PHN-PREP

McMaster University

Impacts of the COVID-19 pandemic on Ontario's Public Health Home Visitation Programs for Families with Young Children: An Environmental Scan

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Executive Summary

Background

Since the declaration of the global pandemic by the World Health Organization (WHO) on March 11, 2020[1], Ontario public health units have provided significant leadership in supporting communities to respond to the COVID-19 pandemic. However, with the needs to a) engage public health staff in contact tracing, phone line management, and case management work and b) adhere to public health measures in an effort to limit the transmission of the SARS-CoV-2 virus; traditional delivery of public health programs and services, including the home visiting programs Healthy Babies, Healthy Children (HBHC) and Nurse-Family Partnership (NFP), have been impacted in many public health units.

Home visiting programs provide important health promotion and disease prevention services to families with young children. During pandemics, rates of child maltreatment, intimate partner violence, mental health issues, stress, and substance use increase[2,3] In Ontario, during the initial COVID-19 lockdown, families have reported experiencing multiple stressors and that physical and social distancing measures have negatively impacted parents' mental health and children's behaviour and well-being.[4] This highlights that during this period of time, critical public health supports are needed by families.

Environmental Scan

To understand the impact of the COVID-19 pandemic on home visitation programming and service delivery, an environmental scan of Ontario's 34 HBHC and 5 NFP programs was completed. In December 2020, managers and supervisors representing each of these home visiting programs units were invited to complete a survey responding to questions about the delivery of home visiting between March and December 2020. Responses from 39 programs, reflecting a 100% response rate, were received. Additionally, 9 virtual group discussions were held in November and December 2020 to develop a deeper understanding of public health nurses' experiences of home visiting and providing outreach services to families during the pandemic.

Key Findings

The COVID-19 pandemic and public health response had a significant impact on HBHC and NFP service delivery. The home vising workforce was impacted by redeployment with the majority of Ontario's HBHC programs providing public health nurses to deliver services in other programs as part of the COVID-19 response. This redeployment, unsurprisingly, affected the overall capacity to provide home visiting including a decrease in overall services, in-person or blended visits, and capacity for completing in-depth assessments. It also increased some programs' reliance on family home visitors and the caseloads of remaining nurses. Many health units ultimately prioritized or triaged services toward families experiencing the greatest needs..

Response to the COVID-19 pandemic also resulted in changes to the 'home visiting' landscape. COVID-19 led to reduced in-person home visits and a shift toward new modes for 'meeting' with families. The majority of HBHC and NFP teams rapidly transitioned to offering some program services via interactive video conferencing, however this shift came with challenges related to both the technology itself (e.g., access to Wi-Fi and video conferencing equipment) and overall receptivity to virtual home visits – particularly related to client safety while communicating in the online environment and the ability to conduct aspects of home visiting programming with similar fidelity to in-person encounters.

Despite the rapid onset of the COVID-19 pandemic and the initial public health measures, as well as the ever-changing landscape, many HBHC and NFP programs pivoted and developed innovative strategies to deal with the challenges outlined in this report.

Concluding Key Themes

Taking into consideration the constantly evolving changes to service delivery that the public health response to the COVID-19 pandemic brings, several key themes were identified that serve as important points for reflection by public health units and home visitation programs.

These key themes include:

- ensuring the home visiting workforce and their programming remain available to families disproportionately affected by the COVID-19 pandemic,
- prioritizing the public health nursing home visiting workforce to ensure that professionals skilled in assessment, intervention, and system navigations are able to identify and respond to the complex challenges experienced by families,
- providing high quality reflective supervision and opportunities for peer debriefing as strategy to address practice challenges and to reduce stress among the workforce,
- creating networks amongst other programs and services providing support to families,
- ensuring robust referral pathways into the program and to additional supports where needed,
- developing guidance to address the challenges raised in this environmental scan to support home visiting practice moving forward,
- planning for a post-pandemic context where families are provided with options that align with their preferences (and availability of resources) on how they connect with public health nurses and family home visitors (e.g., in-person or flexibility to tailor mode to client situation), and
- equipping families with the resources required to engage in virtual programming, and from an equity lens, consideration to how the digital divide can be minimized among families.

Impacts of the COVID-19 pandemic on Ontario's Public Health Home Visitation Programs for Families with Young Children: An Environmental Scan

The COVID-19 pandemic imposed sudden and unprecedented levels of stress and adversity on the global population. Since the declaration of the pandemic by the World Health Organization (WHO) on March 11, 2020[1,] efforts to limit the transmission of the SARS-CoV-2 virus have included the implementation of a range of public health measures at global, federal, provincial/territorial and local levels. In Ontario, from mid-March to the beginning of June 2020 (introduction of Stage 2 reopening)[5] the COVID-19 pandemic resulted in closures of schools and daycares, as well as a broad range of services and businesses. From June to November 2020, a phased approach to the reopening of services and businesses was adopted depending on geographic region.[6] Throughout these periods, a significant portion of the workforce shifted to reduce in-person operations or implemented remote work from home routines. For many health care professionals working in public health units, this shift has also included delivering health promotion or disease prevention services through remote or virtual telehealth mechanisms. For public health staff who continued to provide in-person services, COVID-19 infection prevention and control practices have required programs to adapt existing services to maintain the safety of clients, families and staff.

Ontario's 34 public health units provide a range of services and supports, including home visits from public health nurses and family home visitors, to families with children from birth up to their transition to school through the provincial Healthy Babies Healthy Children (HBHC)[7] program. Five of these public health units also deliver the Nurse-Family Partnership (NFP)[8] program, which specifically serves young (typically, <24 years), first-time mothers experiencing social and economic disadvantage. Eligible women must enroll in the program early in pregnancy (<28 weeks gestation) and receive regular visits from a public health nurse until the child's second birthday.

Home visiting programs provide important health promotion and disease prevention services to families with young children. During pandemics, rates of child maltreatment, intimate partner violence, mental health issues, stress, and substance use increase.[2,3] In Ontario, during the initial COVID-19 lockdown, families have reported experiencing multiple stressors and that physical and social distancing measures have negatively impacted parents' mental health and children's behaviour and well-being.[4] This highlights that during this period of time, critical public health supports are needed by families.

Environmental Scan: Purpose and Methods

The purpose of this report is to provide an overview of service delivery adaptations and challenges within HBHC and NFP programs that occurred between March and December 19, 2020 due to the COVID-19 pandemic and public health response. Managers and supervisors of 34 HBHC and five NFP programs from 34 Ontario public health units were invited to participate in the survey. One response per public health unit was requested, with in-house consultation amongst team members permitted. Among managers/supervisors who consulted with their teams to complete the survey, they consulted with a mean of 2.3 team members (range 1-6 people). There was 100% participation, with all programs completing the survey. From November 2020 to December 2020, 9 virtual group discussions were held to develop a deeper understanding of public health nurses' experiences of home visiting and providing outreach services to families during the pandemic. Illustrative quotes from these discussions have been included in this report to provide additional detail about the context of the nurses' practice.

The COVID-19 Pandemic had a significant impact on HBHC and NFP service delivery.

I. Impact of the COVID-19 pandemic on the Home Visiting Workforce

REDEPLOYMENT

The majority of Ontario's HBHC programs were required to redeploy public health nurses to deliver services in other programs as part of the COVID-19 response

When asked about redeployment of the public health nursing workforce within HBHC from March 2020 to June 2020, the majority of health units indicated that one or more HBHC nurses were redeployed to work in another department or program (**97.1%**). Among HBHC teams impacted by reduced workforce, most (**70%**) reported that more than half of their HBHC public health nursing workforce was redeployed. These patterns persisted after July 2020, with only one public health unit reporting no impact of the COVID-19 pandemic on the public health nursing workforce during this time period, and only a slight decrease in the percent of the nursing workforce redeployed to other programs.

Redeployment affected home visiting services

Not surprisingly, redeployments affected overall capacity for home visiting with more than half of the respondents (18 public health units) indicating that home visits were reduced by more than **50%** by HBHC public health nurses. When providing specific comments regarding the impact of redeployment on the home visitation component of HBHC, several themes were noted:

Decreasing:

- Overall services
- In-person and blended visits
- Capacity for in-depth assessment

Increasing:

- Reliance on family home visitors
- Caseloads for non-deployed staff
- Need to prioritize/triage services

There was less of a disruption to home visitation within the NFP program with 2 public health units reporting no reduction in home visitation and 3 reporting a reduction of only **20%** or less.

In many health units, there was a commitment to delivering some level of continued programming, in which some HBHC public health nurses were redeployed to the COVID-19 response, leaving a small number of public health nurses to serve HBHC clients.

Rationale for redeploying HBHC public health nurses to other programs

- Recognition that HBHC core staff are necessary to meet the public health mandate for families, or, in other words, these staff were deemed NOT deployable
- Identification that delivery of the HBHC program to families was considered PART OF a public health response to COVID-19
- Recognition of the need to mitigate factors associated with risk during the pandemic – mental health issues, growth and developmental delays, lack of support, intimate partner violence, etc.
- Prioritization of public health nurse home visits and supports for clients in high-risk situations
- Recognition of the need to support the most vulnerable families – approximately 70% of nurses' caseloads for one health unit were Black, Indigenous, or people of colour, and 30% of families had child protection involvement

Fewer public health nurses working in the NFP program experienced redeployment as visits for families disproportionately impacted by COVID-19 were prioritized.

Among the 5 NFP teams, fewer public health nurses were redeployed to other programs. Four of the NFP teams reported nurse redeployment rates between **0-40%** of the workforce. Only one NFP team reported that **50%** of their public health nurse workforce was redeployed. Despite redeployment within some NFP programs, most NFP teams reported that home visits were reduced by no more than **20%** (3/4 reporting; and one reporting no reduction in home visits).

Rationale for limited to no redeployment of public health nurses from the NFP program

- Senior public health leadership supported the prioritization of programming for those families at high-risk for a range of social, health or economic disadvantages. There was recognition that NFP clients are among the most vulnerable families served by public health home visiting programs.
- NFP was considered an essential component of the COVID-19 response.
- NFP was identified as an effective intervention to address and mitigate risks/harms resulting from COVID-19 and related public health measures.

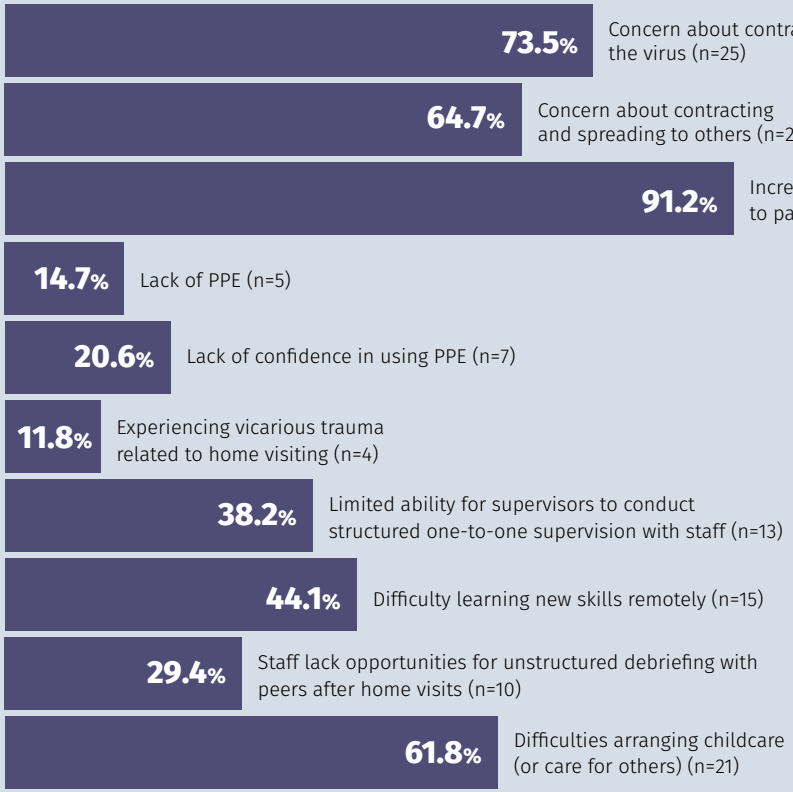
WORKFORCE CHALLENGES

There were numerous workforce challenges due to COVID-19

Several workforce challenges were noted for both HBHC and NFP teams as a result of the COVID-19 pandemic. Most public health units identified providing education to new and existing staff as a major challenge (**65%**), as well as providing opportunities for debriefing (**59%**) and reorienting staff back to the program after redeployment (**50%**) or orienting new staff (**56%**). Several public health units indicated that staff attrition (resignations or leaving the program; **38%**) or extended leaves of absence (**29%**) were major challenges.

NFP programs experienced similar challenges; with staff attrition and difficulties providing reflective supervision noted as the most prominent. When asked about what perceived factors were contributing to workforce challenges, concerns about contracting and spreading the virus and increased stress related to the pandemic were the most frequent responses.

PERCEIVED FACTORS CONTRIBUTING TO COVID-19 CHALLENGES (HBHC)

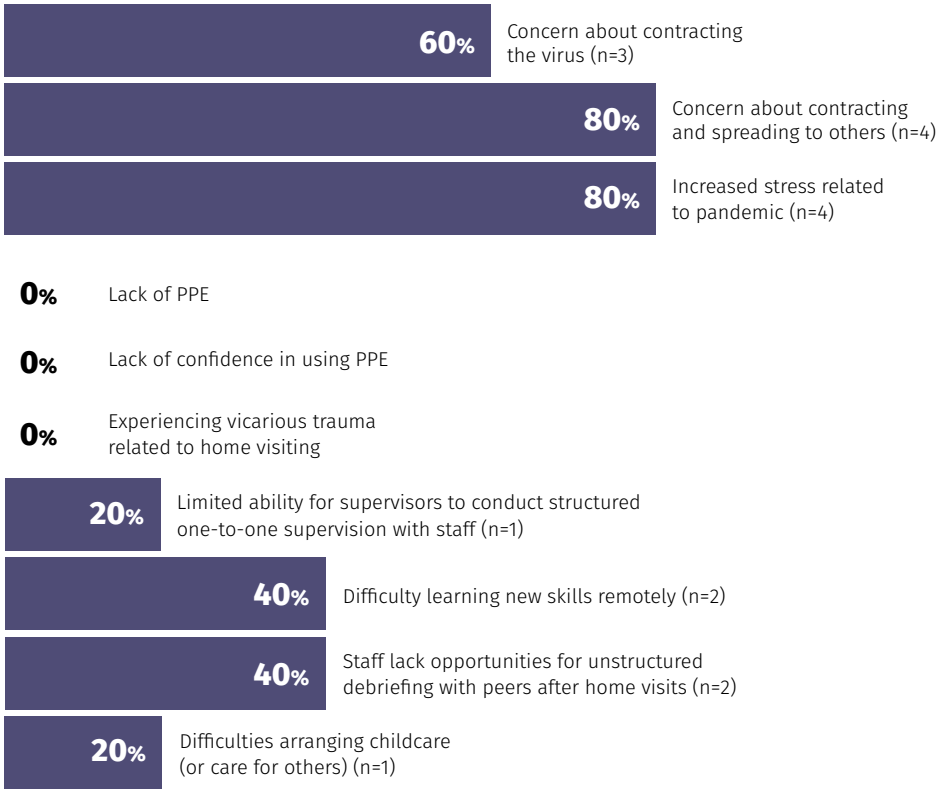


Other challenges noted included:

- Adaptation of most policies/procedures for COVID-19 context
- HBHC staff assumed responsibility for other program functions/activities
- Nurse experiences of burnout/stress related to balancing work and childcare
- Increased complexity of client needs and circumstances
- Public health nurses leave positions; positions remain vacant resulting in increased workload for remaining staff
- Unable to shadow home visits
- Delivery of reflective supervision between supervisors and nurses; often difficult to read cues in a virtual environment
- Ergonomic issues related to working in home environment
- When working within two programs, difficult to meet needs of both
- Impacts on mental health

"We really relied on [family home visitors] to keep that *connection with the families* and then they provide a great segue again when, when we reconnect after a few months with the client. You know we're, we're up to date because the family visitors have been keeping us *in the loop*. So … I think it's not as *challenging* when you've got the family visitor that's continued the involvement."
-HBHC Public Health Nurse

PERCEIVED FACTORS CONTRIBUTING TO COVID-19 CHALLENGES (NFP)



Impact of COVID-19 home visiting policies on the Family Home Visitor Workforce

Fewer HBHC family home visitors were redeployed. Just over half of the public health units indicated that family home visitors were redeployed, with four indicating that there was a reduction in hours allocated to HBHC, and about one-quarter (9/34) indicating that there was no impact of COVID-19 on the family home visitor workforce. A quarter of public health units noted 'other' impacts of COVID-19 on this workforce including emergency leaves by family home visitors and those who were initially redeployed but were brought back to the HBHC program.

26.5% (n=9) health units reported no impact on workforce

11.8% (n=4) health units indicated one or more HBHC family home visitors had reduced hours allocated to HBHC

55.9% (n=19) health units indicated that HBHC family home visitors were redeployed to other programs

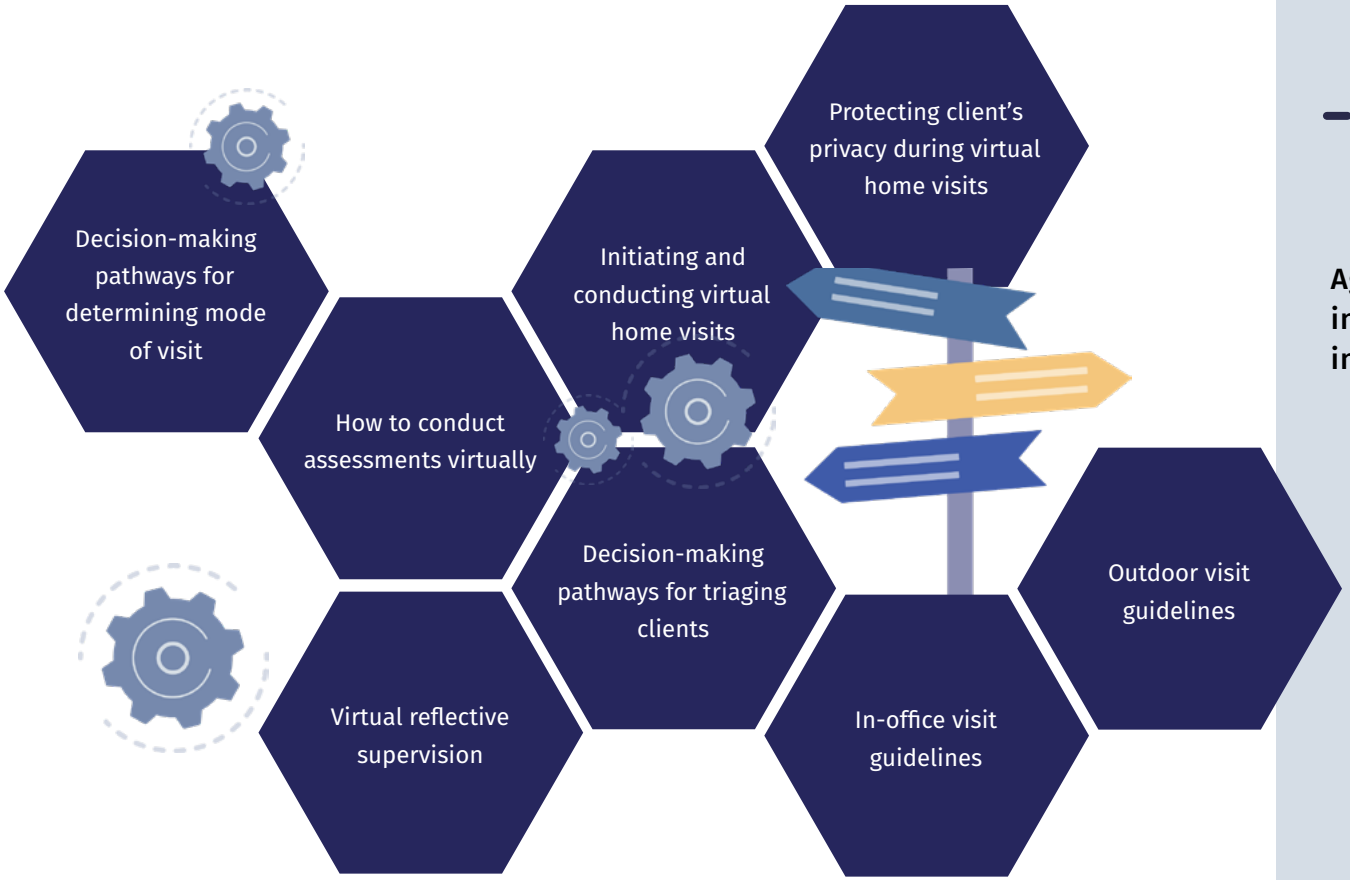
23.5% (n=8) health units selected the "other" response and provided comments including:

- one or more family home visitors chose to go on emergency-related leave due to childcare or other personal issues
- family home visitors received added workload to normal duties - assisted with focus on mental health support for families; had grab and go PIPE kits
- continued to develop PIPE lesson plans
- some were partially redeployed but returned in June and conducted outdoor visits.

In the face of these challenges, several innovations were developed

Numerous innovations were noted to address challenges. These included modified visits (virtual and telephone visits) and relying on other programs to provide some services as well as greater involvement of family home visitors. To address concerns related to the COVID-19 virus, many public health units developed or adapted COVID-19 screening protocols and standardized operating protocols to guide decisions around conducting home visits. Others developed guidelines for COVID Personal Protection Equipment (PPE), criteria for in-person visits and protocols and guidance around outdoor visits.

Specific policies or practice guidelines that public health units identified as devoloping or updating since the start of the COVID-19 pandemic included:



NFP specific innovations included the creation of:

- virtual service standards
- guidelines for adapting delivery of NFP content virtually
- guidance for COVID-19 symptom screening for in-person visits
- Infection Prevention and Control guidance for in-person visiting
- virtual platforms for team meetings and supervision

Agency wide employee health initiatives in several health units included:

- virtual coffee breaks
- newsletters, and
- self-care challenges

II. Impact of the COVID-19 pandemic on the 'home visiting' landscape

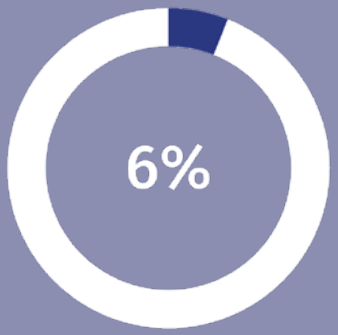
Response to the COVID-19 pandemic resulted in changes to the 'home visiting' landscape

Efforts to limit the transmission of COVID-19 required public health nurses to simultaneously shift from in-person visits to alternative modes of meeting clients AND for many, to working from home.

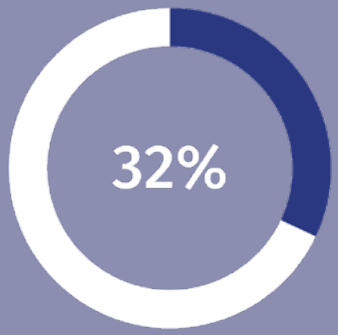
COVID-19 led to reduced in-person home visits

When asked about current policies regarding in-person visits by HBHC public health nurses, the majority of public health units (**76.5%**) indicated they were recommending or requiring the reduction of HBHC in-person home visits.

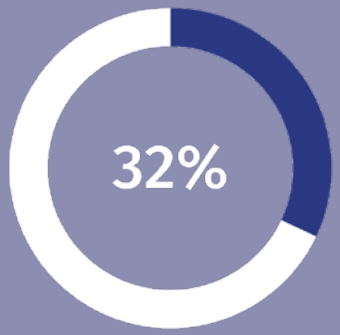
In response to the question, *"in light of the COVID-19 pandemic, what is your health unit's current policy regarding in-person home visits by a HBHC public health nurse?":*



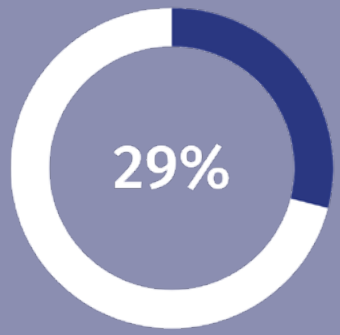
Did not restrict nurses from making in-person visits



Required or recommended stopping all in-person home visits



Recommended cutting back on in-person home visits



Selected the 'other' option:

- Between March-December, policies changed over time,
- In-person visits were only held when deemed necessary, outdoor only visits were recommended,
- In-person visits could not be managed due to redeployment of a significant number of nurses.

For the NFP public health nurses, almost all programs (**80%**) were recommending or requiring the restriction of in-person home visits with visits only allowed for exceptional circumstances, or if the visits occurred outdoors.

COVID-19 shifted the public health nurse's 'home base' from the health unit to their own home

Office-based work was also impacted, with **60%** of public health units indicating that staff were not permitted to work in the office and could only come in for administrative purposes (i.e., printing) or under exceptional circumstances to hold a visit at the office.

60%
of public health units did not permit staff to work in the office

76.5%
of public health units recommended or required the reduction of HBHC in-person home visits

80%
of public health units recommended or required the reduction of NFP in-person home visits.

Reasons for restrictions included: concerns for staff and client safety related COVID-19 transmission.

In-person visits allowed for exceptional circumstances and if certain criteria were met.

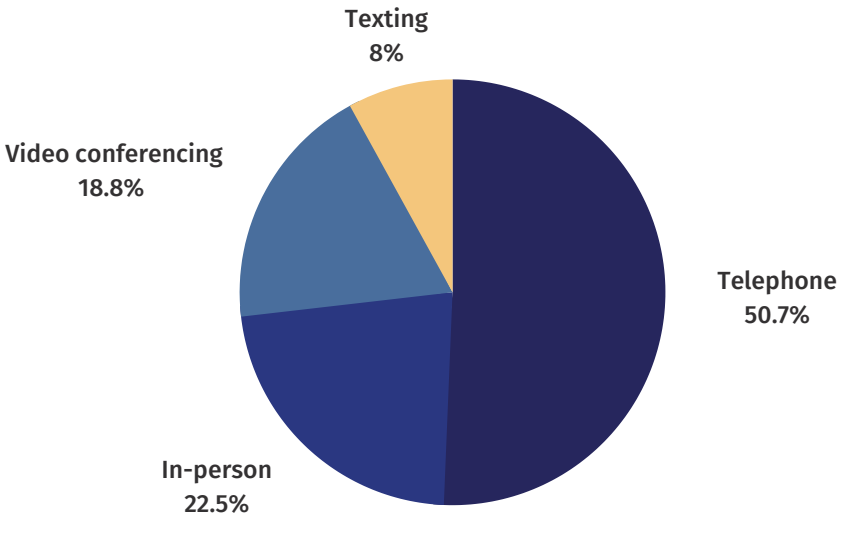
In place of in-person home visits, public health nurses were encouraged to offer phone or virtual home visits.

"Our family home visitors expressed that they were feeling rather *isolated* because they *weren't in the office* and were unsure what everyone was *doing* so then we, we restarted those kind of debrief, touch base about every 2 weeks just so that they could see each other as well and touch base with how their visits are going. So, it was the *worry of isolation* for us with our team." **-HBHC Public Health Nurse**

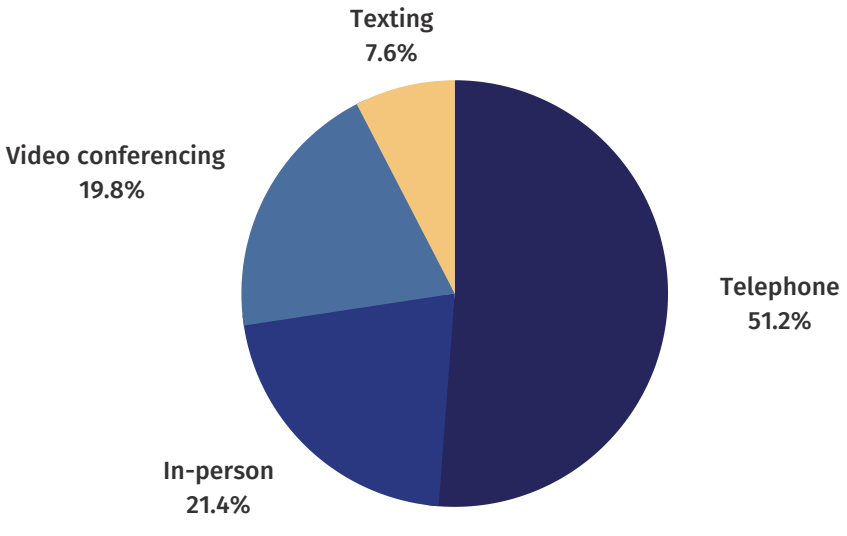
"I have to say personally I find doing this work now *isolating for myself*. Like because *before* you would come into the office, you would, you know, do you morning *chat connection*, and then we would *carry on* and do our *work*. So, I'm finding that that's not happening right now. But our managers have now established a routine for, for *team meetings* and they've become more *structured* and we're meeting more regularly. So, I find that better. But still, that part, that collegial interaction that used to happen is not happening as regularly as it had been when we were in the office." **-Public Health Nurse**

Reduced in-person home visits resulted in home visiting program staff using a variety of communication modes to 'meet' with families

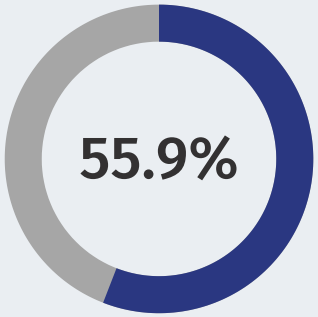
HBHC VISIT AND OUTREACH MODES



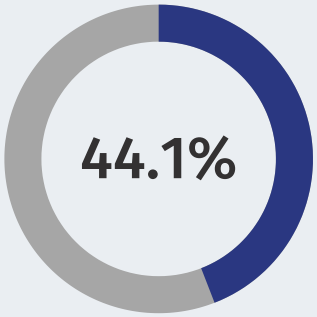
NFP VISIT AND OUTREACH MODES



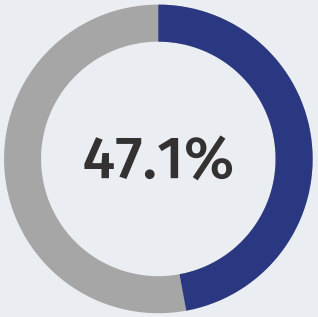
For in-person visits, HBHC programs reported that encounters occurred in a range of places:



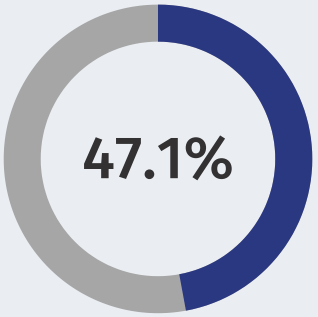
Outdoor public space



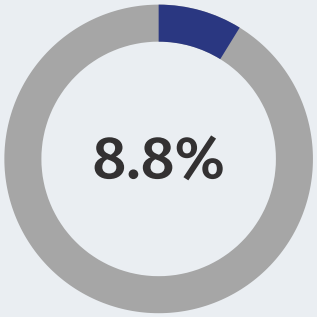
Walking visits



Outside client's home



In-home visits

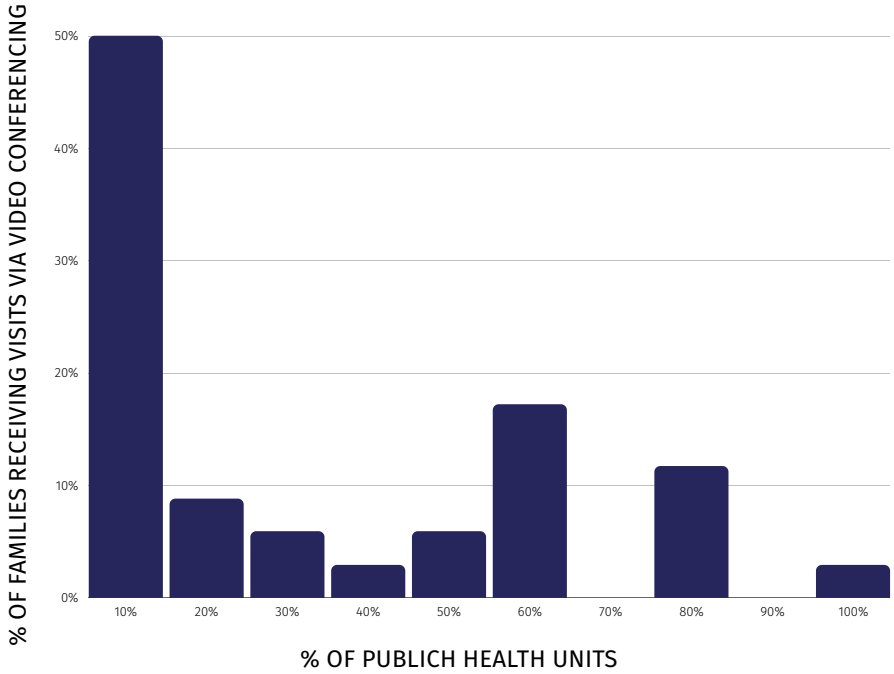


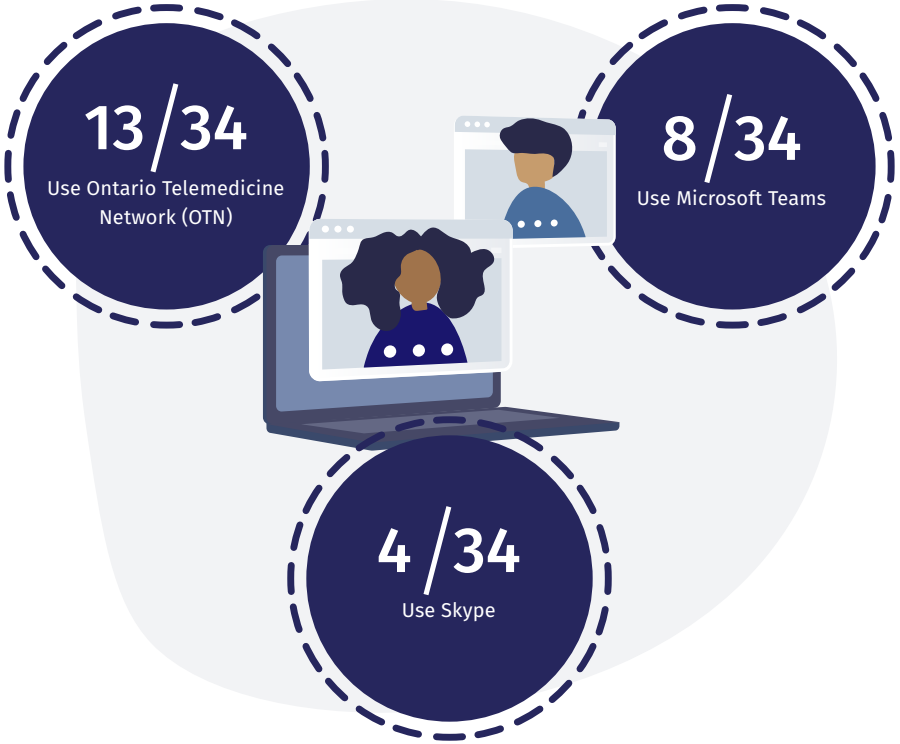
Indoor public space (e.g., library)

The majority of HBHC and NFP teams rapidly transitioned to offering some program services via interactive video conferencing

When asked about what percentage of HBHC families were receiving some home visits using interactive video conferencing, approximately half of public health units (**17/34**) reported **10%** or less of their families were receiving video 'home visits'. Nine public health units reported families receiving between **20-50%** of video conferencing visits, and eight reported that **60%** or more of the public health nurses were using video conferencing to conduct visits with families.

For the NFP teams, responses varied from **10-40%** of the videoconference home visits being used with families.





Across the province, there is not one consistent telehealth platform used by all 34 public health units.

The most used platform was Ontario Telemedicine Network (OTN) (**13/34**), followed by Microsoft Teams (**8/34**) and Skype (**4/34**). Other platforms listed included Google hangouts, Go to Meeting, WebEx, WhatsApp, Facetime, Blizz and Zoom with PHIPPA. Three HBHC programs did not report using any video conferencing platforms.

NFP teams most commonly used OTN (**3/5**), followed by Zoom (**1/5**) and WebEx (**1/5**).

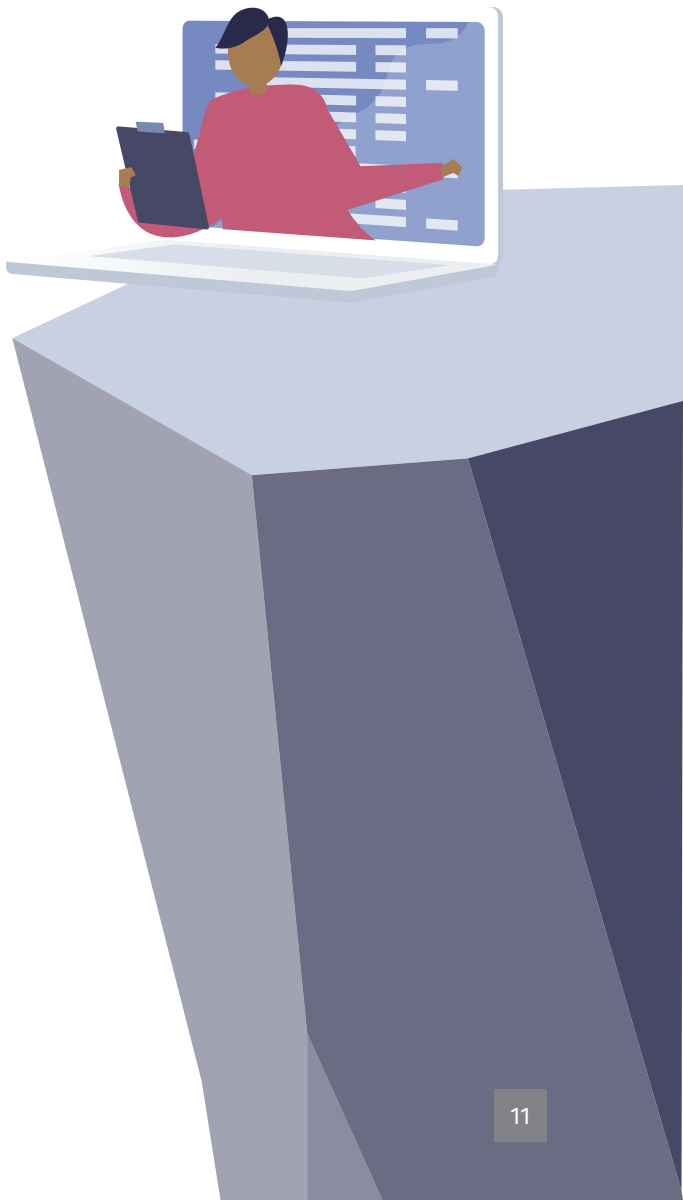
83.9% of public health units indicated that client accessibility to technology has impacted HBHC visits and 60% indicated an impact on NFP service delivery

Lack of access to data or devices was the most commonly cited reason. Families had limited financial means to increase data capacity. In addition, poor Wi-Fi connections were listed as an additional challenge, especially in rural/remote areas. Device restrictions included not having cameras to support OTN and cellphones not accepting the Google Chrome app needed for OTN.

Several challenges related to technology were noted from the perspective of public health nurses

Specific questions were asked regarding challenges that HBHC public health nurses may have encountered when using interactive video conferencing to replace in-person home visits. Major challenges were identified in conducting NCAST and PIPE assessments virtually and uncertainty around how to adapt and then deliver visit content for virtual visits. Challenges around lack of access to a stable internet connection, and discomfort around conducting virtual home visit were also noted.

The NFP teams identified client access to technology and reliable internet was the greatest challenge (**60%** reporting it as a "somewhat to major challenge"). For nurses, access to private space in their homes, training on virtual platforms, comfort levels and knowledge of how to adapt NFP content for virtual visits were noted as somewhat of a challenge (**20%**). No other major challenges were noted.



DIGITAL DIVIDE

83.9%
Indicated that client accessibility to technology has impacted HBHC visits

60%
Indicated that client accessibility to technology has impacted NFP service delivery

The % of health units identifying the following factors as "somewhat of a challenge" to "a major challenge" for HBHC teams are summarized below, also included are reasons why these factors were perceived to be challenging..

FACTOR	A MAJOR CHALLENGE (%)	SOMEWHAT OF A CHALLENGE (%)	WHY THIS WAS PERCEIVED AS A CHALLENGE
Uncertainty around conducting NCAST assessments virtually	45.1	25.8	• Clients feeling awkward in front of a camera • Difficulty reading cues and "feeling" the situation
Uncertainty around completing PIPE assessments	29	35.5	• Challenges in role modelling activities
Uncertainty around how to adapt visit content for virtual visits	19.4	38.7	• Adapting NCAST and ASQ • Lengthy interpreter visits • Challenging to address intimate partner violence
Uncertainty around how to conduct the in-depth assessment (IDA) virtually	19.4	16.1	• Perceived challenges of getting a true picture without face-to-face observations
Discomfort conducting virtual home visits	12.9	32.3	• Privacy concerns • Difficult to use and awkward • Challenge for breastfeeding visits • Shared spaces • Confidence increased over time
Lack of training on interactive video conferencing platforms	12.9	25.8	• Required self-teaching and/or learning on 'the fly' • Limited IT support • Lack of confidence • New processes for many public health nurses
Lack of private space outside of the office	12.9	22.6	• Sharing space with children and family • Needed to prepare to ensure privacy
Lack of access to a stable internet connection	9.7	39.1	• Low bandwidth from home • No access to requisite VPN • Rural areas with unstable or slow connections
Uncertainty around engaging clients virtually	9.7	26	• Difficulty reading non-verbal cues • Parents distracted by other children at home • Missed opportunities for teachable moments • Client's tendency to walk around with phone
Lack of access to the requisite equipment	9.7	6.5	• Not enough Zoom licenses • Lack of access to internet boosters or printer • Need for tablets and double screens.

Numerous challenges related to technology were noted regarding families' access to devices, reliable internet, and relevant platforms for virtual visits

Questions were also asked regarding perceived challenges that HBHC families may have encountered in using interactive video conferencing to replace in-person home visits. Lack of access to stable internet, required equipment, and access to video conferencing platforms, as well as knowledge to use these platforms were all noted as somewhat-to-major challenges for families. These same challenges were identified by NFP teams. When provided an opportunity to openly comment about challenges – the greatest concerns revolved around technology including access, training, connectivity, and difficulties engaging families over virtual platforms. Several additional challenges were noted including families losing interest in the program and discontinuing services, as well as challenges around language barriers – which is even more challenging without face-to-face or video interactions.

NFP teams reported challenges around the need for greater support and strategies needed with specific issues (e.g., assessing and responding to intimate partner violence or mental health concerns) when conducting virtual visits. It was also acknowledged that assessing the client's physical environment and child safety issues cannot adequately be conducted virtually. Finally, it was mentioned that some of the typical NFP assessments require direct observation or rely on body language and other nuances which are difficult to assess virtually or not at all by phone.

Families also experienced challenges in connecting virtually with their public health nurses.

FACTOR	A MAJOR CHALLENGE (%)	SOMEWHAT OF A CHALLENGE (%)	WHY THIS WAS PERCEIVED AS A CHALLENGE
Lack of stable internet access	38.4	48.4	• Families live in basement apartments with unstable Wi-Fi • Limited financial resources for larger data plans • Rural communities with limited connectivity.
Do not have equipment required	38.8	41.9	• Limited financial resources
Do not have video platform required	32.3	12.9	• Different apps needed depending on device • Only have a phone • Do not want to use video or download new apps.
Do not know how to use video conferencing platforms	9.7	51.6	• Difficult especially with language barriers and/or newcomers

Beyond technological challenges, teams perceived that many families did not feel comfortable or have the necessary privacy for engaging in virtual home visits

Home visiting teams felt that not all families were receptive to, or comfortable with a virtual home visit; with some clients voicing a preference for phone visits or disinterest in the program altogether if it was only delivered by remote modes (i.e., telephone or interactive video conferencing). Concerns around families finding private spaces, not trusting technology, or needing to balance childcare were also raised as somewhat or major challenges when conducting virtual home visits. For example, in regions with high proportions of intergenerational homes, ensuring privacy for virtual visits was an issue.

% of Public Health Units reporting that...

58.1%
Families are uncomfortable with virtual home visits

64.6%
Families indicated they were not interested in virtual home visits

64.5%
Families do not have safe/private space for virtual visits

Despite these challenges, some benefits to virtual video conference visits were noted. Managers and Supervisors indicated that benefits were observed for:

CLIENTS

- Save on bus or transportation costs
- Families appreciate not having to get house ready/clean for visit
- Increased active participation in the visit, when "coached" by public health nurse to complete tasks (as opposed to public health nurse/family home visitor taking over task in a visit)
- Increased confidence to contact public health nurse between visits with questions or concerns
- For some clients, virtual video conferencing is a natural/common form of communication, more engaged and "chatty" with public health nurse in comparison to in-person visits

PUBLIC HEALTH NURSES

- Increased time available for client contact due to efficiencies gained with reduced time travelling between clients
- Able to connect with families hesitant to have public health nurse in the home during COVID-19
- Fewer safety risks (e.g., from pets, unsafe home environments)
- Quality of interaction improved over past option of "phone support"
- Increased flexibility for scheduling, means seeing more clients, seeing some clients more frequently and more time for providing additional case management/referral supports for clients
- Virtual video conference (instead of phone visits) provide visual cues to non-verbal communication – can be useful for assessment i.e., NCAST and breastfeeding.

PROGRAM

- Reduced costs related to mileage and other expenses
- Increased number of interactions/visits completed with clients/day
- Reduction in number of "no-shows" or cancelled visits

Public Health Nurses are **saying...**

"What we've noticed now is many clients are used to virtual and do have the technology and are much more comfortable now with that way of receiving service. Because they are receiving that service from many of our other partners as well. So, I think for my team they would say to me IDAs go much better when you can have a virtual platform, absolutely 100%, because you can build that therapeutic relationship much better. And it is more challenging for sure over the phone."

"With virtual you can also share it, right? Like just, like screen share the ASQ itself which is what I always do. So, in advance I always know, okay, I'm going to be doing the 12-month ASQ, I have it prepped on my ... to, to do a screen share, and they follow along with me. Because there are those pictures, for example, on them that I find helpful during a visit, you know, so that they can look at it. But again, you need that virtual platform to do that."

"If I can get them seeing me face to face it does go so much ... You know I can develop that relationship a bit faster than I would on the phone."

III. Impact of COVID-19 on Program Implementation

COVID-19 had a significant disruption on HBHC and NFP program implementation. Public health nurses reported disruptions in both the HBHC and NFP referral pathways and experienced increased difficulty in contacting and engaging families in program services

REFERRALS

67.6% of public health units reported disruptions to HBHC referral pathways

60% of NFP teams reported disruptions to referral pathways (both into the program and nurse referrals to other community supports/services for clients)

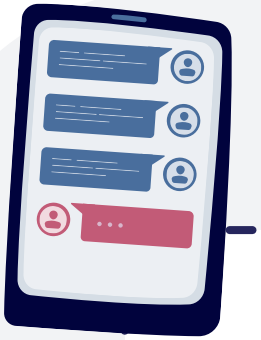
Factors that impacted referral pathways:

- Removal of some HBHC hospital liaison nurses impacted postpartum referrals to public health
- During the early days of the pandemic, a number of services that would typically send referrals to the NFP program were operating at a reduced capacity or not at all. For example, with school closures and virtual learning, there was a decrease in referrals from the School Health program
- Limited opportunities to refer HBHC clients to other community agencies that were also experiencing service reductions, cessation of programs, lengthy waitlists or limited ability to provide supports (e.g., infant/child development assessments virtually)

"We don't have our liaison nurse going in to see clients or seeing clients at the hospital and *starting that*. And that's something I'm finding as I try to reach out and start my contacts with clients that we're really *missing*, especially for those *higher risk* because often our liaison nurse would start her assessment and give us that, that knowledge *before we're making the phone calls*. So, we had a little bit more information behind us and kind of *knew* how to navigate things to best meet the client's needs in a much more efficient way." **-Public Health Nurse**

"I truly miss the HBHC liaison - being able to have information particularly about something that's happening in the family unit *itself*. Like the client may *need* some relationship support. Or they may have seen something in hospital and reported to the liaison nurse that becomes a valuable piece for us moving forward. Or even something like knowing... It just seems that things get *missed* that would be valuable to us in terms of maybe this client doesn't have a secure residence and they're, they're going from place to place. So, we need to *know those things* so that we can maybe work a little bit more to try to make contact with people that might really need us, you know, a little bit more than somebody else does." **-Public Health Nurse**

REACHING AND ENGAGING CLIENTS



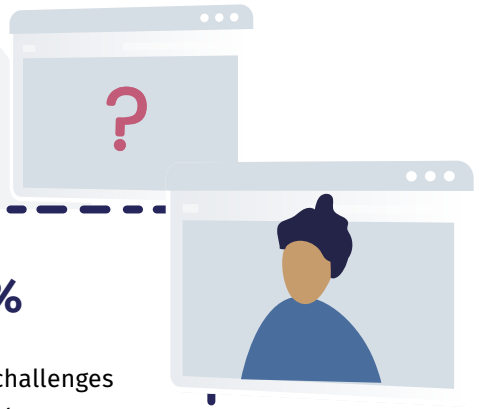
62%

of HBHC teams reported challenges in reaching clients

"So one thing that I find that helps that's pretty simple is just the fact that when I call the [names Region] will come up on their call display. Because I'm finding like nowadays...people are a little bit reluctant to talk to us like are we really nurses and I really don't want to tell you personal information because I want to kind of fact check who you are." **-Public Health Nurse**

Factors that limited initial contact and engagement

- Suspicion that the public health nurse is a fraudulent caller
- Clients do not answer their phones or return messages
- High client anxiety related to in-person home visits
- Increased family stressors related to COVID-19
- Inability for nurse to conduct "drop-by" visit
- Limited access to electronic devices or reliable Internet

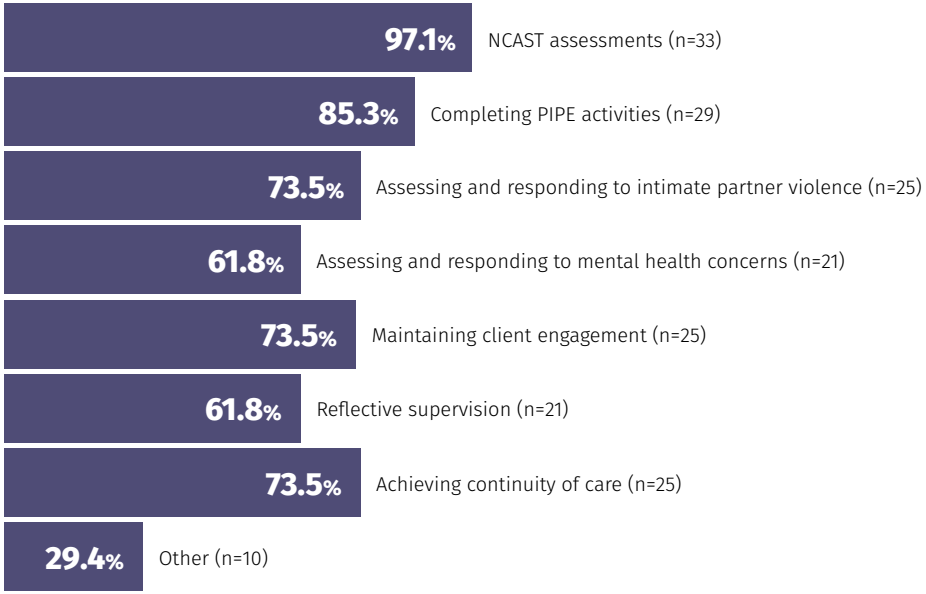


100%

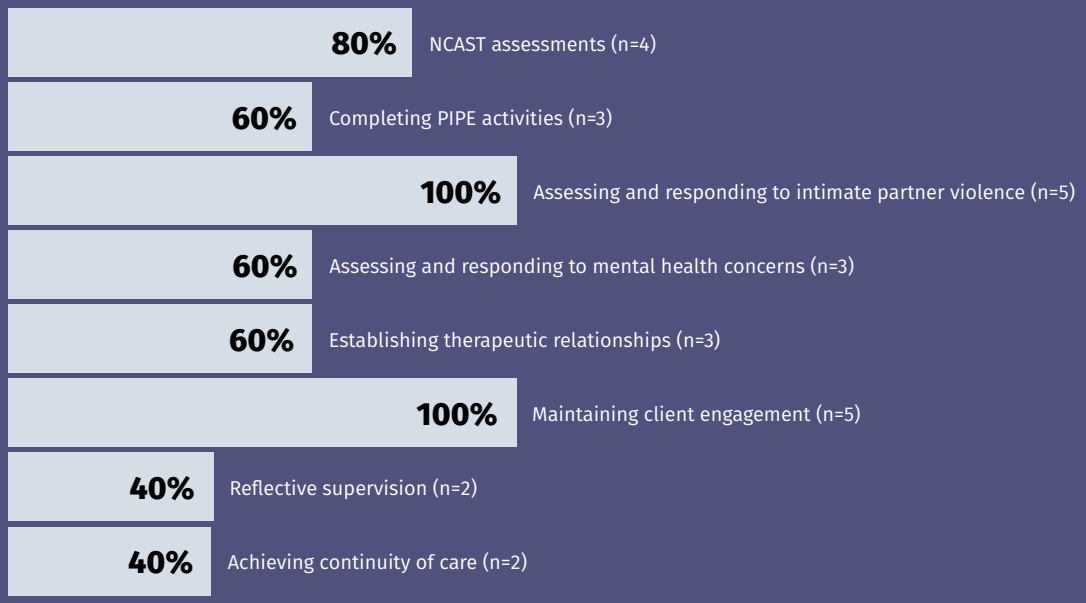
of NFP teams reported challenges in reaching clients

Program staff experienced challenges in delivering multiple program components

HBHC

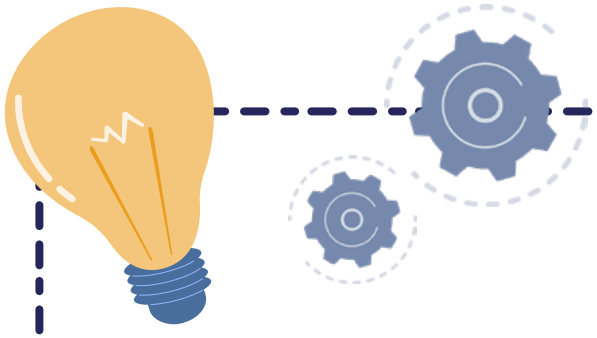


NFP



Impact of COVID-19 on delivery of key components of HBHC and NFP programs.

The majority of HBHC and NFP teams reported high levels of disruption across all key components of the programs. The biggest challenge was related to conducting NCAST assessments, followed by completion of PIPE activities and assessing and responding to intimate partner violence. Not surprisingly, given the high-risk nature of NFP clients, maintaining client engagement was reported as a significant challenge with all teams indicating this was an issue. Other challenges that were noted were all related to implementing aspects of the program which typically required a more 'hands on' approach for example, role modeling, breastfeeding support, and monitoring child growth and development by visual assessment.



Some of the greatest challenges, present new opportunities for innovation.

Despite the rapid onset of the COVID-19 pandemic and the initial public health measures, as well as the everchanging landscape, many HBHC and NFP programs pivoted and developed innovative strategies to deal with the challenges outlined in this report.

"The other positive I would add too is that we are going to be starting actually probably next week, we're going to have our interpreters who have always been wonderful and supporting our service by phone. They're actually going to be able to join our virtual platform now for all of our visits. So, I think that for the staff that will make doing assessments so much better in terms of having that interpreter on, the client being able to visually see them. You know and again it's just building that rapport. Oftentimes for some of our languages that are more difficult to find an interpreter for the clients do get used to them because they have the same interpreter over and over again. So, I think that will be a really great addition to our practice." **-Public Health Nurse**

"accept what the clients would want. Because I think some would jump at it and say yes I want a home visit; and maybe some people are more hesitant then you just kind of go with that. I know that we're using virtual. It may be the way of the future and I would hope that we can keep virtual and have access to that. Why? There are days when the clients may prefer that. There are days when you have bad weather days in the winter. Instead of not going for a home visit we could offer virtual." **-Public Health Nurse**

Accelerated development of local policies and procedures to integrate virtual visits into practice

- In-service education to staff on navigating and conducting virtual visits
- OTN flow maps and resources to facilitate staff use of different platforms
- Virtual service standards and HBHC virtual service guidelines – including templates and scripts to service provision and instructional manuals for staff and clients.
- Increased sharing of resources (including policies, evidence) and learning about delivering virtual care within teams, between public health units, and with other community agencies or providers such as EarlyON and family health teams

Opportunities to pilot innovative strategies for connecting and supporting families

- Development of virtual support groups (breastfeeding support, prenatal and parenting)
- Opportunities to develop individualized options for mode of service delivery for each family

Discussion

The findings of this report highlight both the challenges, as well as the innovation of public health units in delivering home visitation and outreach services to families during the COVID-19 pandemic in 2020. The rapid and unprecedented events of COVID-19 upended the delivery of HBHC and NFP programs across Ontario. Almost all public health units reported that one or more of their public health nurses were redeployed to other programs or services. This left a sparse workforce to attend to the significant and increasing challenges that families were confronting and continue to face. Many public health units implemented a triaging protocol to provide services to the most vulnerable families first. After the second and third phases of re-opening (during the summer months and early Fall 2020), many programs moved to outdoor visits; where driveways, parks and neighbourhood walks became the 'home' in home visiting.

Access to technology and reliable internet services were identified as major challenges facing the provision of services to families virtually. In addition, given the observational nature of many of the program assessments (i.e., NCAST, PIPE, breastfeeding), challenges were also noted in conducting these evaluations virtually and safely. Despite these difficulties, several public health units developed, or were in the process of developing innovative strategies to address these challenges.

Key Themes

Given the continuing and ever-changing impacts of the COVID-19 pandemic and public health responses on Ontario's home visitation programs, several key themes were identified that serve as important points for future reflection by stakeholders involved in delivering these programs. These include:

1. Efforts should be made to protect the HBHC and NFP workforce as services necessary to meet the health and social needs of families. Limiting future work disruptions and redeployment is important to ensure that adequate supports are available to families disproportionately affected by the COVID-19 pandemic.

2. When the blended model of home visiting cannot be maintained due to necessary redeployments to other programs, the maintenance of the public health nursing home visiting workforce should be prioritized to ensure that professionals skilled in assessment, intervention, and system navigation are able to identify and respond to families experiencing multiple, complex challenges – especially those that were amplified during the pandemic.

3. To address the digital divide and ensure equitable service delivery, devices and internet provision should be obtained for families engaging in programs requiring a shift to virtual programming.

4. Creation of referral networks with other community agencies that provide support and services to families to address gaps in services when reduction in home visiting services occur.

5. Referral pathways to home visiting programs should be evaluated to ensure a robust process of identifying eligible families that is resilient to redeployment. Similarly, clear referral pathways for additional services where needed (e.g., mental health services) should be established to ensure limited gaps in supportive services.

6. Rapid shifts to where, and how, HBHC and NFP teams provide care and services to families, within the context of a global pandemic, as well as emerging practice challenges increased stress among the workforce. During periods of transition when public health nurses and family home visitors are adapting their professional practice and work to correspond with new conditions, it is critical that teams continue to receive high-quality reflective supervision, opportunities for debriefing with peers, and scheduled time to connect and meet as a team.

7. To support home visiting nurses, guidance to address the challenges raised in this document need to be developed and made available across all 34 public health units.

8. In planning for a post-pandemic context, consideration could be given to offering flexibility and choice on how families connect with public health nurses and family home visitors, with options for in-person or video conferencing, or a blend of multiple modes of connecting. This will require organizational support and resources to ensure that home visiting teams have the technology, support, training, and skills to deliver services using multiple modes.

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