delivery and it is driving people crazy because it is too much. I would recommend they slow down the implementation. Because nurses are generalists it isn't even just maternity. They have to do competency for emergency, PALS, NRP.

There is more development needed in the area of guidelines.

I get a sense that their mandate has changed a bit, maybe in how education is provided. They used to come out and do the education and now they are working on building capacity and we don't have the resources to have the capacity.

Of the six community health respondents, one indicated the program was meeting their expectation, one thought it was partially meeting their expectation and four did not perceive the program was meeting their expectations. A number of those who answered in the negative were nevertheless positive about the program and indicated they look forward to more connectedness with the program.

No – the first time we will be interacting with the program formally is through the LBW conference and we are delighted about that. We would love the APHP to get more involved in the first year of life. I would like to receive their reports formally. It may be my problem in terms of needing to look for these reports, but I'm not even sure where to look. I would like to be better linked with what is available. I read about the C/S rates in the newspapers.

Corine was clear that it would take some time before we get to the community health pieces, so I was expecting a delay, and see that we are getting there now.

Because they took on the mandate of the three programs, it is important that they focus on those areas and there are still important issues to be addressed and tackled in these areas. To tack on additional work would require identification of new resources. Perhaps they could structure a working group on preconception and the first year of live – task groups, working groups to develop option papers for these areas.

The majority of medical directors interviewed responded "yes" or "partially" to this question. One medical director stated that this program was *one of the things that Alberta Health is doing well and to the benefit of the patients.* Those that indicated "partially" or "no" generally remarked that they had limited knowledge of or personal communication with the program.



3. Have there been any changes made within your regional health authority that you could attribute to the APHP?

Respondent comments reflected four predominant themes – changes attributed to MORE^{OB} and other education activities, QA/QI, and organizational or staffing changes. Other items mentioned were data, collaboration, and support.

▪ **Changes attributed to MORE^{OB} [15 respondents in 8 RHAs]**

Respondents in all categories noted impacts experienced as a result of the MORE^{OB} program, including:

- Improved communication, connectedness, continuity of care, multi-disciplinary approach, culture;
- Strengthened review/audit processes;
- Strengthened or standardized policies, procedures or guidelines;
- Heightened awareness of/interest in best practice in obstetrics;
- Rejuvenated interest in obstetrics;
- Better health care or stronger practice;
- Increased nurse confidence;
- Improved staff recruitment and retention;
- Sustained obstetrical practice; and
- Enhanced risk management.

Sample comments included:

MORE^{OB} has made a difference in this region. There had been a move afoot to standardize policy, procedures and guidelines but there was an impetus from MORE^{OB} to bring people together – physicians, nurses meeting together, hearing the same messages. It moved the agenda along nicely.

Before the program started there was a task force on obstetrical care and we were discussing the main problems we were having in sustaining obstetrical services. The MORE^{OB} program appears to have addressed the issues we identified. It has changed the culture. We were on the verge of closing down some sites.

I'm keeping nurses employed and it is not as hard to get nurses who want to work labour and delivery. This is the most immediate benefit.

It used to be that only three or four staff wanted to work maternity, but now anyone that has taken MORE^{OB} is willing to go in there – suggests increased confidence and competence.

We have identified maternal child events. We have had 40 events reported since March 2006. We did four multi-disciplinary reviews and have made changes based on the reviews and a review of trends based on the 40. We have changed policies. There would not have been a process to collect the data or review the data. There wouldn't have been a catalyst. The program has prompted a group audit process.

The best thing about MORE^{OB} is that it is an evolution. It has changed how we communicate and who is involved. It has been the template that has led us down the road. Once MORE^{OB} is gone, the processes will stay in place. They wouldn't have



been initiated without MORE^{OB}. I can see that it isn't happening in other areas of medical practice. It should be the way we go with all of health.

As a region, MORE^{OB} is connecting us and connecting our practice in the region. It is making us a stronger practice in the region.

▪ **Changes attributed to other educational initiatives [5 respondents in 5 RHAs]**

Women's health administrators and educators and one community health representative noted educational efforts that have influenced their region include STORC, NRP and ACoRN.

▪ **Quality assurance and quality improvement [4 respondents in 4 RHAs]**

Respondents from two regions mentioned they have strengthened their regional QA and QI processes based on direct consultation received from the program. Another mentioned that they have standardized their fetal monitoring paper speed because of the APHP.

Sample comments:

They have helped us develop a perinatal health mortality/morbidity QA/QI committee. That is up and coming and they helped us. We have a Terms of Reference that they reviewed. Without their help, we wouldn't have gotten this far.

Regionalization of perinatal death reviews resulted from direct consultation and communication from the APHP through Grace Guyon.

▪ **Organizational/staff changes [3 respondents in 3 RHAs]**

Respondents from two regions that provincial coordination of perinatal health issues prompted their RHA to look at organizational changes or the hiring of a maternal child health nurse. While one region previously had such a position, the position had been vacant and there was now a recognition that a gap existed.

With the start of the tripartite, it signaled to the region that we needed a coordinated approach. In our region, the program was the biggest driver to establishing a regional coordinated approach rather than a site-based approach. Recognition that there was a provincial program was a big factor that spoke to our region about the need for a coordinated approach.

▪ **Other**

Other items mentioned by one or two respondents were:

Data:

- *The annual provincial report – is very well put together. It is helping us to become more evidence based.*
- *The program has helped us look at provincial data elements – those that will go into Meditech (non-metro regions).*

Increased collaboration:

- *There is increased collaboration with other health regions.*

Support:

- *Without them I would not feel any support in my role as perinatal health director. Just having them there is a support. If I have a question they are there.*



4. With which what aspects of the program have you been most satisfied in the last year?

Responses to this question fell under the themes: MORE^{OB}, data/information management, education generally, information and support, preconception health, collaboration and networking, standardization and STORC.

- **MORE^{OB} [6 respondents in 4 RHAs]**

Medical directors and women's health administrators noted the MORE^{OB} program as an aspect of the APHP with which they have been most satisfied.

- **Data/information management [5 respondents in 4 RHAs]**

Five respondents representing all respondent categories noted this item. Community/public health representatives were pleased that relevant items for public health were being addressed and standardized. One medical director noted satisfaction that the prenatal forms are being redesigned.

- **Information and support [4 respondents in 3 RHAs]**

Four respondents, all women's health administrators or educators, noted their reliance and satisfaction with the information, expertise and support they receive from program staff.

The regular updates and meetings – lots of good contact, support and people to go to for questions.

It is reassuring for us to have the expertise just a phone call away.

- **Preconception health [3 respondents in 3 RHAs]**

Two community health and one women's health administrator/educator noted the work on preconception health as a main cause of satisfaction.

- **Collaboration and networking [3 respondents in 2 RHA]**

Three respondents mentioned their satisfaction with having a venue for provincial collaboration and networking. One of the three mentioned the use of telehealth as a vehicle for meetings and coordination.

- **Standardization [2 respondents in 2 RHAs]**

The fact that the program is striving to ensure a standard quality of reproductive care in the province with a goal that women and infants have the same access to quality care was noted as the main satisfaction for one respondent. Another stated satisfaction with standardized education of new nurses and the fetal monitoring program.

- **STORC [2 respondents in 2 RHAs]**

Two respondents noted satisfaction with the development and implementation of STORC, which one indicated is going to be used as an orientation program for labour and delivery. In this region, STORC is used for child health and for their mentorship program (graduate nurses).



- **Health technologies [2 respondents in 2 RHAs]**

Two medical directors noted their satisfaction with the introduction of new technologies; one mentioned fetal fibronectin, the other the expanded screening for metabolic conditions.

One individual mentioned satisfaction with the rural strategy evaluation, which was noted to cause the region to ask if some of what was found applied to them. The respondent reported a plan to strengthen rural obstetrics, starting with having a road show in that region.

5. On a scale of 1 – 10, with 1 being not at all satisfied and 10 being highly satisfied, rate your satisfaction with each of the following aspects of the program.

Respondents were asked to rate the four functional areas and to provide their comments on these areas were invited. In addition, they were invited to offer comments about (but not rate) their satisfaction with the program's preconception health initiative, how LBW was being addressed, and finally, with their own involvement in the APHP.

All of the four functional areas rated highly, with averages between 7.3 and 8.5 on the 10-point scale. Of the four areas, education, and leadership and coordination rated the highest. Positive aspects and issues are discussed for each of the aspects included in the interview.

- **Education and Consultation (Mean 8.5; range 5 – 10; n = 12)**

Women's health administrators and educators were most familiar with this aspect of the APHP and their scores averaged considerably higher than the community health and medical director ratings.

Positive feedback centered on the excellence of the education programs, their enhancement in recent years, the importance of education, responsiveness of staff and satisfaction with gains made through MORE^{OB} and ACoRN.

That was always a strong focus and they have gotten better.

I know they have this new program for novice nurses. We haven't had any experience with it yet but it is very exciting and we look forward to putting it into place.

They/we have made excellent strides with MORE^{OB} and ACoRN.

Concerns or challenges for this functional area are that there may be too much happening too fast, lack of resources to undertake the scope of education activities needed, and desire for education for the birth to one year age category and for public health.

I'm not sure if they are trying to do too much. It is hard to follow through on all things. MORE^{OB} is critical and all encompassing. STORC is good but perhaps too rushed and not as thought through. There is considerable onus on every RHA to roll it out. ACoRN is similar. There is so much going on that it is hard for regions to keep up. Everyone's resources are so stretched. There is barely enough staff to deliver babies. All are needed but we should prioritize and perhaps slow down. We have been delivering babies for many years. The down side is that now that we are focusing on this, we are identifying our shortcomings.

They are coming too fast. ACoRN and NRP at the same time. We are experiencing staffing shortages and you need extra staff to relieve people to do these programs. For the NRP, the educators were told they had to implement by June 1. Who said so?



I wouldn't mind seeing more for education for the zero to one year category. I'd like to see education extend up to one year. Obstetrics is the big star in the program but we need to start expanding upward.

I don't see education with public health.

Is some of the STORC and MORE^{OB} information relevant to community health?

▪ **Leadership and Coordination (Mean 8.3; range 7 – 10; n = 12)**

This aspect was rated relatively consistently across the three respondent categories. Several people commented that everything the program does is about leadership – and they do it well. Examples of leadership noted include raising the profile of perinatal health, coordination of MORE^{OB}, best practices, enhanced data role, advocacy for fetal fibronectin and newborn hearing screening, and broad representation of stakeholders at meetings.

This is truly what the APHP is doing. They are truly offering leadership to the province.

This [leadership] is one of the strengths of the program. It has been able to raise the profile of perinatal health. Website development, coordination of MORE^{OB}, leadership with the LBW conference are examples. After this conference, more people provincially, nationally and internationally will recognize the leadership.

Recently I brought an agenda of our meeting to our regional meeting and showed what this program is doing for us.

The program seems very well organized. They seem to know what their goals are. I am very impressed. The more meetings I attend the more impressed I am.

There is no one else in the province that does this. Especially in smaller regions we don't have access to academics, experts, etc. so we look to a program like this to provide the leadership.

I feel confident that with people at the table from the AMA and universities that it is well represented at the advisory and leadership level. It gives me confidence that we are identifying the right issues.

The program has been successful in managing/controlling the rivalry between regions. There is more of an environment of collaboration and coordination between RHAs and universities.

Noted challenges for the program are managing their broad mandate with existing resources, need for greater involvement on the community health side, and increasing program awareness in rural areas.

The only concern is the resources provided by government for the mandate.

Within acute care, this is an important and relevant function, but I would like to see more on the community side and I am trying to be patient.

Sometimes [I have a concern about] role clarity and partnership. For example, newborn metabolic screening. We [community health] have been doing this screening since inception and we take pride in our achievements with following up on 100% of the clients. So [we ask] just for acknowledgement that public health is doing that program.



▪ **Information Management and Research (Mean 7.6; range 6 – 9; n = 14)**

Community health and medical director respondents rated this functional area somewhat higher than did women's health directors. Generally, respondents are positive about the production of the perinatal health reports and the direction of the program to enhance data elements. Community health representatives express satisfaction that the program is linking to their provincial work related to maternal child health. With time, they expect to have assessment data available on postpartum depression and breastfeeding. A few respondents recognized the work involved in developing the data system and expressed their appreciation for it.

The yearly report they release is an awesome report.

We are getting more and more of a request for this generic report so feedback has been positive.

They did an excellent job and I am pleased they have moved to their new database.

It was not apparent from the comments that all respondents understood the difference between the Reproductive Care Report (produced by AHW in collaboration with the APHP and others) and the Provincial Perinatal Health Report (produced by the APHP).

The predominant concern expressed during the interviews was with timeliness, especially for program planning purposes. The second issue noted was the lack of site-specific comparative data, which some noted had been available previous to the formation of the APHP. Other concerns mentioned were the level of data collection effort at the local level and associated possibility for error, duplication of data elements, need for data to be returned on specific indicators, and concern that perhaps the consultation with rural physicians in development of the prenatal record was insufficient.

I use data in my job every day. If I had data every day when I needed it that would be great and if I had comparative data that would be even better.

The information is old. When we do program planning, we already have the data. We collect data by hand in our region. We want to change that. I get a report every month so I am pretty current on things from each site. It is helpful to see the comparative data but the issue is timeliness.

The amount of data we have to collect is huge. It is time consuming to collect.

The Notice of Live Birth form is retrospective so we have the information only when they give birth. It is a two-page document and it takes a half hour to complete and it duplicates other information from the Alberta prenatal record that physicians fill in (e.g., drugs is asked on ante-natal record). I'm sure there is a lot of error in that form because it is filled in by many different people. In our region we found 18 points where we are asking the patient the same information.

One thing I don't know is how much consultation is done with rural regions. I took a draft of the prenatal record to an Obstetrics and Gynecology Committee and then provided feedback [to the program] but they [the regional committee] noted that none of their feedback was incorporated in the next draft. I don't know how many people were consulted outside Edmonton and Calgary. It is hard to convince doctors if they haven't bought into it.

There is a need for timely release of the report, now that issues have been sorted out. We should move to more timely data and more frequent data release – two times a year with more recent data.



- **Quality and Innovation (Mean 7.3; range 5 – 10; n = 9)**

More people declined to comment on this functional area than on the other functional areas, citing unfamiliarity with the function – e.g., “she hasn’t come to our region yet” or “I haven’t had anything to do with that aspect”.

Positive comments were made about the coordinator’s presence in the region to help with the establishment of their review process, with the quality improvement aspect of the MORE^{OB} program, and a hope that this aspect of the program would be brought to community health.

The review process – our region has just got started and Grace has come down and helped us set up. She has been very supportive and helped with the Terms of Reference. She has been awesome.

It has given us an impetus to have a look at our mortality/morbidity reviews at our sites to ensure we are doing them.

Look at MORE^{OB} – it is all about that [QA and QI].

I’d love it if they could bring this over to the public health/community health side of the perinatal health continuum.

Once we get preconception going, this will also be needed.

Concerns related to lack of presence or involvement at the regional level and slower progress than anticipated (although some noted the pace was not the fault of the program).

We have site QI teams and they are directly linked to Quality Council, but the link from Quality Council to APHP isn’t there.

We have major problems here and we have had no involvement. We need help. We have no beds and we struggle and [we wish] for someone to come in and give us some support.

We have been slow in getting up and running with our processes in this region, but this is not related to Grace’s lack of trying.

- **Preconception health initiative**

Respondents were not asked to rate this aspect because it was only in development stage, but comments were encouraged.

The majority of interviewees in all respondent categories who were aware of this initiative were supportive of it. Some noted they appreciated the population health approach and others mentioned this aspect has the potential in the long-term for positive impact.

I’m quite pleased that they are beginning this initiative. We have always recognized that this would be one of the initiatives that would be undertaken. The process they are taking is a good one. It is one that has not been focused on in the past.

We have a lot of issues within this region with behaviour of mothers. Addressing this would have potential impact in the long term and is a good area to focus on.

I’m so impressed that this is on the agenda. I was impressed that it includes domestic violence. I liked some of the population health pieces in there.

This is a tremendous opportunity for partnership with public health around preconception, education and health promotion.



Clearly it is an extremely important area, e.g., folic acid supplementation and the associated reduction in neural tube defects. Proof that population level interventions work.

I like the population health approach and how she has put the information together.

The most prevalent theme was the enormous challenge represented by this issue. Some women's health directors/educators noted that while this issue was important, there was a need for direction or guidance regarding what can be done at the regional level and whose responsibility this is. Community health representatives also noted that the issue and framework for approaching the issue was "huge". They advocated that if additional resources are not available, there will be a need to make it manageable. A number of representatives from all respondent groups suggested this topic area offered an excellent opportunity for public health involvement. The lack of knowledge and sensitivity of the issue were also noted items.

It is a little difficult to put a finger on this, because it is so huge. Is this the place to look at versus looking at the first year of life? The issue is large and difficult. If they have the resources to start looking at age zero to one, then that is more tangible and better defined.

It is hard because we wonder whose responsibility it is – whose responsibility is this area?

The framework is gigantic. It was superb work. If it doesn't come with resources you need to make it manageable – by using a few messages at each contact, "A Million Messages" approach, for example.

The challenge in preconception health is that there is a balance between a focus on the individual and focus on the population. It is important to have a focus that gives important consideration to population level interventions (e.g., Joanne Johnson).

Some of the challenges from the population perspective is delayed childbearing and I don't think we have a good handle on what are the societal factors that are driving that. Are there social policies, public attitudes that we need to be addressing in that area – career paths, etc.

There is a larger research agenda here. The quality of the data that we have on risk factors, risk exposures and reproductive health outcomes, comes back to gaps in data capture in Canada.

It is important that they do the whole coordination piece. There is a limit to what each region can independently do. They need to make sure that regions don't overlap.

I can envision a list of things that we think affects the health of women and babies, those with the biggest effect on health (e.g., drug use). Then we could do a quick scan to see if anyone is working on this and then we can say that aspect is looked after, and if there is another area that isn't looked after, then we could look to initiate something.

I'm supportive of a mass media campaign at the provincial level.

Some people think you should just focus on high-risk groups. We need to be really clear about factors relating to premature birth and LBW. Other factors are about when you choose to have your children. This is more delicate.



- **How the program is addressing LBW**

All respondents commenting on this question were positive about the upcoming LBW conference. None suggested it was not a good idea. Several mentioned the leadership demonstrated by tackling this long-standing issue. A number of respondents indicated that the conference was a starting point only and there will be a need to determine the next steps. Some were hopeful that the conference would inform their practice.

They are taking really strong aggressive leadership on this. This is a good opportunity for the program to do the whole work of its mandate.

This was a very innovative first step and the APHP has a lead in that.

It is innovative for the perinatal health program to tackle this issue when the program is so new. We will be attending and are looking forward to seeing what comes out of it.

I'm glad someone is addressing this without having all of us address this from scratch. The concept is good, but we haven't seen how it would be implemented yet.

I think they are being responsive. The conference is wonderful.

We are very excited about the work as it was part of my mandate. We have young and/or single and/or disadvantaged women who are pregnant and I think it will inform our practice in the future.

One respondent from a northern health region noted that, in that region, large for gestational age was a greater issue than LBW. Nevertheless, this respondent acknowledged the importance of LBW as a provincial issue and suggested that a conference was a good way to get started.

- **Satisfaction with involvement in APHP**

In general, women's health directors/managers and educators expressed satisfaction with their involvement in the APHP. They commented on the effectiveness of the telehealth meetings as a communication vehicle, noted the program was very accommodating and enabling, and their feeling of ownership of the program. Three of these respondents noted concern with time issues restricting their ability for greater involvement in the program.

Most of the non-medical community health representatives expressed an interest in greater involvement, especially if there was a greater focus on the community side or on topics relevant to them (e.g., LBW, preconception). Medical Health Officer (MOH) representatives noted interest and expressed appreciation for their involvement. Some noted that if it were not for the committee meetings they have been invited to attend, they would not know of the program. Several suggested it may be worthwhile to extend an invitation for MOHs to attend the Partnership Accord meetings with the option of attending or not attending, depending on time demands.

The medical directors interviewed were very positive about the program and satisfied with their level of involvement, noting they did not have time for greater direct involvement.

6. From your perspective, what are the most important perinatal health issues in your region?

In Table 3, the themes derived from respondent comments by respondent category are presented. Four predominant and various sub-themes were identified.



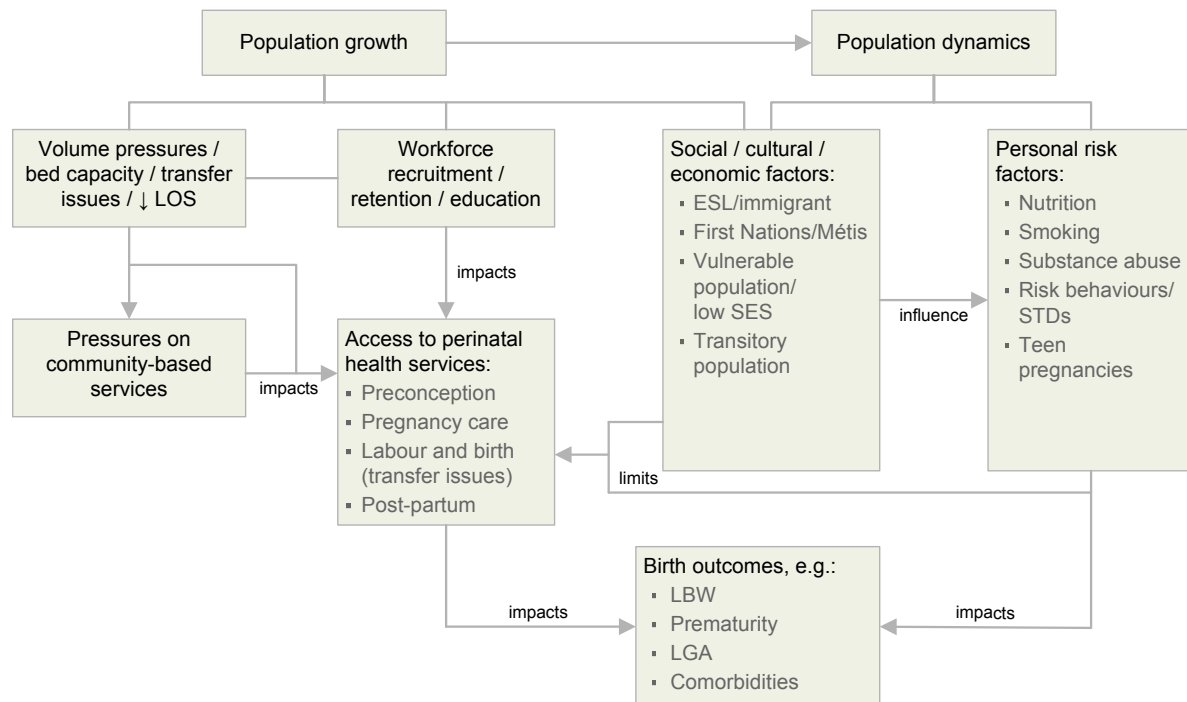
Table 3. Perinatal Health Issues

Theme	# of RHAs	Number of respondents by respondent category		
		Women's Health	Community Health	Medical Director
System issues				
▪ Staff shortages (recruitment, retention)	7	7	1	2
▪ Obstetrical readiness/staff education needs	6	5	1	
▪ Acute care growth/volume pressures/bed capacity	3	3		1
▪ Community pressures resulting from volume pressures and reduced LOS	3		3	
▪ Sustainability of rural obstetrics	3	3		
▪ Continuity of care	3	1	1	1
▪ Transfer issues	2	2		
Preconception and/or prenatal risk behaviours	9			
▪ Preconception health (general)	3	3		
▪ Substance abuse	5	4	1	
▪ Smoking/tobacco use	4		5	
▪ Nutrition	4		3	1
▪ Teen pregnancy	3	1	1	1
▪ Sexually transmitted diseases/ women in high risk occupations (e.g., sex trade)	3		3	
Access to care issues due to social/cultural factors				
▪ Ethnic / cultural / linguistic population groups (e.g., ESL, immigrant, First nations, Métis)	4	1	3	
▪ Social issues (e.g., transient, housing, food)	3	1	2	
Birth outcomes				
▪ Low birth weight	6	4	4	
▪ Large for gestational age	2	1	2	



Based on the interview results, an issues map depicting the current stresses on perinatal health services is presented in Figure 1 below.

Figure 1. Perinatal Health Issues Map



In general, the underlying drivers for the issues may largely be attributed to population growth and dynamics. Women’s health administrators and medical directors from the majority of health regions described staff shortages as a primary perinatal health issue in their region. Those from cities representing the largest population growth also mentioned volume pressures and bed capacity issues. Some community health representatives indicated pressures resulting from the increased volume of births as well as decreased length of hospital stay (LOS). Continuity of care and patient transfer issues were noted as additional associated problems.

Readiness for obstetrical services on the part of staff (i.e., staff education needs) was mentioned by respondents from six of the nine health regions.

Respondents from all health regions mentioned preconception or prenatal risk factors as key perinatal health issues. Some of those representing non-metro health regions and community health noted environmental and personal risk factors as key issues, often relating these to Alberta’s population growth. In turn, these issues were perceived to influence access to perinatal health services. For example, recent immigrants and the transitory population sub-group lack sufficient access to prenatal care, and in some cases, “show up at the door” shortly before or at the time they enter labour. Where physician shortages were evident, some people were noted to access services through walk-in clinics. In more rural areas, for vulnerable groups and for the First Nations on-reserve population, limited access to prenatal services due to distance, transportation or socio-cultural factors was mentioned as a concern.



Finally, low birth weight was a noted issue by respondents from six health regions. This was noted to be less of a concern for the northern regions; however, in these regions, a greater concern for large for gestational age (LGA) infants was mentioned.

7. Do you think the APHP is addressing these issues?

The large majority of women's health directors and administrators perceive the APHP is addressing their issues. A few noted there are limits to what the APHP can do for regions and with existing program resources. Some stated specific issues as are documented in the sample comments below.

Yes, but it is a two-way street. They are there for us so we have to include them in some of our issues. We should be doing that because it is a partnership accord.

They are certainly starting to help us address our issues. At the end of the day they are our issues and we have to take the responsibility for addressing them.

They are addressing the issues that can be addressed at the provincial level; we are addressing the region's work.

Not so much capacity [a priority issue] but low birth rate for sure.

Large for gestational age isn't on the provincial agenda yet, but the priorities identified are priorities. They actually hear us.

There is a sub-committee working on the substance abuse issue; however, we couldn't wait long enough for provincial protocols to come down so we developed our own.

They are in the midst of doing things on this [our priorities] – e.g., STORC. I'd like to see them keep the momentum. We went into an evaluation phase to use it, but then there seemed to be an expectation that while it was being revised we shouldn't be using it – which made me wonder what are we supposed to be doing in the meantime. Perhaps this wasn't that well thought out.

If this preconception plan helps us address some of the substance abuse issues.... I'm not sure how, but if we identify people earlier and do something about it.

Generally, community health representatives and medical directors perceived the APHP was not or was only partially addressing their issues. Some community health respondents mentioned that the program is beginning to get to their issues or is moving in the right direction – for example, with infant nutrition. A few medical directors indicated their major concern was manpower issues and this was not a current focus of program attention, although one indicated uncertainty as to what the program could do about this issue. Finally, one rural medical director perceived the program was primarily dealing with Capital and Calgary issues.

8. How might the APHP help you to address these issues?

Responses reflected different knowledge of the APHP services across the three respondent groups, with community health and medical directors expressing a need for greater communication/linkages and public education associated with perinatal health issues, while women's health directors most frequently mentioned education (which has historically been their primary experience of the program), advocacy for increased workforce and strengthened post-secondary education, development of guidelines, and exploration of alternate service models.

- **Communication/linkages/networking** – seven respondents, primarily community health and medical directors indicated the need for better linkages or communication, including greater visibility of program staff at the health region.



I wonder if they were to come and do a walk-about to see what our unit is like, to give them an idea of what we are dealing with.

The next time any representative comes to [my community], I would like to be invited to meet them. There is nothing like having that personal touch.

Consultation, coordination and communication – this is what makes it work. I need to understand what the APHP does to know how and when to access them. A letter and phone call would work to reach us. We don't have time for meetings.

Come out and talk to us more. I'm a believer in communication.

The preconception health piece would be absolutely essential to share with public health nurses – so link to public health nursing is very important.

Arranging a conference in Edmonton for the leaders of obstetrical services. One of the issues we have and others have is how to engage the last hold-outs. Having a forum to address some of these types of issues – some problem-solving. A face-to-face meeting every so often would be helpful. I think people would be willing to travel to attend such a meeting.

- **Advocacy re: workforce issues** – five respondents suggested the APHP should be involved at the provincial level to address staffing requirements and to advocate for enhanced post-secondary education opportunities.

Lobbying with educational institutions and governments regarding more nursing graduates. Are we graduating enough nurses? Do we have enough doctors interested in rural practice?

Advocacy and lobbying around recruitment/retention. All of us would benefit from more of that.

They need to approach the universities and see if they can have perinatal health in their programs.

There is a need for a 12 week program for nurses interested in obstetrics – six weeks of modules followed by six weeks of practical experience. I would like this to develop in partnership with Mount Royal College or others.

- **Education** – four respondents reinforced the existing role in education or suggested additional educational opportunities, specifically for physicians and in the area of preconception and prenatal health.

We absolutely need the ongoing training and development, and continuing education.

Maintenance of MORE^{OB} – to keep the momentum going and keeping physicians engaged.

The only thing might be around more physician education, perhaps through telehealth, that makes it very clear that there are different levels of services between urban and rural, and tertiary versus regional.

If we can impact preconception and impact pregnancy, then we should see better outcomes for the child. If we can help with that education we would be delighted but we would need to be educated first.



- **Public education** – four respondents suggested the program could become involved in public education efforts. Specifically mentioned were mass media campaigns regarding preconception health, perinatal nutrition, sexual health education and public education materials in multiple languages (the latter was associated with the identified issue of immigrant and English as a Second Language issues). One individual advocated the program could expend effort to convince people to stay in their community – *subtly give messages [to this effect] over time.*
- **Guidelines/standards** – three respondents suggested the need for guidelines or standards. Specifically mentioned were hospital or resource guidelines, and guidelines for client transfers, different care levels, inductions and postpartum.

Can the program help the rural hospitals by making recommendations regarding hospital standards? Support from a higher authority would be helpful. I would like to see selective political involvement [in the area of] provincial resource standards per size of hospital. How many beds per 1000 deliveries? We could set resource standards for physicians practicing obstetrics – e.g., they must take the ALARM course, MORE course – conditions for practicing obstetrics.

I would like to see more explicit guidelines around what is safe to provide at the different care levels – e.g., access to pediatrician, respiratory therapy. Is a pediatrician a neonatologist? The national guidelines are too general. There are always going to be grey areas, but there is room to be more explicit. It has to do with infrastructure. Most rural facilities had nurseries built but they became a place for the mother rather than operating as a true nursery delivering a particular level of care.

Perhaps advocacy and standards for staff ratios.

Perhaps some provincial guidelines around postpartum and transferring clients. When do we transfer – what are the guidelines. Also, recommendations around inductions. We have national guidelines and the SOGC and I don't know if there are provincial guidelines.

- **Alternate service delivery models** – two women's health directors suggested the program could become involved in exploring alternate service delivery models, possibly looking at nurses that cross the spectrum of perinatal health services, linked with physicians or with primary care networks.

There are primary care initiatives underway, but one thing I'm wondering is if we shouldn't be looking at other alternatives to assist general practitioners in smaller communities and hospitals in smaller centres – e.g., midwives or prenatal/postnatal nurse that works with the physician.

In addition to the above suggestions, a number of women's health directors suggested they were comfortable with the support received from the program or that the program could not take on additional work with their current resources.

Their plate is currently full and with the resources they have (human and financial), are at capacity. Where they can help us – education or data – they are doing it to the best of their ability.

I feel so supported. They need more staff though to do all the things I'd like them to do.

We've been in this relationship for 1½ years. They've only been an organization for a few years and just look at what they have already done. Given all the initiatives they are working on, they are appropriately meeting my needs.



9. How effective do you think the APHP committee structures are? What is working for you? What could be improved? Should alternative meeting formats/frequencies be considered? If yes what are your suggestions?

The vast majority of women's health directors and community health representatives who had experienced membership on an APHP committee were positive about the committee structures and processes. The use of video-conferencing/telehealth was noted to be especially effective.

I think they are effective because there is so much work to be done and I don't think it could be done in another way.

Just the one meeting I was at, I felt good about what was discussed. I got a sense of what the other regions were doing.

I wouldn't suggest any changes. I'm always surprised at how much gets done between meetings. I'm surprised at the breadth of what they address. They get information out to us in a timely manner, provide and update and tell us where they are at. I'm not sure how much response they are getting from the regions. Sometimes we don't have time to get back to them. What I'd like from them is feedback about us. Do we need to be doing more to be moving the agenda forward? We are their clients and they are our clients. What more can we as RHAs be doing to support them?

Telehealth is great. It works very well. It is convenient. If you have to travel somewhere it is a day shot. I don't have the time for a day to be away.

I like the idea that there is representation allowed from every region and I like the Standing Committee highlights because I am not on those committees and sometimes I would like to know more.

Two women's health directors who were involved in multiple committees suggested there were perhaps too much on their plates. One of these suggested the committee and communication processes be streamlined and that the program make more use of time-limited initiatives such as was used for fetal fibronectin. Other respondents mentioned that the agendas from the last meetings they attended were full and suggested the program consider increasing the frequency or lengths of the meeting.

There is just so much and the same people sitting on the committees.

There are too many documents. The program needs to take a leadership role, get feedback where they need it and run with it.

It is working for me. Some of the committees are very busy in terms of agendas being full. Sometimes we run out of time to address all the issues. I wonder if quarterly is appropriate [for the Partnership Accord meeting]. I almost wonder if it wouldn't be better to meet every other month and be able to keep up with things.

When the agenda gets too long, they may have to extend the meeting. When I get there and put in the time, I don't want to feel like I am missing something. Once my time is booked off it is booked off.

When asked, almost all individuals suggested that an in-person meeting at least once a year would be appreciated. One person mentioned they could only attend if the meeting were in their half of the province. Two community health representatives indicated they would only attend an in-person meeting if the agenda was relevant to community health.

Every once in a while it is beneficial to have a face to face meeting. It made such a difference in STORC to have a two-day meeting. The whole context of the meeting



changed after we met face to face. I was looking forward to the release of the provincial report as an opportunity to see people. I understand the reasons for not doing that. I guess the LBW conference will give us an opportunity for this. Would discourage not having a face to face meeting on an ongoing basis.

We are used to traveling for other meetings. I would recommend at least one face to face meeting per year. Do it close to the airport.

I'm supportive of once yearly face to face meetings. The opportunity for networking is really beneficial. Probably the clinical lead and medical director, and with luck, a couple of physicians and a couple of clinical people.

Two community health representatives expressed interest in involvement in potential working groups that would follow up on the preconception health initiative or first year of life. One person advocated for community health representation on all relevant APHP committees.

If the program is dealing with areas like preconception and first year of life, then I would like to be on a committee (e.g., centering pregnancy).

There is an opportunity to establish some new working groups in terms of the preconception and first year of life areas.

I don't have a clue as to how to go about trying to get onto any of the committees. I'd like to ensure public health representation on those committees. Public health needs to be a recognized player at the table. We really just want to be a partner.

Medical director responses varied from disinterest in attending APHP meetings on a regular basis to encouragement for increased program visibility to physicians.

I'm happy I'm involved and I'm happy to be involved.

I haven't been [to any meetings] and don't intend to go.

I recommend that they increase their visibility to the physicians. They could get a mailing list of physicians doing deliveries, so that the APHP can have a newsletter directed to them. This would be the way they could tell people who they are and get information out to them.

The evaluator was asked to specifically probe whether changes to the Partnership Accord meetings were desired, especially in light of the signing of the Partnership Accord Letter of Agreement. Specifically, an alternate format was suggested whereby the Partnership Accord meeting would become the primary strategic vehicle for directing the program's activities with the existing Standing Committees serving more as Working Committees under the direction of the Partnership Accord. This question was asked only of those respondents with the longest and most extensive committee experience.

Respondents were mixed with half suggesting that no change was warranted and the other half indicating they were open to the concept of a more strategic oversight committee with an enhanced role. One individual who thought no change was warranted at present suggested the question should be revisited as the program becomes more developed.

I have no suggestions for change. What they are doing they are doing phenomenally well. They use people's time very efficiently. They do a lot of work behind the scenes, so they bring forward items for decision. I don't feel my time is wasted sitting on all the committees.

It is working fine as it is. As things get more developed, you might work towards another structure. It could be a goal to work towards.



The notion of using the Partnership Accord for more of a strategic direction is a good one. I don't know if that means more meetings or just ensuring the agenda items are decision oriented rather than information sharing.

I wouldn't mind a strengthened Partnership Accord meeting because I'm interested in all those areas but I'd rather not do the work. We could learn from the Stroke initiative. Every region has a Stroke Implementation Committee. In this case we don't have this for perinatal health in our region – but we could have.

General Comments

Respondents were asked if they wished to make any final comments before the interview ended. Many took the opportunity to reinforce their satisfaction and appreciation for the work of the APHP.

I think staff do an excellent job and are a pleasure to work with. My staff and the physicians really enjoy working with them. We are lucky to have them.

I have the utmost respect for Corine and her group. They have done a great job in selecting the people who are working. They are a dedicated group of people and I appreciate all they have done so far. No one has ever said no. They help us out with whatever issues we have.

It is remarkable what the program has been able to achieve. We are experiencing very challenging times in Alberta and overall I'm very satisfied with the program. Front-line staff are not as aware of the program, of course.

Overall, I am completely impressed with the work these people do. Frustrations are minor.

The APHP model is the way to go – it should be considered a model for the rest of the health system.

The Partnership Accord agreement was a significant piece of work – a very tangible document that indicates everybody's commitment to the program.

For a program that is only a few years old, the regions and the staff of the program can be proud of what they have achieved. Staff need to be highly commended.

This program has a different structure operating. There are people paid to work provincially. In others we meet from the regions and we are it [although] we have some support for RSHIP [and] the Alberta Stroke Council has hired one person. This one [APHP] is better funded. Because of that we rely on these people to do the work and we don't have to be involved.

I'm just very happy with the progress we've made in our unit. I have positive people around me and we are excited to move forward.

I was impressed with the breadth and number of issues they were willing to take on. They talked a lot about the MORE^{OB} program, event tracking, clinical practice guidelines. They looked at legal issues for physicians. A lot of focus on rural capacity. Education they are trying to improve across the province. I thought it was amazing that they were willing to take on all these issues. I'm not sure if they are on the right track but I was pretty impressed.

I wish that AHW would get as involved in a positive basis in other areas [of the health system].

The only final comments that indicated room for improvement related to a desire for the program to become more active across the full continuum of care and increase their focus on population health. This was expressed by both women's health and community health respondents.



Public health is not involved enough; they are part of the continuum. They need to be included more and also the newborn up to one year (pediatric). Same with MORE^{OB}. We are [currently] looking at outcomes for obstetrics only.

There seems to be a particular bent for the program to look at high-tech issues and I don't understand this preoccupation when we have the whole population that could be looked at in a different way. From public health, I'm keenly interested in the transition process and what is happening in the home. I'm trying to be patient knowing that community health will come, but I don't quite understand why the details that affect only a very small portion of the population seem to get the attention of the program.

Have we got all the important linkages in place? Are we missing inter-departmental coordination? How much policy expertise has AHW retained internally so it can drive policies forward at the government level? What is happening as far as the AISH program policies, even payment for single embryo transplants?



Summary

A summary of this formative evaluation, based on data collected through observation and from RHA stakeholder interviews, is presented below according to the evaluation questions established at the outset in consultation with the Program Director.

Evaluation Question	Summary
<p>What has been accomplished?</p>	<ul style="list-style-type: none"> . The program's milestones and activities over the past year are numerous. The most significant milestones include: <ul style="list-style-type: none"> . The signing of a Partnership Accord Letter of Agreement . Development of a Preconception Health Strategy . Planning for a large-scale low birth weight conference in partnership with a number of health regions and agencies . Generation of the first Provincial Perinatal Health Report using a consolidated database . Involvement of 60 Alberta facilities actively participating in the MORE^{OB} program . Completion and distribution of the STORC educational package to the nine health regions and North West Territories. . Completion of NRP instructor registration requirements for 120 health professionals . Completion of a baseline evaluation of rural perinatal health issues . 100% completion of data entry for 2005 perinatal cases . Support for 41 case reviews by the AMA Committee on Reproductive Care . Development of a framework for a network of QA and QI processes at the provincial, regional and site levels . Preparation of submissions for the AHW health technologies decision process . Progress was noted on six of nine recommendations made in the first Interim Evaluation report.
<p>How satisfied are key partners, specifically RHA representatives with the program?</p>	<ul style="list-style-type: none"> . Overall, RHA representatives express a high level of satisfaction with the APHP. . The vast majority of women's health administrators/educators and medical directors report that the program is meeting their expectations. Community health representatives desire greater emphasis on the population and community health aspects of the perinatal health continuum. . When asked with what aspects they have been most satisfied over the past year, those that have had the most experience with the program mentioned the MORE^{OB} program, data/information management, information and support they received, the preconception health initiative, and collaboration and networking. . Positive feedback on the education and consultation functional area centered on the excellence of the education programs, their enhancement in recent years, the importance of education, responsiveness of staff, and satisfaction with gains made through MORE^{OB} and ACoRN. Concerns in this functional area expressed by a minority of respondents were that perhaps there was too much happening too fast, lack of resources to undertake the scope of education activities needed, and desire for expansion of education services to the birth to one year age group and to public health.



	<ul style="list-style-type: none"> Examples of leadership and coordination activities noted were the increased profile of perinatal health in the province, coordination of MORE^{OB}, development of best practices, enhancements in their data role, progress in the introduction of new technologies, and success in bringing together diverse perinatal health representatives. Noted challenges for the program were managing their broad mandate with existing resources, need for greater community health involvement, and need for increased program awareness in the rural areas. Generally, respondents are positive about the production of the perinatal health reports and the direction of the program to enhance data elements. Community health representatives express satisfaction that the program is linking to their provincial work. The predominant concerns expressed by RHA representatives related to the lack of timeliness of data, especially for program planning purposes and lack of site-specific comparative data. Positive feedback on the quality and innovation functional area centered on the assistance received in planning or establishing regional review processes. Concerns related to the lack of presence or involvement at the regional level and slower than anticipated progress in this area.
<p>What aspects of the program functions are working well?</p>	<ul style="list-style-type: none"> The program is recognized as providing strong provincial perinatal health leadership. RHAs perceive themselves as partners in this provincial program. The program has been highly successful in implementing and enhancing the education and consultation function. RHAs express tremendous need and appreciation for the program efforts to maintain or strengthen the competencies and confidence of hospital staff and physicians providing obstetrical care, especially in light of perceived inadequacies in post-secondary education opportunities. The impression given is that the RHAs rely heavily on the program to support the delivery of safe, high quality obstetrical services. The program continues to make progress on developing an enhanced database. The program is increasing its visibility in the regions, with on site visits made to some regions for the Rural Strategies and Quality and Innovation functional areas. The program has been successfully in bringing relevant health technologies forward to AHW for decision. While the provincial process may be longer than some would like to see it, the program can point to successes in the implementation of fetal fibronectin testing and the expansion of the newborn metabolic screening program. The program's work on preconception health and planning for a low birth weight conference is very well received and has signified to stakeholders the program's extension of activities towards the full scope of its mandate.
<p>What adjustments to program functions and activities are needed?</p>	<ul style="list-style-type: none"> No major changes to the program's functions and activities are indicated. The four functional areas continue to be relevant and necessary. The most significant theme arising from the RHA interviews that suggest the need for considering future priorities was a desire for greater focus on the birth to one year age period.
<p>Were committee structures adequate?</p>	<ul style="list-style-type: none"> Generally, RHA stakeholders perceive the existing committee structures to be working well for them and do not recommend that changes be made. They are particularly positive about the use of telehealth.
<p>What adjustments to program inputs/structures are recommended?</p>	<ul style="list-style-type: none"> No changes to the existing committee structures are recommended at the present time; however, the program may wish to revisit the structure again in one to two year's time when the Partnership Accord has become more established. Organization of a face to face meeting on an annual or at least bi-annual basis would be well received by most Partnership Accord meeting participants.



<p>What are the most important perinatal health issues facing the RHAs?</p>	<ul style="list-style-type: none"> . RHAs most frequently mentioned staff shortages and preconception or prenatal risk factors as their most important perinatal health issues, impacted largely by Alberta’s tremendous population growth. Volume pressures appear most critical in the regions Level 3 and 2 hospitals and are impacting community health as well as hospital-based services. . Additional issues involve staff and physician education needs and low birth weight.
<p>How might the APHP best support the RHAs in addressing these issues?</p>	<ul style="list-style-type: none"> . The greatest needs of the APHP by RHAs at the present time are: <ul style="list-style-type: none"> . Support with guidelines, protocols or standards; . Continued program emphasis on education; . Access to timely, comparative data; . Expansion of the program’s focus beyond services provided in hospitals, particularly in the first year of life; . Continued information and support; and . Continued provincial perinatal health leadership and coordination. . Additional suggestions for how the APHP might best help regions address their most important perinatal health issues included: <ul style="list-style-type: none"> . Provincial advocacy to address the workforce issues; . Program involvement in public education (to address risk factors and preconception health issues); and . Exploration of alternate service delivery models.



Conclusions and Recommendations

Over the past year, APHP staff has continued their ambitious agenda under the four functional areas of the program. Based on the results of interviews with RHA stakeholders, the program is perceived as a cohesive entity that is addressing a broad range of relevant perinatal health issues. While issues and suggestions are noted, stakeholders continue to be overwhelmingly positive about the program. Generally, those representing the acute care sector are very satisfied and able to describe tangible benefits of the program. Community health representatives and medical directors have had less exposure to the program and are, thus, less familiar with its role and functions. Nevertheless, they express interest and, in some cases, see potential for greater involvement in the program.

With the development of the preconception health strategy, planning for the low birth weight consensus conference, and work on expanding the data elements into the pregnancy and postpartum periods, program staff have made gains towards expanding their efforts to address an expanded program scope. These efforts have been very well received by RHA stakeholders and, in particular, by community health representatives who are keen to become more involved in these aspects. Now that the program has made this effort to expand their scope of activity, stakeholders from both the acute care and community health side are anxious that the birth to first year of life also be addressed.

At the same time as enthusiasm for an expanded program scope is apparent, the demands for support from acute care stakeholders representing the program's traditional areas of work are noted. In particular, the RHAs rely heavily on the program's education and consultation services and its data/information resources. These are aspects for which the program has carved out a unique niche and there are no other players evident to fulfill these needs.

Balancing the existing demands for services with the expectation for expanded scope continues, therefore, to be a significant challenge for the program. It is noted, for example, that the preconception health and LBW initiatives were only achieved through retained or additional program dollars. This evaluator endorses the program staff's attempt to make the most use of their available time by moving away from direct service provision (e.g., presentation of workshops, quality assurance reviews) towards a greater capacity building approach (e.g., by developing education curriculum for delivery by others, working with RHAs to identify and develop regional QA/QI processes). Even with these changes, it is uncertain whether the program will be able to fully meet the expectations of RHA stakeholders across the full program mandate without additional resources. In the absence of additional dollars, continued prioritization and staging of implementation over time is required.

It is clear that RHAs are experiencing phenomenal pressures associated with Alberta's recent population growth and these pressures are not expected to abate within the foreseeable future. Volume pressures and bed capacity issues, especially noted in the regional and tertiary hospitals, are exacerbated by difficulties in recruiting physicians and nursing staff, and the lack of obstetrical education received as part of post-secondary education for family physicians and nurses. Any assistance with addressing the recruitment and retention issue through linkages with provincial workforce planning initiatives would be well received by the RHAs. Workforce issues and sustainability of rural obstetrical services have been long standing issues for regions. Is the time appropriate to reconsider fundamentally different service delivery models? For example, regionalization and the primary care networks may offer the potential for consideration of nursing models that "follow the client" across the perinatal stages and service locations (acute care and community health), linked with primary care physicians practicing in service networks.

While the program states that the focus of the education services are on "continuing" education needs (see Logic Model in Appendix A), in fact, one must ask whether they are actually supporting the delivery of basic obstetrical education for these professionals through the STORC and MORE^{OB} programs, i.e., is the program in effect subsidizing the post-secondary education system? Might the efforts of the program better be directed towards addressing the underlying issue of insufficient obstetrical education by working collaboratively with the post-secondary institutions and government to identify a more effective means to



address the issue than to have the APHP continue to hold the primary onus for the provision of obstetrical education to nursing staff and physicians?

In addition to the volume pressures and recruitment and retention issues, RHA stakeholders, mainly in acute care, clearly identified the need for support in the area of guidelines and standards. These ranged from the development of hospital and resource standards that regions could use to argue for specific local policies or resources, to support in the development of practice or educational guidelines. Program efforts to develop educational guidelines (e.g., fetal fibronectin) have been very well received. The phenomenal growth pressures experienced by regions are stretching available resources to the limit and RHA stakeholders perceive they have no resource capacity or time at the regional level to undertake guideline, policy and procedure development. They express this as the main area of support needed from the APHP.

RHA stakeholders who are involved in the APHP committee structures perceive they are working well and are effective for their needs. It appears their primary need at present is to receive information about provincial and regional perinatal health developments. Generally, community health and medical director stakeholders interviewed are only beginning to understand the APHP committee structures. With these considerations in mind, it may be premature to consider changing the program's structures at present. However, given that the Partnership Accord is relatively new and these committee members generally have not had many meetings upon which to base their feedback, it may be worthwhile to revisit the APHP structures in the future, perhaps in two years' time.

RHA stakeholders were positive about any face-to-face meetings that could be organized. They appear similarly interested in on-site visits made by program staff. While those that know the program well appear not to hesitate to pick up the phone to contact the programs, others have not yet developed that kind of relationship with program staff. Greater visibility of APHP staff and face-to-face contact with all regional partners would be well received.

Based on the findings and conclusions of this evaluation, it is recommended that:

1. *The APHP, with its limited program resources, identify and target their efforts where they will make the greatest difference to their RHA partners and where they are uniquely positioned to address issues. In particular, program staff:*
 - 1.1 *Target their efforts to addressing systemic recruitment, retention and obstetrical education needs in collaboration with representatives from provincial initiatives and post-secondary institutions.*
 - 1.2 *Together with their RHA partners, explore options for alternate service delivery models, especially for rural perinatal health services.*
 - 1.3 *Continue to pursue a capacity building rather than direct service delivery approach, especially in their educational and QA/QI functional areas.*
2. *The APHP further develop the preconception health strategies in collaboration with the RHAs, most predominantly with community health representatives. This continues the momentum achieved and provides an avenue for active community health involvement in the program.*
3. *Given limited available resources, and clear need and support for the services currently provided, the APHP continue its cautious approach to further expansion of the program scope. Over the course of the next year, program staff prepare a more detailed plan for what might be feasible activity in the birth to first year age range.*
4. *APHP staff, in collaboration with the Partnership Accord, develop and implement a plan for how they may support the RHA needs with respect to guideline development.*



5. *Given concerns expressed by some women's health administrators about the amount and pacing of education activity, the APHP consider slowing the pace of introduction of the acute care educational programs in favour of effort directed to working with community health representatives in the preconception health and postpartum periods.*
6. *The APHP committee structures not be changed at the present time and committee Terms of Reference be reviewed on an annual basis..*
7. *The APHP organize a trial face-to-face meeting with the Partnership Accord and Standing Committee members in 2008.*
8. *As resources allow, the APHP staff continue to arrange on site visits to the health regions, particularly to the non-metro regions. Ideally, each region should receive at least one on site visit by at least one member of the program each year, with an attempt made to connect with as many acute care, community health and physician representatives as possible.*

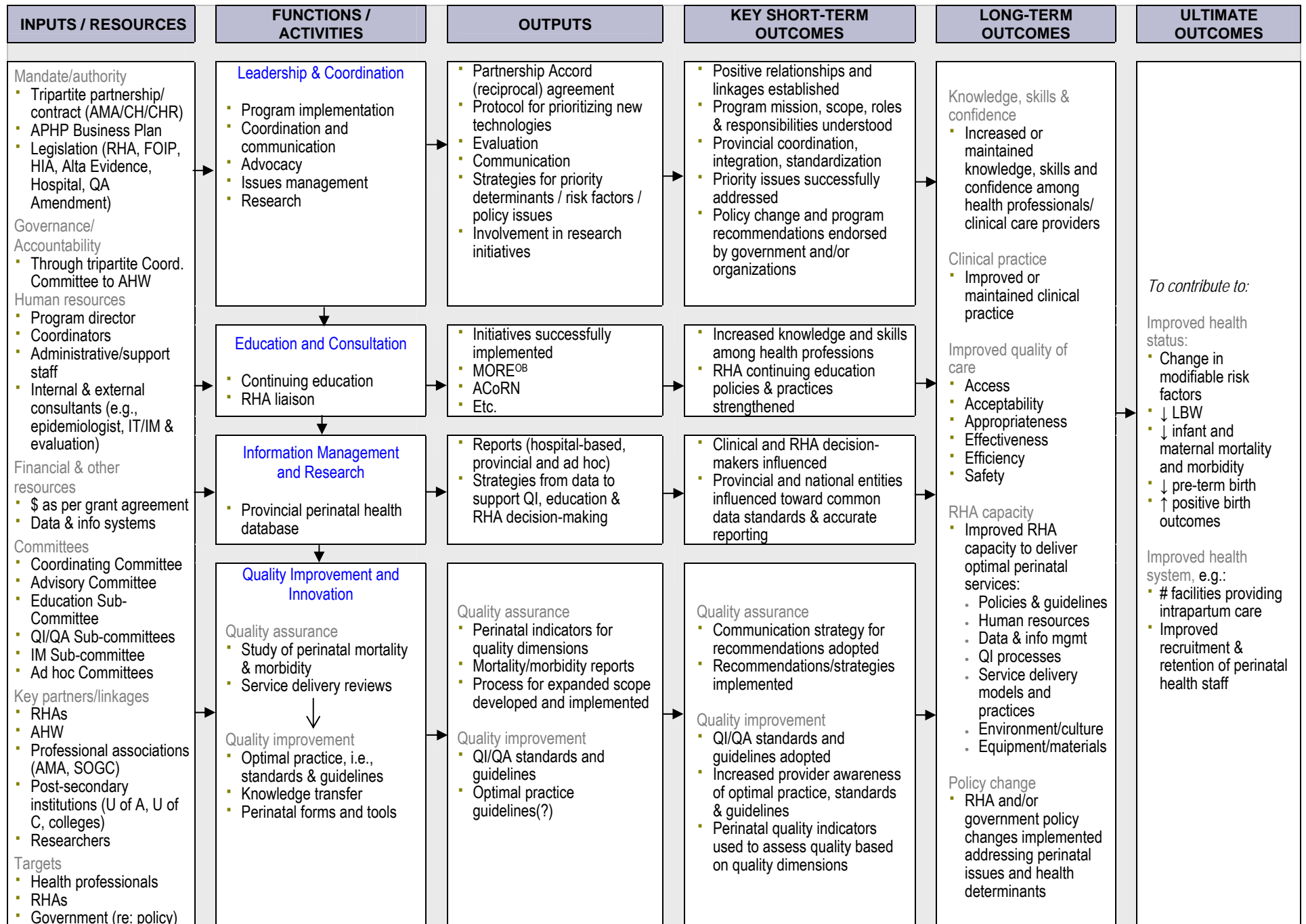


Appendix A: Program Logic Model and High Level Evaluation Questions

- Level 1: Alberta Perinatal Health Program
- Level 1: Evaluation Questions



Alberta Perinatal Health Program Logic Model



Alberta Perinatal Health Program: High Level Evaluation Questions

INPUTS / RESOURCES	FUNCTIONS / ACTIVITIES	OUTPUTS	SHORT-TERM / INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES	ULTIMATE OUTCOMES
<p>Was the program mandate appropriate?</p> <p>Are adjustments needed?</p> <p>Were structures adequate?</p> <ul style="list-style-type: none"> ▪ Partnership agreement ▪ Accountability mechanisms ▪ Financial and human resources ▪ Committee structures <p>Were effective partnerships established with key players?</p> <p>Was the program cost appropriate for the success it achieved (cost-benefit)?</p> <p>How effective are the program inputs/resources perceived to be?</p> <p>What adjustments to the program inputs/structures are recommended?</p>	<p>Were the functions implemented as planned (as per business plan)?</p> <p>Was a cohesive provincial program established? What are the benefits of a provincial program?</p> <p>What is working well?</p> <p>What barriers and challenges are identified? How were they addressed?</p> <p>What adjustments to the program functions and activities are needed?</p>	<p>What are the program outputs, by function?</p> <p>What has been accomplished?</p>	<p>How satisfied are key partners with each program function?</p> <p>Have priority issues been successfully resolved?</p> <p>Has integration been achieved to satisfaction of key partners? E.g.,</p> <ul style="list-style-type: none"> ▪ Provincial database <p>Have educational strategies been effective? E.g.,</p> <ul style="list-style-type: none"> ▪ MORE^{OB} ▪ ACoRN <p>Is the provincial database accurate, effective and efficient?</p> <p>Have QI/QA standards and guidelines been adopted?</p> <p>Are optimal practice guidelines/ recommendations supported and adopted?</p> <p>Is support for recommended policy change(s) evident?</p>	<p>Is there indication that:</p> <ul style="list-style-type: none"> ▪ APHP has resulted in increased knowledge, skills and confidence among health professionals/ clinicians? ▪ APHP has resulted in changes towards optimal clinical practice? ▪ Has influenced quality of care? ▪ RHAs have increased their capacity to deliver optimal perinatal health services? ▪ RHAs have implemented organizational policies recommended by APHP? ▪ Government policies recommended by the APHP have been adopted or implemented? 	<p>Recognizing that APHP cannot be solely accountable for ultimate outcomes, is there any indication of:</p> <p>Improved health status</p> <ul style="list-style-type: none"> ▪ Modifiable risk factors ▪ ↓ LBW ▪ ↓ infant and maternal mortality and morbidity ▪ ↓ pre-term birth ▪ ↑ positive birth outcomes <p>Improved system of perinatal services, e.g.,</p> <ul style="list-style-type: none"> ▪ # facilities providing intrapartum care ▪ improved recruitment & retention of staff

Formative ----- Summative



Appendix B: RHA Interviews

- Letter from Program Director
- Interview Questions



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Vision: Optimal health for expectant mothers and the infants that are born each year in Alberta

February 13, 2007

Dear Colleague

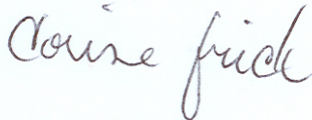
In the interest of ongoing quality improvement for the Alberta Perinatal Health Program, I have asked Margaret Wanke of Charis Management Consulting to undertake a second interim evaluation of the program with an emphasis, this year, on regional health authorities' feedback. As part of this evaluation, I would like to have Margaret interview the key stakeholders representing perinatal health services in each region. Specifically, we are looking to interview the following representatives within each program:

Primary women's health program director/manager;
Primary public health representative responsible for prenatal, post-partum and newborn programs, and
Medical director responsible for the quality of maternity services.

Someone from Margaret's office will be contacting the individuals, including you, who are listed on the attached Partnership Accord contact list, to arrange a half hour telephone interview. The interview questions will focus on the following themes: satisfaction with APHP services, program impact, APHP committee structures, perinatal health issues, and suggestions for APHP improvement and priorities.

Your assistance with this evaluation is greatly appreciated. We hope to make our services as relevant as possible to the health regions.

Sincerely,



Corine Frick, R.N., M.N.
Director

Alberta Perinatal Health Program Evaluation
February/March 2007

Introduction

As mentioned in Corine Frick's letter, the APHP desires feedback from RHA representatives for this year's evaluation. I estimate that 25 – 30 telephone interviews will be conducted in total. Results will be compiled and presented anonymously by theme. No one individual's or RHA's name will be presented in the evaluation report. The data will remain in my office which is independent of the APHP.

There are approximately 11 questions under the themes mentioned in the letter – expectations, satisfaction, perinatal health issues and program structures. You can choose to decline to answer any of the questions.

Do you have any questions before we begin?

Do you consent to participating in the evaluation?

Expectations and impact

1. What are your greatest needs of the APHP at the present time?
2. Is the program meeting your expectations? Yes ___ No ___ Partially ___
3. Have there been any changes made within the RHA that you could attribute to the APHP?

Satisfaction

4. With what aspects of the program have you been most satisfied in the last year?
5. On a scale of 1 – 10 with 1 being not at all satisfied and 10 being highly satisfied, rate your satisfaction with each of the following aspects of the program. Please provide any comments on each aspect.
 - . Information management functional area
 - . Education functional area
 - . QA/QI functional area
 - . Leadership and coordination
 - . Preconception initiative
 - . The way the program is addressing LBW
 - . How satisfied you are with your involvement in the APHP?

Perinatal Health Issues

6. From your perspective, what are the three most important perinatal health issues in your region?
7. Do you think the APHP is addressing these/your issues?
8. How might the APHP best help you to address these issues?

Structures

9. What APHP committees do you sit on?
10. How effective do you think the APHP committee structures are? What is working for you? What could be improved?
11. Should alternative meeting formats/frequencies be considered? If yes, what are your suggestions?

