Using participatory methods

to create a logic model for

Healthiest Babies Possible

by

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RD, B.Sc., SFU, 2016

Capstone Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Health

in the
Masters of Public Health Program, Population Health Concentration
Faculty of Health Sciences

SIMON FRASER UNIVERSITY

Fall 2016

Approval

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Date Defended/Approved: December 12, 2016

Abstract

Healthiest Babies Possible (HBP) is a perinatal nutrition program that supports women facing challenging life circumstances in Vancouver and Richmond. The program has existed since 1976 and has undergone multiple changes to its service delivery model. HBP is now embarking on an evaluation that will be used for quality improvement and to identify best practices that can be shared with other service agencies. Stakeholder engagement and participatory methods have led to successful evaluation plans in similar programs. This document focuses on engaging with an Evaluation Stakeholder Workgroup (ESW) consisting of partners, HBP staff, patient advisors, leadership and funders, to create a program logic model. The program logic model is intended to form the basis of a future evaluation plan.

Keywords: Stakeholder engagement; patient engagement; evaluation; nutrition; perinatal nutrition

Dedication

In the first week of starting my Master's of Public Health, I was overwhelmed by an article I had to read for my *Social and Behavioral Contexts of Health and Disease* class. The article was about people who had different views in life; organic, mechanistic, and two other types which I have forgotten (or blocked out of my mind). I tried to read it, and re-read it. I read very slowly, and it took me forever. It was highly theoretical, and I couldn't make sense of it. I hated it. I started to question why I ever decided to go back to school, and why I would impose this torture on myself. I considered dropping out. And now here I am. I made it.

I couldn't have finished this degree without the help of my family and friends. First and foremost, to my husband Brad who encouraged me to go back to school. Who took a backseat while I spent evenings and weekends studying, and who chipped in far more than any husband I know in child-minding and household chores so that I could do my coursework to my own personal standard. I couldn't have done it without you.

To my parents Adrian and Aurelia, and my aunt Marinela, who gave us the financial support to keep my children in daycare and to ensure we had enough to pay bills and tuition. Who wanted only for me to succeed in life. We couldn't have done it without you.

To my children Gabriella and Roxanna. I switched my classes so that I didn't have to take night classes in first semester, so I could keep breastfeeding you Roxy. I'm sorry I couldn't avoid night classes after that, and for the times I didn't get to tuck you in at bedtime. I tried to do homework after you girls were asleep as much as possible so we still got our quality time together. I did it all for you, so that mommy could get a good job and afford a house. I did get that job, and we got the house (with the help of the family). Now I hope I will be more present with you, now that I won't be doing double shifts anymore.

Now for my family at Vancouver Native Health Society: to my role model David Tu who encouraged me to go back to school and specifically into the SFU MPH program. To Lou Demerais, Corinne Mitchell and the rest of the staff and clients, who gave me my hands on public health education in the DTES. Thanks to you, the

“innovative” public health philosophies taught in my MPH classes were already familiar to me. Other people are starting to realize what Indigenous people have known all along; your whole medicine wheel needs to be in balance to achieve health. Huy chexw!

To my professors, in particular Malcolm Steinberg, Paola Ardiles and Beth Snow, who helped me bridge practice and academia, and do my degree in a way that would best serve my career goals. Thank you for taking the time to guide me.

To my new family at VCH who believed in me and hired me as coordinator at Healthiest Babies Possible even though I came with a very different skill set, background and philosophy than previous coordinators. And who are coming along with me for the ride of this evaluation process. Thank you for believing in me.

And last but never least, to the Healthiest Babies Possible clients. I will do my best to serve you. To all of you I dedicate this publication.

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Acknowledgements

I would like to acknowledge the Healthiest Babies Possible Staff, partners, and patient advisors who participated on the Evaluation Stakeholder Workgroup to produce the logic model. Thank you for going on this exploratory journey with me in an attempt to improve services for pregnant and parenting women facing challenging circumstances in Vancouver and Richmond.

Agnes Luk (Support Worker, Healthiest Babies Possible, VCH)

Alison Westwood (Dietitian, Healthiest Babies Possible, VCH)

Anne Ling (Social Worker, BC Women's Hospital, PHSA)

Colleen Wickenheiser (CPNP Regional Lead, Public Health Agency of Canada)

Danielle Sangwais (Patient Advisor)

Karen Dunn (Clinical Coordinator, Youth Pregnancy & Parenting Program, VCH)

Linda Pearson (Social Worker, Building Blocks Vancouver & Healthiest Babies Possible/Youth Parenting Program, VCH)

Radhika Bhagat (Public Health Manager, Robert & Lily Lee Family Community Health Centre, VCH)

Rebecca Tibasimwe (Patient Advisor, Volunteer with the Youth Pregnancy & Parenting Program, VCH)

Stephanie Do (Patient Advisor)

Tracey White (Social Worker, Richmond Public Health, VCH)

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BCAFM	BC Association of Farmers' Markets
BCAPOPs	BC Association of Prenatal Outreach Programs
CPNP	Canadian Prenatal Nutrition Program
ESW	Evaluation Stakeholder Workgroup
HBP	Healthiest Babies Possible
HC	Health Canada
GWG	Gestational Weight Gain
IAP2	International Association of Public Participation
ISFR	Invitation to submit funding request
LBW	Low birth weight
LICO	Low income cut-off
MDD	Montreal Diet Dispensary
MoH	Ministry of Health
MPH	Masters of Public Health
PARIS	Primary Access Regional Information System
PHAC	Public Health Agency of Canada
PHN	Public Health Nurse
POPs	Prenatal Outreach Programs
SFU	Simon Fraser University
VCH	Vancouver Coastal Health
YPPP	Youth Pregnancy and Parenting Program

Patient Advisors Reviewing Logic Model (October 24, 2016)

“We do this work for the ones that are still coming” ~Elder Eugene Harry (XiQuelem)

Chapter 1. Introduction

An estimated 13% of British Columbians are food insecure, with even greater rates for single mothers, Aboriginal women, new immigrants, and those who with inadequate housing (Kurrein, Li & Rasali, 2016). These risk factors are associated with malnutrition during pregnancy, which can contribute to an increased risk of morbidity and mortality for the mother-baby dyad (Kurrein *et al.* 2016). For example, infants born to malnourished mothers may have increased risk for prematurity, low birth weight (LBW), cognitive, immune and respiratory impairment, and increased risk for developing chronic diseases later in life (Fall, 2013). Meanwhile malnourished mothers are at higher risk for obstetric complications such as preeclampsia and sepsis (Fall, 2013).

About 8,500 women give birth in Vancouver and Richmond every year (PSBC, 2016). Research suggests that women living in Vancouver/Richmond are at particularly high risk for food insecurity and malnutrition, as the average cost for healthy food is higher than in other urban areas in BC (Kurrein *et al.,* 2016, Lowell & Miller, 2010). Additionally, about one in twenty women in this region face additional challenges associated with poor birth outcomes such as maternal age under 24, inadequate access to health care services, or substance use (PSBC, 2016).

The consequence of malnutrition during pregnancy can be irreversible, preventing a child from ever reaching their genetic potential (HC & PHAC, 2016). Addressing the social determinants of health during a woman's pregnancy has proven to be more effective and cost-efficient than treating the downstream consequences of maternal malnutrition, which often require multiple interventions across the life course of the child (HC & PHAC, 2016). Healthiest Babies Possible (HBP) is a perinatal nutrition program that aims to improve the nutrition status of socially vulnerable pregnant women living in Vancouver and Richmond. A program evaluation was proposed to examine how and to what extent HBP is achieving its goals. Before examining the rationale for an evaluation in more detail, HBP's history and service model will be depicted.

1.1. HISTORY OF HEALTHIEST BABIES POSSIBLE

The inspiration for HBP can be traced to the Montreal Diet Dispensary (MDD), an organization initiated by volunteers in the late 1800's to distribute food and nutrition supplements to the low-income and medically compromised (Marquis, 2011). The MDD later incorporated nutrition counseling into the service model, and in the 1960's began focusing on supporting pregnant clients to help prevent LBW babies. In 1975, the Vancouver Health Board realized that prenatal services were not meeting the needs of Vancouver's socially vulnerable women, and embarked on developing a prenatal nutrition program modeled after the MDD (Marquis, 2011). The result was the formation of the HBP program in 1976 (Thompson, 1976). There are other programs in Canada also called HBP, but for the remainder of this document HBP will refer to the HBP program currently operated by Vancouver Coastal Health (VCH).

HBP initially employed a dietitian as a coordinator, and multilingual lay counselors that spoke the languages of the low-income immigrant populations prevalent in Vancouver (Marquis, 2011). The original model provided food and vitamin supplementation and one-on-one nutrition counseling delivered through home visits. Other communities in BC began to recognize the need for and benefits of this type of prenatal outreach program (POP), and similar programs began to appear across the province. In 1988 the BC Ministry of Health (MoH) began funding a handful of POPs (Marquis, 2011). A qualitative evaluation conducted in 1990 strongly suggested that POPs increased clients' self-efficacy to improve their own health and the health of their babies (Marquis, 2011). Thus, in 1991 the BC MoH decided to increase funding to start more POPs and to expand already existing programs such as HBP.

In 1994 the federal government initiated the Canadian Prenatal Nutrition Program (CPNP), with the aim of enhancing nutrition for pregnant women and new mothers who were facing challenging life circumstances (PHAC, 2011). Fittingly, HBP applied for CPNP funding. Archives show that after two failed attempts, HBP was successful in obtaining CPNP funding in 2000 (HBP Program Data). At that time HBP was a program of the Vancouver-Richmond Health Board, and thus decided to use some of the CPNP funds to expand services in to Richmond. Subsequently, the structure of healthcare in BC reorganized and HBP was folded into the newly formed health authority of VCH.

At the beginning of the millennium, primary care renewal became a priority for BC (MoH, 2007). Funding was released to enhance primary care, and in 2005 VCH was successful in receiving support to create a new maternity clinic for Vancouver's pregnant youth, later termed the Youth Pregnancy and Parenting Program (YPPP). YPPP clients were also able to access HBP staff and services for nutrition support, but had additional access to drug and alcohol counselors, youth counselor, doctors, and nurses who were available during clinic days. YPPP originally had its own cost-centre, but because there were so many similarities and shared resources between the two programs, YPPP was folded into HBP's larger budget in 2013 for logistical reasons.

Other changes that occurred over the years include the relocation of the program main office from Evergreen Community Health Centre (CHC) in the Collingwood neighbourhood to Robert and Lily Lee Family CHC in the Commercial Drive neighbourhood. Since the new program site was relocated to one of the city's most accessible hubs, the proportion of client visits to the CHC increased while the portion of home and community visits decreased. Additionally, the staffing mix changed overtime with the hiring of additional healthcare professionals including dietitians, nurses and social workers with a parallel displacement of some of the paraprofessional support workers

HBP originally worked exclusively with prenatal clients, but increased its scope to follow clients during the postpartum period in a group setting. The original postpartum follow up was six months, and was later extended to one year. Staff felt that providing opportunities for group interaction postpartum would allow clients to meet others and enhance their social support networks. They then further expanded the postpartum follow-up to 18 months for youth and Aboriginal clients, based on a perceived need and benefit of continued connection with health care services and enhanced food access for those who were deemed to be the highest need populations.

In terms of changes in client demographics, the most notable difference has been in the number of youth referred, which has more than tripled since YPPP's formation (Mills, 2011). Client demographics have also changed as a result of international politics and immigration trends, such as the recent influx of Syrian refugee clients. These external factors have impacted the need for language specific support

workers. Another trend observed over the last several years has been clients moving out of the program service delivery area to seek more affordable housing (SFU, 2008).

1.2. OVERVIEW OF CURRENT PROGRAM

1.2.1. Philosophy and mandate

HBP is a woman-centred program that uses a harm reduction philosophy in supporting women to have healthy pregnancies. The target population is Vancouver and Richmond women facing challenging life circumstances in the perinatal period. HBP has adopted the CPNP objectives, which were stated in the 2016 invitation to submit funding request (ISFR) as follows:

1. To improve the health of pregnant women and their infants facing conditions of risk by helping pregnant women and families improve their nutrition status and decrease substance use.

2. To strengthen maternal and family capacity, skills and social supports in the areas of: infant care, food skills, social support network, ability and access to services.

3. To strengthen capacity at the community level to address the public health needs of pregnant women, new mothers, and their infants facing conditions of risk.

1.2.2. Funding

HBP receives about $900K from VCH and about $150K from CPNP annually to support labour and non-labour related expenses. In addition, HBP receives other smaller short-term grants, food donations, and in-kind staff time and program space. The annual CPNP report for HBP reports the estimated in-kind donations for 2015-2016 were worth about $80K, from over 10 partner agencies. HBP employs approximately 13 full-time equivalents of staff, including a dietitian coordinator, clinical coordinator, public health nurse (PHN), doula coordinator, program assistant, three dietitians, eight cultural support workers, two clinical office assistants, four sessional physicians, and a contracted social worker. Volunteer, in-kind staff from other VCH departments (such as the public health dental program staff, PHNs etc.) and staff from agencies provided

approximately 2,700 hours of in-kind support to the program in 2015/2016 (HBP Program Data, 2016).

1.2.3. Service Delivery

HBP accepts referrals from a variety of sources including community services, healthcare providers, as well as self-referral. After clients are referred they go through an intake process where they are screened for social risk factors associated with poor pregnancy outcomes. Those deemed at-risk are triaged to a dietitian or support worker depending on client's age, language and medical diagnoses. The dietitian or support worker engages in one-to-one visits with pregnant clients on a bi-weekly basis. During visits, HBP staff provides nutrition counseling and other supports and referrals to address social determinants of health. For example they may help connect clients to a social worker to help with housing applications, financial support, or immigration issues. Visits occur at the CHC, in the client's home, or a community setting based on client preference. Clients are also invited to attend free prenatal classes provided by the program

Low-income clients (which account for about 90% of HBP's clientele) receive a $30 gift card at every prenatal visit, prenatal supplements, and transit tickets if needed. HBP's determination of low-income has recently changed. The previous benchmark was income less than the federal low-income cut-off (LICO) plus ten percent (Statistics Canada, 2014). In light of the increasing cost of housing and food, HBP now uses a calculation based on the 2016 living wage for Greater Vancouver (modified for family size), which results in a more generous cut-off point (PHSA, 2016; CCPA, 2016).

After the birth of the baby, clients have one final postpartum visit with their individual support worker or dietitian, and are then invited to remain connected to services though HBP postpartum groups. HBP runs seven different postpartum groups, some of which are language, culture, or age specific. Postpartum groups focus on parenting education often provided by a PHN. Low-income clients continue receiving grocery gift cards and transit tickets at group sessions.

Food is a central component of the program. In addition to providing meals or snacks at every group, food demonstrations and nutrition tips are incorporated to build food skills and food literacy. Clients are also invited to participate in community kitchens. Furthermore, HBP offers food access programs such as a monthly Good Food Bag and the seasonal Farmer's Market Nutrition Coupon Program (BCAFM, 2014).

Youth clients (under 25) living in Vancouver have the opportunity to participate in enhanced services, including access to a youth counselor, drug and alcohol counselor, and maternity doctors if needed. On Thursday afternoons, the YPPP prenatal clinic acts as a one-stop shop for youth to access a variety of healthcare professionals on one afternoon, as well as have a meal and a prenatal class if they are interested. After giving birth, Vancouver youth have continued access to counselors, a social worker and a nurse practitioner until their child is 18-months old, through a postpartum clinic that occurs on Mondays. Hot lunches and parenting classes are offered concurrently.

1.2.4. Client demographics

In the fiscal year 2015-2016, HBP received 448 new referrals and had about 750 perinatal women participating in the program (HBP program data, 2016). A breakdown of clients by social risk factor for poor birth outcome is shown in Table 1 below.

Table 1: HBP client demographic breakdown by risk factor 2015 - 2016

Risk Factor	Number of HBP Clients
Low-income women (income ≤ LICO + 10%)	670 (90%)
Youth < 25 years old	331 (44%)
Women facing substance use and/or addiction	90 (12%)
Women facing family violence	90 (12%)
Aboriginal women	135 (18%)
Recent immigrants or refugees	217 (29%)
Less than high school education	199 (27%)

Chapter 2. HBP and Evaluation

2.1. Justification for Evaluation

I was hired as coordinator of HBP in January 2016. With previous experience in health promotion for vulnerable populations, but no previous experience in POPs specifically, I had many questions about why things were being done the way they were, how HBP was measuring outcomes, and how clients were being impacted by the program. A new manager and director started around the same time, and had similar questions. Staff who had worked with HBP for varying lengths of time had conflicting opinions about program mandate, target population, staffing needs, and necessary versus superfluous program activities. It appeared that an evaluation would help clarify all the previous points, and also provide the opportunity to see which interventions were truly making a difference in the lives of the clients.

In June 2016, HBP was required to submit a funding request application and work plan for a continuation of CPNP funding for 2017 - 2020. After reviewing previous work plans, it appeared that there were no clearly defined HBP activities related to one of the three CPNP mandates; capacity building at the community level to address the public health needs of the target population. Although HBP staff had been providing staff education at ad-hoc internal VCH training events and participating on a VCH dietitians' committee around development of client hand-outs, the reach to build capacity for supporting vulnerable pregnant women did not appear to extend beyond VCH services.

HBP's solid reputation, broad reach and staying power suggests that it has an effective program model and operating philosophy that other service providers may wish to learn about. Since the ISFR required the development of a knowledge translation plan, it was conceived that HBP's best and promising practices could be synthesized

into a teaching module and shared with other agencies and professionals that work with the same population. Prior to developing the teaching module, best practices would have to be clearly identified and substantiated by evidence. Therefore, it was decided that HBP would undertake a rigorous evaluation. The objectives of the evaluation would be twofold: 1) For program quality improvement and 2) To identify best practices utilized by HBP.

2.2. Dual role of coordinator/evaluator

In 2016 HBP had a unique opportunity to embark on an evaluation given the new requirements of the CPNP contract, the curiosity of the new leadership team, and the requirement of the coordinator to complete a capstone project in part fulfillment for a MPH degree. The evaluation was initiated internally with myself (the coordinator) as both the primary intended user of the evaluation and evaluation lead. Part of the coordinator's role is to conduct continuous quality improvement. Since one of the objectives of the evaluation was to inform decisions for quality improvement, the work plan activities associated with evaluation were assigned to the coordinator as the staff person responsible. Because I was fairly new to VCH and to the program, with no prior relationship to any of the HBP staff, I felt like somewhat of an outsider and anticipated having the ability to remain relatively objective during the evaluation planning process. Furthermore, since conducting this portion of the evaluation was part of my degree requirements for my MPH, I attempted to use my student hat while working on the portion of the evaluation that is the focus of this document.

My role as the evaluation lead draws some parallels to what Miller *et al*. (2006) describe as "insourcing evaluation". Insourcing evaluation utilizes a mix of in-house and outsourced evaluation, considering low-cost options for external evaluators. In this case, since there was no extra budget for evaluation, HBP would likely rely on students to carryout a significant portion of the evaluation as part of their degree requirements. Other HBP staff members were not meant to have a major role in data collection and analysis, as not to place extra burden or detract them from their role of patient care.

To socially locate myself in this work, I am a married, middleclass Caucasian female in my mid-thirties. I have some similar lived experiences as HBP clients in that I am also a mother and have lived in both Richmond and Vancouver. In my youth, I faced some challenging life circumstances and suffered from malnutrition. Therefore, while I acknowledge the difference between my social location and that of HBP clients, I also feel that I could have been in a client's position or they could be in mine, given different circumstances. To illustrate, since working with HBP I have crossed paths with two women who I went to school with. We all grew up in two-parent middle-class families in the same neighbourhood. One former schoolmate was a physician for the YPPP clinic and the other was an HBP client facing conditions of social risk in her pregnancy.

2.3. Monitoring And Reporting

Other than a formative evaluation done in 1976 on the HBP pilot, a formal evaluation of the full scope of HBP services has not been performed (Thompson, 1976). HBP is constantly reviewing outcomes and outputs for ongoing reporting purposes, however Miller *et al.* (2006) argue that such internal evaluations driven by mandatory reporting requirements are often subjective and lack scientific rigour. Data sources for HBP ongoing monitoring and reporting include the electronic medical record system called Primary Access Regional Information Service (PARIS) as well as internally developed client surveys (VCH, 2006). Although these data sources provide large amounts of quantitative information, which are useful for monitoring and tracking trends, they also are subject to significant bias and error as highlighted below.

2.3.1. PARIS Data

PARIS is used for charting by most VCH Public Health service providers, including HBP staff. PARIS contains several standardized forms such as referral and assessment forms. The forms contain fillable fields from which data quantitative data can be extracted. Data available from PARIS ranges from patient demographics, to gestational weight gain (GWG), and birth outcomes. Additionally, overall volumes such as number of clients, client contacts, assessments and case notes per program are also available from PARIS.

Although it is fairly easy to extract large amounts of data from PARIS, the validity and reliability of the data is questionable. For example, in 2015-2016 demographic data for ethnicity was not entered for 7% of clients, while another 3% were entered as “other” because there was no appropriate field available in the pick-list and no ability to add new selections (HBP Program Data, 2016). Similar trends are seen with respect to language, education and other demographic elements.

Furthermore in the patient demographics module, there are several categories, which are not mutually exclusive. For example, a person of mixed Aboriginal and French heritage could be entered as: Canadian, Aboriginal, First Nations, Metis or Caucasian. The way the information is entered is subject to inter-rater discordance, as there are no standard rules for entering demographic information. Inter-rater reliability also impacts the quality of data retrieved from other vague and undefined fields related to social determinants of health on the PARIS referral form such as “financial stress” and “social isolation”.

Gaps in client information can introduce additional error into the data. For example a significant percentage of HBP clients are unsure of their pre-pregnancy weight. When this occurs, weight at initial prenatal visit is often used as a substituted. However, since pre-pregnancy weight affects the recommended total GWG, using the indicator of ‘total GWG within target range’ is subject to inaccuracies. Furthermore, the stage of pregnancy the clients enter the program and the number of client contacts also affects how much HBP can be expected to impact birth outcomes. Clients are often referred in their third trimester and as such, it is more difficult to attribute birth outcomes to HBP exposure.

2.3.2. Survey Data

Clients also have multiple opportunities to contribute feedback through surveys. Client surveys are done at the last one-to-one client visit, which is usually three weeks post-partum. The first half of the survey is intended for the client to fill out, while the corresponding staff member is to fill out second part for the survey based on her interactions with the client (see Appendix A). HBP also distributes quarterly evaluation surveys during group education sessions. All surveys are entered in Survey Monkey™

for data analysis (Collier, Johnson & Dellavalle, 2005). Because surveys are only available in English, they often require verbal translation from staff to clients. As surveys are usually done in the presence or with the help of staff that worked directly with the client, they are subject to social desirability bias. In addition, clients who exit the program early or who do not come to groups are not surveyed. Since the current practice is to only surveys people who are active clients in HBP, the data may be prone to self-selection and bias. Because of the two potential biases noted, it is likely that the survey data is positively skewed.

2.4. Relevant Evaluations

Understanding a program's prior experience with monitoring and evaluation provides insight to inform future evaluation planning (Patton, 2012). Relevant evaluations that might be applied to this exercise were sought using Medline and Google Scholar databases using the key terms: Prenatal OR Perinatal AND logic model OR evaluation; Nutrition AND logic model; CPNP AND logic model OR evaluation. Additionally, government and institutional websites were utilized to locate grey literature. Familiar literature from MPH coursework and well as internal reports from VCH and CPNP also informed this research.

The Public Health Agency of Canada (PHAC) has completed several large evaluations on the national impact of the CPNP, with the latest report published in 2016 (PHAC 2010; PHAC 2011; HC & PHAC, 2016). Similarly, BCAPOPs conducted a regional evaluation comparing data from all the CPNP programs in BC. The quantitative data that informed these evaluations was collected through analysis of questionnaires completed as part of the mandatory reporting for CPNP programs (PHAC 2010; PHAC 2011; HC & PHAC, 2016; 2016; SFU 2008). Although both federal and provincial evaluations reported positive outcomes with regards to the reach and health benefits associated with POPs, summative information about the overarching federal and provincial programs give little information about the local impacts of HBP. Miller *et al.* suggest that smaller scale programs require innovative and sustainable evaluation strategies that are separate from large summative evaluations (2006).

There are very few published evaluations of comprehensive prenatal programs with a social determinants of health focus (Hubberstey, Rutman, Hume, Van Bibber & Poole, 2015). Two published documents relating to evaluation of CPNP funded programs were located. The first is from a Vancouver program called Sheway, which published a comprehensive evaluation document in 2000, and the second is from the Healthy Mothers Healthy Babies program in Saskatoon, which published an evaluability assessment in 2004 (Poole, 2000; Bowen, 2004). In both cases, the evaluation plan was created through a participatory process. Sheway utilized an advisory council consisting of staff, clients, subject matter experts and partners (Poole, 2000). The advisory council ensured the evaluation was completed in such a way that aligned with Sheway's philosophy in that clients themselves would have a say in how information was gathered and utilized (Poole, 2000). For Healthy Mothers Healthy Babies, the evaluator created the logic model together with the staff. The logic model was then shared with clients and partners to see if the logic model aligned with their understanding of the program (Bowen, 2004).

Additional research revealed that two sub-components of HBP underwent an evaluation process, namely VCH's public health dental program for HBP clients, and YPPP (Lin & Harrison, 2010; Lin, Harrison, & Aleksejuniene, 2011; Mills, 2011). A key difference between these two evaluations is that the dental evaluation was carried out to completion while the YPPP evaluation was not. The dental program's evaluation was led by an internal staff person working on her Master's degree, while the YPPP evaluation was planned by a Master's student who was external (Lin & Harrison, 2010).

The internal evaluation lead for the dental hygiene partnership with HBP described her experience working as both an internal staff person and an evaluation lead. Perceived benefits included easy access to data, and having pre-existing relationships and trust with staff and clients (Lin & Harrison, 2010). The internal staff person also emphasized the need to use diplomacy and objectivity, to avoid letting pre-existing relationship bias the assessment (Lin & Harrison, 2010). Some challenges noted included the encroachment of evaluation-related work on regular duties (Lin & Harrison, 2010).

In the case of YPPP's attempt at evaluation, the clinical coordinator stated that the main reason the evaluation was not carried out as per the plan was that the student/evaluator left before the evaluation was completed and there were no additional resources budgeted to carrying out the work (personal communication Karen Dunn, 2016). This fits with the commonly noted phenomenon that evaluations that require external evaluators or add a significant burden of work for staff are often uneconomical and unsustainable (Miller, Kobayashi, & Noble, 2006). Additionally, the theory of change selected, which assumed that positive health outcomes were linked to increases in self-esteem for YPPP clients, turned out not to hold up in practice (Mills, 2011; personal community Karen Dunn, 2016).

2.5. CHOOSING THE EVALUATION APPROACH

Based on the literature from related evaluations, the key elements associated with successful evaluation planning for CPNP programs appeared to be the use of participatory methods, including collaboration with staff, partners and clients. Involving clients in decision-making also aligns with VCH's philosophy of patient-centred care, and the organizations strategic direction (VCH, 2015). A major benefit in using a participatory process is that it can help facilitate partnership, build capacity and create user-friendly evaluation frameworks (MacLellan-Wright, Patten, Dela Cruz, & Flaherty, 2007). Participatory approaches can also lead to innovative indicators, better data quality, and useful results (MacLellan-Wright *et al.*, 2007). There is a paucity of literature regarding engaging stakeholders, particularly clients, in the formative stages of healthcare evaluation. However, VCH best practices indicate that including them from the initial planning stages creates the best opportunity for meaningful engagement (VCH, 2014).

Keeping with the intention for the HBP evaluation to co-construct knowledge with stakeholders, it was decided that the evaluation would not test an a priori theory of change, but rather take a grounded theory approach and let the theory of change emerge from the evaluation itself. The evaluation objective of discovering best practices will provide insight into the theory of change which can help explain how exactly the HBP service model works to achieve intended outcomes.

Creating a logic model is often one of the first steps in evaluation (Bowen, 2004). A logic model can be described as “a framework for planning, implementation, and evaluation that links investments to results” (p. 12, Taylor-Powell, Jones, & Henert, 2003). The process of creating the logic model ensures the evaluator understands the rationale behind how the program reaches its intended outcomes (Renger & Hurley, 2006). Getting buy-in from program staff about the importance of the logic model is equally important to confirm that the program activities are meaningfully linked to outcomes (Renger & Hurley, 2006). As such, it was decided that HBP would use a participatory model, engaging with staff, clients, and partners to create the logic model.

Chapter 3. Methods

Methods chosen were reflective of the resources available to HBP and the goal of engaging stakeholders. Both qualitative and quantitative methods were utilized and are explained in further details below.

3.1. EVALUATION STAKEHOLDER WORKGROUP RECRUITMENT

To promote meaningful engagement from the planning stages of the evaluation an Evaluation Stakeholder Workgroup (ESW) was assembled to create the logic model. An ESW generally includes:

> *members who have a stake or vested interest in the evaluation findings, those who are the intended users who can most directly benefit from the evaluation, as well as others who have a direct or indirect interest in program implementation (p.7, CDC, 2011).*

After consulting with HBP staff and leadership, the important stakeholder groups identified were: HBP staff, YPPP Clinical Coordinator VCH leadership, funders, Richmond Public Health, referring sources, partner agencies and clients. For logistical purposes, an ESW ideally consists of no more than 8 – 10 members (CDC, 2011). HBP staff were consulted to identify partners and clients that could contribute to balanced and diverse representation. A combination of purposeful and convenience sampling was used to select ESW members who represented the various stakeholder groups and who were interested and available to meet.

Potential ESW members were approached by HBP staff to discuss the possibility of participating, with emphasis that their participation was voluntary. Those that expressed interest were emailed an invitation and asked to RSVP (a copy of the email

can be found in Appendix B). Responding to the RSVP and/or attendance at a meeting implied consent to participate.

A patient advisor can be defined "as someone who has a recent and specific experience in health care and can share it in an advisory role" (p.4, VCH, 2015). The following inclusion criteria was used to select patient advisors who: were current or previous clients who had been through HBP or YPPP at least once before, were comfortable communicating in English, had childcare available if needed, felt comfortable participating in a group session with other professionals and clients, and did not have a prior conflict with the meeting dates. Best practices from The *VCH Committee Workbook: How to Engage Patients and the Public on committees* were utilized in recruiting advisors including: inviting more than one advisor, explaining the role and expectations, and offering incentives for participation (VCH, 2015). Appreciating that clients often miss appointments due to family responsibilities and health appointments, four patient advisors were invited in the hopes that at least two would come to each meeting.

3.2. ESW MEETINGS

The overarching goal for the ESW meetings was to create a shared understanding the purpose of the evaluation and to agree upon a logic model for HBP. The meetings were planned with considerations of balancing the time required for meaningful engagement while respecting ESW members' other commitments and priorities. Three two-hour meetings were scheduled on days and at times that accommodate most people's schedule. The meetings occurred from 12:30 – 2:30 on October 7, 12 and 19th at Robert and Lily Lee Family CHC in Vancouver. Teleconferencing and online participation (through GoToMeeting™) was offered at the first meeting to decrease the barrier to participation (Perron & Ruffolo, 2011). Group discussion was recorded directly on the PowerPoint slides so online participants could visually follow the discussion. Online participation at the second and third meeting was not a viable option, as extensive group work was required at these meetings. Lunch was offered to all participants during meetings. Patient advisors were provided with a $15 honorarium for participating, as well as transit tickets.

The meetings were meant to be iterative, so that each meeting would build on the information discussed at the prior meeting. Meetings included a combination of information sharing, as well as large group brainstorming and discussion, group work, and individual input through questionnaires. Group guidelines were discussed at the beginning of each meeting to ensure respect and inclusion. Icebreaker activities were also incorporated to enhance the formation of relationships, since some ESW members had never met or worked together before. The high level goals for each meeting and the methods and tools used to achieve each goal are summarized in Table 2 below. Facilitation guides for meetings can be found in appendices C - E.

Table 2: Overview of ESW meeting methods

	Meeting Goals	Methods/Tools
Meeting 1	Build understanding about the background and context of HBP	• Pre-questionnaire (see Appendix F) • Information sharing via PowerPoint • Facilitated Group Discussion
	Build capacity related to the task at hand (program evaluation and logic model)	• Information sharing via PowerPoint • Discuss in pairs: ESW member's current skills and experience in evaluation
	Discuss long-term goals for HBP	• Facilitated group discussion
Meeting 2	Critically examine short, medium and long-term outcomes of HBP (see Appendix G)	• Small-group work to rate outcomes using the *Outcomes Checklist Worksheet* (Taylor-Powell, *et al.* 2003). (See Appendix H).
	Reach consensus on outcomes, which to use in draft logic model	• Facilitated group discussion
Meeting 3	Review a draft logic model based on outcomes discussed at prior meeting (see Appendix I for draft logic model)	Review draft logic model in small groups: • Clarify item lacking consensus (items flagged for follow-up in draft) • Draw linkages between activities, participants, and outcomes. • Examine logic model for spurious associations • Examine logic model for anything that is missing • Report back finding and discuss with group at large
	Revise logic model and achieve consensus on revisions	• Large Group discussion • Email logic model to ESW for feedback • Call or meet with participants for further follow up if needed

3.3. ESW MEETING FEEDBACK AND EVALUATION

Verbal feedback was solicited at the end of each meeting and then again at the beginning of the following meeting. Participants contributed their reflections individually around the table. Additionally, an evaluation survey called Evaluation Stakeholder Workgroup – Phase 1 Meetings Evaluation (henceforth referred to as "the survey") was created to capture anonymous feedback. The survey, created in Survey Monkey™, consisted of eight questions, including two demographic question, four rating questions with sub-questions, one multiple choice question and one open-ended question (Collier *et al.,* 2005). The final draft of the logic model and link to the survey was emailed to ESW members after the meetings were complete, on October 30, 2016. The survey was closed on November 16, 2016. Survey Monkey™ report-building functions were utilized to collate data (Collier *et al.,* 2005). A copy of the survey can be found in Appendix J.

3.4. ETHICAL CONSIDERATION

As this project was undertaken for quality improvement purposes, ethics approval was not required. However, the *Program Evaluation Standards* as described by the Joint Committee on Standards for Educational Evaluation were applied throughout the process (Yarbrough, Shulha, Hopson & Caruthers 2011). The standards of utility, feasibility, propriety and accuracy were briefly discussed with ESW members in the first meeting. Additionally, participants were asked for permission to be audio-recorded, identified by name in this document, and photographed for potential utilization of photographs in the capstone and the evaluation.

Chapter 4. Results

4.1. ESW MEMBERSHIP

HBP staff nominated five potential patient advisors. One was not contacted because she had a very similar background and demographic profile as another client who had already been contacted and agreed to participate. One patient who was originally scheduled to attend was excluded because she could make it to the first meeting due to illness and anticipated she would not be able to attend the last meeting because it was very close to her due date. Since attendance at the first meeting was crucial to set the context, it was mutually agreed this client should not participate in this stage of the process but would be invited to attend in future planning and implementation stages. Unfortunately, HBP staff and Richmond partners were not able to nominate a Richmond client who met the inclusion criteria.

All HBP staff and partners who were approached to be a part of the ESW agreed to join with one exception. A PHN from Richmond was not available during the timeframe of the meetings; therefore an alternate staff person from Richmond was nominated and agreed to attend. The final make-up of the ESW included three HBP staff (a dietitian, a support worker and the YPPP Coordinator/PHN), three social workers representing partner agencies or departments, one funder, one manager, and three patient advisors. An overview of the final ESW is included in Table 3 below.

Table 3: Evaluation Stakeholder Workgroup Members		
Name/ Organization	Relationship to HBP	Additional information
Social Worker, Building Blocks Vancouver, Ministry of Child and Family Services.	HBP refers many first time moms who are Vancouver residents to Building Blocks, which will continue home visiting services with families until children are up to five years old. Building Blocks focuses on parenting skills.	Also contracted to work 10 hours per week as a social worker for HBP and YPPP.
Social Worker, BC Women's Hospital, Diagnostic & Ambulatory Clinic, PHSA	Refers many clients to HBP/YPPP, including new immigrants and refugees without healthcare coverage who are being seen at the New Beginnings Clinic at BC Women's Hospital	The previous BC Women's Hospital social worker was the original social worker involved with the creation of YPPP
Social Worker, Richmond Public Health VCH	Works with Richmond's high-needs mothers and prenatal clients, including youth clients	
Current prenatal HBP client, Patient Advisor	4th time in HBP. Has been through YPPP as well.	Also representing an Indigenous perspective.
Former YPPP client, current volunteer Doula with YPPP, Patient Advisor	Participated twice as a YPPP client. Started volunteering as a doula in 2016.	Also representing a youth and immigrant perspective.
Current HBP prenatal client, Patient Advisor	Had gone through HBP once as a post-partum client only, now a current client near the end of her 2nd pregnancy.	
Support Worker, HBP, VCH	Support worker with HBP for the last 30 year. Works both in English and Chinese mainly with the immigrant population.	Because of her great length of service, this staff member acts as the verbal historian of HBP
Dietitian, HBP, VCH	Dietitian with HBP for 4 years. Has worked primarily with the youth and Aboriginal population in the program.	Former Dietitian Sheway and a former Support Worker Surrey Healthiest Babies Possible
Clinical Coordinator YPPP for YPPP and PHN YPP & HBP	Coordinator for Youth Pregnancy and Parenting Program and clinic for 5 years. Also does prenatal education for youth and older clients.	Former PHN, having working with moms and babies on the North Shore for many years prior to this position
Manager for Public Health at Robert and Lily Lee CHC	Current manager for Healthiest Babies Possible. Manages all Vancouver city-wide services targeted to vulnerable populations including public health dental, audiology and speech and language, and well as public health nursing.	Former Public Health Nurse for Healthiest Babies possible in 1999 – 2001
Program Consultant CPNP & FASD Lead, Western Region, PHAC.	Consultant for CPNP programs in BC for the past several years, including the program and funding oversight for HBP.	

4.2. ESW MEETING ONE

All eleven members of the ESW attended the first meeting; seven in person, and four via GoToMeeting™ (Perron & Ruffolo, 2011). Seven ESW members also completed some or all of the pre-questionnaire. The results from the pre-questionnaire are summarized in Appendix E.

The important outcome from meeting one was deciding what would be considered "long-term outcomes" for HBP clients. Furthermore, the ESW discussed which outcomes could realistically be attributed to HBP intervention and which were possible to measure in an evaluation. The group decided that it was reasonable to look at outcomes up until the child of the participant was two years old. Youth and Aboriginal clients can remain in the HBP until child is 18 months, and other clients until the child is twelve months. The group felt that looking post-discharge to when children were two years old gave participants time to reflect on how the program had impacted them and their child and give insightful feedback without being so far in the future as to forget or lose the ability to link outcomes to exposure to HBP. Also, looking two years postpartum would allow HBP to follow up and see if women transitioned successfully to other program that fit their needs, as well as if they were able to sustain positive changes in absence of the program. Two years old is also a time when toddlers undergo developmental testing, such as the Ages and Stages questionnaire (ASQ) (Kerstjens *et al*., 2009). The group felt the ASQ could be a useful indicator for healthy child development. A list of the long-term outcomes brainstormed by the ESW in meeting one is summarized below.

Long –term outcomes when children of HBP participant are 2 years old:

- Participants sustain healthy behaviors as related to: diet, substance use, self-care practices, parenting, efficacy
- Participants sustain social/community support network
- Participants and children remain connected with healthcare services
- Participants practice family planning strategies
- Children of participants meet developmental milestones or if not are connected for early intervention

4.3. ESW MEETING TWO

Nine ESW members came to the second meeting. One patient advisor and one partner had work-related conflicts. The ESW was divided into groups of three and each group worked on rating short, medium or long-term outcomes using the *Outcomes Checklist Worksheet* (Taylor-Powell *et al.*, 2003) (See Appendix G). Short and medium outcomes were taken from previous HBP work plans while long-term outcomes were taken from discussion at the first meeting. The ESW engaged in lively discussion while rating outcomes. The conversation continued longer than anticipated, however even with the extension of time not all groups were able to rate all outcomes assigned to them. Thus, during the reporting back period, outstanding outcomes were discussed as a group.

Most of the outcomes were rated as important, reasonable, realistic and with little or no possible negative impact. However, there were some outcomes on which the ESW had not reached consensus. For example, the potential for positive mental health outcomes with HBP clients were discussed as an unintentional positive impact, but the group struggled about how to represent that as an outcome in the logic model without creating the impression that mental health counselling was an overt focus of HBP. The group suggested the routine perinatal depression screening and referrals would lead to a series of outcomes that could lead to improved mental health starting with increasing awareness of community resources. The ESW also discussed whether the medium-term outcome of clients increasing their social network was reasonable. For instance, for HBP clients who do not participate in group activities, it may not be reasonable to expect them to expand their social network through participating in the program. Similarly, if they have a large social network to begin with they may not be interested in expanding their social network.

Finally, there was some disagreement on whether it was HBP's role to increase awareness or influence the role of best practices in working with the at-risk pregnant and parenting population. This was a new component that was added to the work plan based on the intended utilization of the evaluation targeting the CPNP mandates to strengthen capacity at the community level to address the public health needs of pregnant women, new mothers, and their infants facing conditions of risk. There was

discussion about whether this was the role of other public health dietitians in VCH, what types of activities would be suitable for HBP to undertake, and who would be responsible for undertaking those activities. At this part of the meeting, the group was informed about the 2017 – 2020 ISFR application, which required a knowledge translation plan.

The second meeting sparked further post-meeting discussion between HBP staff members and partners. For example, family planning and birth spacing, one of YPPP's original goals from 2005, was brought forward as an item that was possibly missing from the logic model. All the feedback provided during and after meeting two was used to produce the first draft of the logic model (Appendix I). Items lacking consensus or that were added afterwards are summarized in the Tables 4 and 5 below.

Table 4: Items added to the logic model after meeting two

Activities	• Family Planning Education and Access
Short-Term Outcomes	• Increase knowledge around family planning and birth spacing • Knowledge Exchange
Medium-Term Outcomes	• Increase consumption of healthy food • Increase connection with healthcare (as appropriate) • Increase contact with community resources • Decrease social isolation
Long-Term Outcomes	• > 18 Months between pregnancies

Table 5: Outcomes that needed clarification or consensus after meeting two

Short-Term Outcomes	• Increase self-advocacy skills, help seeking • Increase awareness of best practices in working with at risk perinatal population
Medium-Term Outcomes	• Increase social support network • Use family planning strategies • Influencing roles for best practice

4.4. ESW MEETING THREE

The draft logic model was presented to the ESW at the beginning of the third meeting (see Appendix I). It included the items in Table 4 and 5 above, which were flagged by underlining new additions or placing question marks beside items that needed further clarification. After reviewing the flagged items, “knowledge exchange” was removed from the short-term outcomes for being too non-specific, and “> 18 months between pregnancies” was removed from long-term outcomes because the ESW decided it was better suited as an indicator linked to continuing positive self-care practices and increasing personal capacity. “Increase social support network” was also removed from medium-term outcomes as the ESW felt “decreasing social isolation” was more appropriate. Furthermore, “influencing roles for best practice” was changed to “implement best practices for working with at risk pregnant and parenting populations”, as the group felt it would be difficult to measure influence, whereas HBP could likely identify changes implemented based on evaluation findings and knowledge translation activities. All other highlighted items in Table 4 and 5 were incorporated into the logic model with some slight changes to wording.

While reviewing the draft logic model, ESW members had questions about some of the terminology used in the draft logic model. For example, the phrase “life coaching” was used to describe the activity of support workers and dietitians providing advice and support around whatever the client is struggling with. Some ESW members did not like the term because of the separate profession calling themselves Life Coaches, and also because of the potential association of the athletic style of coaching. Instead the term “life coaching” was rephrased to read “addressing social determinants of health” to emphasize that the program provided more than just nutrition counselling.

The ESW felt that client participation in HBP could potentially result in all outcomes in the logic model. While the ESW members present expected a relatively high percentage of HBP clients to achieve short-term outcomes, they expected less to reach the medium-term and even less to achieve the long-term outcomes. For example, perhaps 90% of HBP clients would increase knowledge about nutrition recommendations, 75% would improve nutrition intake, and 30% would sustain the

improved intake when their child was two years old. It was agreed that a future step of the evaluation plan would be to think about reasonable targets for each outcome.

The group was then asked if anything was missing from the logic model. One ESW member mentioned that there could be an outcome around increasing access to healthcare services for the pregnant vulnerable population, but it was decided that access could be measured as an output (under participation) as well as continued connection to healthcare services.

The third meeting had poor attendance compared to the first two meetings with only five attendees present. Two of the patient advisors had childcare conflicts and one advisor had mistaken the time. Three of the other partners were not available. Therefore, the group that attended was mainly VCH internal staff. Since it was crucial to obtain external stakeholder input, the second draft of the logic model, which included revisions from meeting three, was emailed to the partners and with a request for their feedback (see Appendix K). No further suggestions were made by partners. Meanwhile an additional meeting with patient advisors was arranged to review the second draft of the logic model.

4.5. ESW MEETING FOUR (Extra patient advisor meeting)

Childcare was the main barrier preventing patient advisors from attending meeting three. To overcome this impediment, the extra meeting was held at a baby-friendly restaurant and was set at an earlier time to ensure that it did not conflict with naptime for the children. All three patient advisors, two toddlers and one infant attended this additional fourth meeting on Monday October 24, 2016. The patient advisors were presented with the second draft of the logic model. As it was being shown, the patient advisors were warned that it was very technical in nature, and they agreed it was overwhelming to look at. The patient advisors were guided though the logic model and asked to comment on any missing or superfluous items. They were also asked if they felt their input was represented in the logic model, and they all agreed it was.

One advisor questioned how HBP hoped to achieve the long-term outcome of keeping clients connected with healthcare services. After explaining that HBP aims to connect clients with other services, such as PHN's and Building Blocks, that can see clients until their children are five years old, she agreed with keeping it as a long-term outcome. No further changes were suggested by the patient advisors.

Patient advisors were then asked their opinion on how HBP could represent the logic model in a more user-friendly manner that could be easily interpreted by new clients or service providers. They were given large sheets of paper, pens and felts to write or draw their ideas. Some common imagery in the drafts they produced included a pregnant woman journeying through or at the centre of HBP services, leading to positive outcomes and the end result of a happy healthy mother and child. Figure 1 below is one advisor's drawing depicting a pregnant woman walking through an open door to HBP. The words "happy, larger belly" are written on the woman, who is surrounded by services and peers. The outcome in the bottom right corner is a happy baby and mom.

Figure 1: Patient advisor's draft of a user-friendly logic model

4.6. ESW MEETING FEEDBACK AND EVALUATION

Informal verbal feedback given during the meetings was generally positive in that ESW members felt like they were enjoying the process, learning, and getting the opportunity to hear different perspectives. One ESW who has worked with HBP for thirty years said "[t]his is my first time attending a meeting like this."

The response rate for the evaluation survey was 73% (n = 8). An ESW member who only attended one meeting did not feel she able to respond due to her minimal participation. Two others did not respond for unknown reasons. Results of the evaluation survey indicated there were differing opinions about who should have been part of the ESW, with 75% of respondents indicating there were too few patient advisors in the group. One respondent also commented in the open-ended questions that she felt there were too many social workers and not enough dietitians in attendance.

In terms of perceived benefits of meeting attendance, the top three survey responses in descending order included: increased in knowledge about evaluation and logic models, contribution to a process that will help women and families, and new skills gained in planning and evaluation (see Figure 2 below). Regarding the creation of the logic model, 100% of respondents felt that their voices were heard and their opinions were reflected in the final logic model (see Appendix L for a summary of survey results).

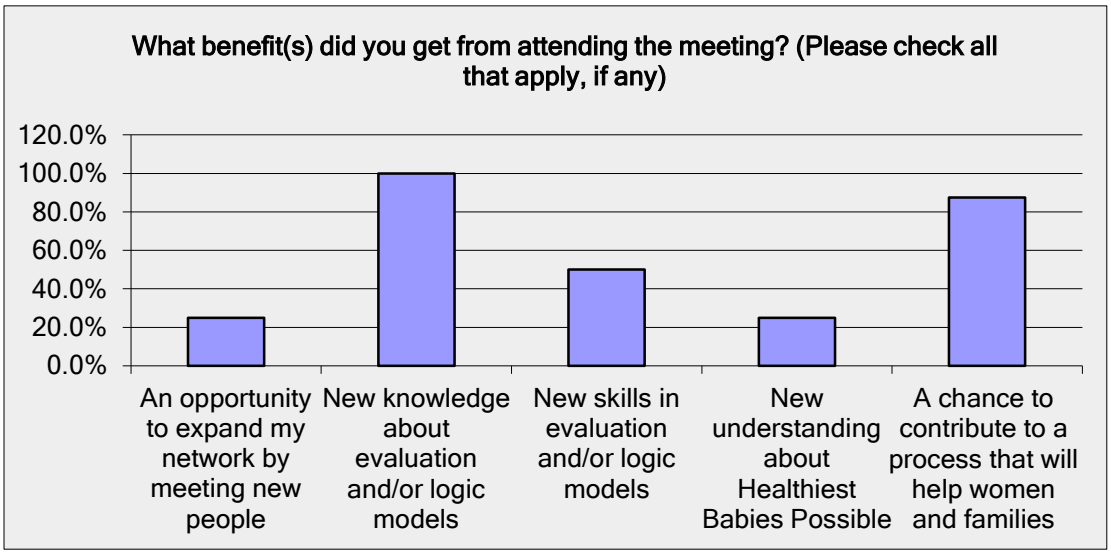

Figure 2: Perceived benefits of ESW meeting participation

Chapter 5. Discussion

5.1. BENEFITS OF USING A PARTICIPATORY MODEL FOR LOGIC MODEL CREATION

5.1.1. Creating a culture of patient engagement

There are a wide variety of terms and definitions that describe patient engagement (PE), but the main essence of PE is involving the end users of healthcare services in decisions that impact them - or the philosophy of 'nothing about us without us.' (Kovacs Burns, Bellows, Eigenseher, & Gallivan, 2014; Sarrami-Foroushani, Travaglia, Debono & Braithwaite, 2014a; BC MOH, 2013a). PE has been widely promoted in BC for the last several years through provincial documents such as the *Integrated Primary and Community Care Patient and Public Engagement Framework* (BC MoH, 2013). The framework encourages PE in an ongoing and sustainable fashion in areas such as healthcare service redesign and quality improvement (BCMoH, 2011). In September 2016, PE was a central theme of VCH's health authority wide accreditation process. Nevertheless, it remains a relatively new concept for many frontline healthcare workers and clients, including the majority of the ESW members.

PE in the health care setting has shown numerous benefits to patients, providers and institutions (see Table 6 below). Judging from the verbal and survey feedback, it appears several of these benefits were achieved during the process of HBP logic model creation. In particular, members of the ESW appeared to increase their understanding around the healthcare system, particularly around HBP, program planning and evaluation. Relationships between partners, clients and VCH were also appeared to strengthen, and new insights into patient and partner perspectives were gained.

Furthermore, all ESW members all expressed that they felt like their voices were heard and their opinions were incorporated into the logic model, while 7/8 survey respondents reported feeling like they contributed to a process that will help women and families. This may correspond with the sense of empowerment that often result from PE initiatives (Kovacs Burns *et al.*, 2014).

Table 6: Benefits of community engagement

Value to the Participants	Value to Organization (VCH)	Value to the Service Provider
• Become meaningfully engaged in the system that supports their health • Increase understanding of the issues and the health care system, including VCH • Appreciate being part of the program, being listened to, and having their opinions valued • Learn to become more effective advocates • Understand how to be an active participant in their own health care	• Helps target resources where they are most effective and valued by the community • Brings diverse perspectives into the planning process • Demonstrates accountability and transparency • Provides a direct link to clients, residents or patients • Supports a culture of people-centred care • Improves quality of patient experience • Strengthens community relations	• Learns to provide care from a patient-centred approach • Recognizes the role of other caregivers, such as family and friends • Increases awareness of the barriers encountered by patients • Helps identify system issues that need to be addressed to provide people-centred care • May increase satisfaction ratings from patients

Note: Reprinted from *How to Engage Patient and Public Advisors on Committees: a Guide for Staff*, p. 3, Chapter 2, Table 2. 2015 Copyright by VCH.

In the ESW Phase 1 Meetings Evaluation Survey, 6/8 survey respondents felt that there had been too few patient advisors at the table, and one patient advisor also gave the same feedback verbally. This was an unexpected result given that that there were three advisors on the ESW, which is more than the average number of patient advisors on VCH committees (VCH, 2015). Literature suggests there is a lack of interest in patient engagement among Canadian health professionals, in part because it opposes traditional roles and power dynamics in healthcare (Sarrami-Foroushani, Travaglia, Debono & Braithwaite, 2014b; BCMoH, 2011). However, in this case, the feedback from the HBP stakeholders indicates that they value the voice of the client in decision-making and are open to challenging the dominant healthcare dogma of systems-centred care, in favour of patient-centred approaches.

5.1.2. Creating clarity about the HBP service model

Including diverse stakeholder in program evaluation planning creates an opportunity to network with and learn about the roles of different stakeholders (Maclellan-Wright *et al.*, 2007). The ESW meetings provided new insight into the history and impact of HBP. Additionally, some of the information gained from the pre-questionnaire around partner and client perceptions of HBP were illuminating for HBP staff (see Appendix E). For example, one long-term referral source did not previously know that HBP was intended for socially vulnerable clients, and had thought any pregnant woman in the geographic catchment area was eligible. Similarly, one patient advisor commented that she did not realize there was a screening process to be accepted into the program. This aligns with feedback from other referral sources that have referred ineligible clients to HBP because they were not aware of the target population.

The meetings provided an opportunity to clarify these misconceptions with ESW members. It also gave HBP key insight that HBP's mandate and service model is not transparent in the community. Additionally, since there are differing opinions among staff, the logic model could help clarify mandate and intended outcomes internally, so HBP staff can give consistent messaging to clients and partners.

These discussions sparked further internal review of program advertising materials that contain vague wording, such as HBP serving women who need "extra support" during pregnancy, since extra support can be interpreted many ways (see Appendix M). Similarly, the term "high risk" in HBP advertisements can be interpreted as medically high-risk, which again gives a false impression of the scope of HBP services.

5.1.3. Innovation and creating buy-in for the end-users

Evaluating outcomes beyond client's discharge will be a new undertaking for HBP. Since HBP shares a medical records platform (PARIS^{TM}) with other VCH services that see children beyond HBP discharge, tracking these clients will be possible (VCH, 2006). However, following clients becomes more complicated after clients leave HBP and creates additional steps for VCH's Decision Support team to retrieve data. Decision

Support commented they may be able to provide this type of data if it is a priority for the organization and if management are supportive (personal communication, Paula Di Marco, October 14, 2016). Since a PH manager was part of the ESW and believes in the importance of evaluating long-term outcomes, she may be able to help advocate to access the necessary data for the evaluation. This demonstrates one of the benefits of using participatory methods for logic model creation, garnering stakeholder buy-in around the necessity and value of the evaluation (Renger & Hurley, 2006).

Buy-in was also created around adding logic model outcomes for sharing best practices with external organizations. Minimal staff consultation occurred when the new deliverable of "sharing best practices identified by the evaluation" was initially incorporated into the ISRF in June 2016. Most HBP staff felt that their main communications with external agencies should focus on increasing awareness of HBP for the purpose of increasing referrals. Putting on my HBP coordinator hat in the ESW meeting, I explained how the previous approach may create more dependency on HBP, rather than building community capacity to support the vulnerable perinatal population. Since HBP staff only interact with clients every one to two weeks, building capacity outside of VCH would help create more opportunities for them to access appropriate services. After engaging in further discussion about the CPNP mandate, the target audience for knowledge exchange activities and logistics for possible capacity building activities, the ESW agreed to keep the outcomes associated with knowledge translation in the logic model.

5.2. CHALLENGES OF USING A PARTICIPATORY MODEL

5.2.1. Getting diverse representation on the ESW

As mentioned in the section 4.6, there was some disagreement about the ideal mix of clients, patient advisors and partners at the meetings. Most ESW members expressed that they would have preferred more patient advisors to attend, a few thought more partners should attend, and all thought that the number of HBP staff was appropriate. If the ESW had included more partners and patient advisors, and kept the

number of HBP staff consistent, it would have far exceeded the CDC recommendation of 8 – 10 members, which would have likely caused logistical challenges (CDC, 2011).

One of the common criticisms with having patient advisors is that staff often feel that the advisors who participate do not truly represent the patient population of interest, and that they are utilized in a tokenistic manner (Kovacs Burns *et al.* 2014; VCH, 2015). One ESW member also brought forward the concern that the patient advisors that were somewhat more stable than a majority of HBP clients. A previous evaluation of VCH committees that included patient advisors also noted this struggle, however the evaluation also highlighted that the highest risk clients are often the most difficult to engage due to competing personal priorities and distrust of the medical system (VCH, 2015). Furthermore, literature suggests that up to 75% of the public is not interested in contributing to healthcare decisions (Kovacs Burns *et al.*, 2014). Thus, there is inherent selection bias in patient advisors resulting from self-selection of those who are often well enough resourced to participate and have a strong opinion about the matter at hand, and the non-response of those who are unable or unwilling to participate.

In terms of the International Association for Public Participation (IAP2) spectrum of engagement, methods of engagement utilized in HBP's logic model formation, such as participatory decision-making and establishing an advisory committee, are considered to be one of the more complex levels of engagement and the stage of collaboration (See Figure 3 below). Other methods of PE, such as interview or surveys may be more suitable to engage harder to reach clients, or a larger number of clients respectively. This type of consultation will likely occur during the evaluation itself. The hope is to garner input from a diverse representation of clients, including the most marginalized, so that the evaluation results and can inform program improvements reflective of their needs.

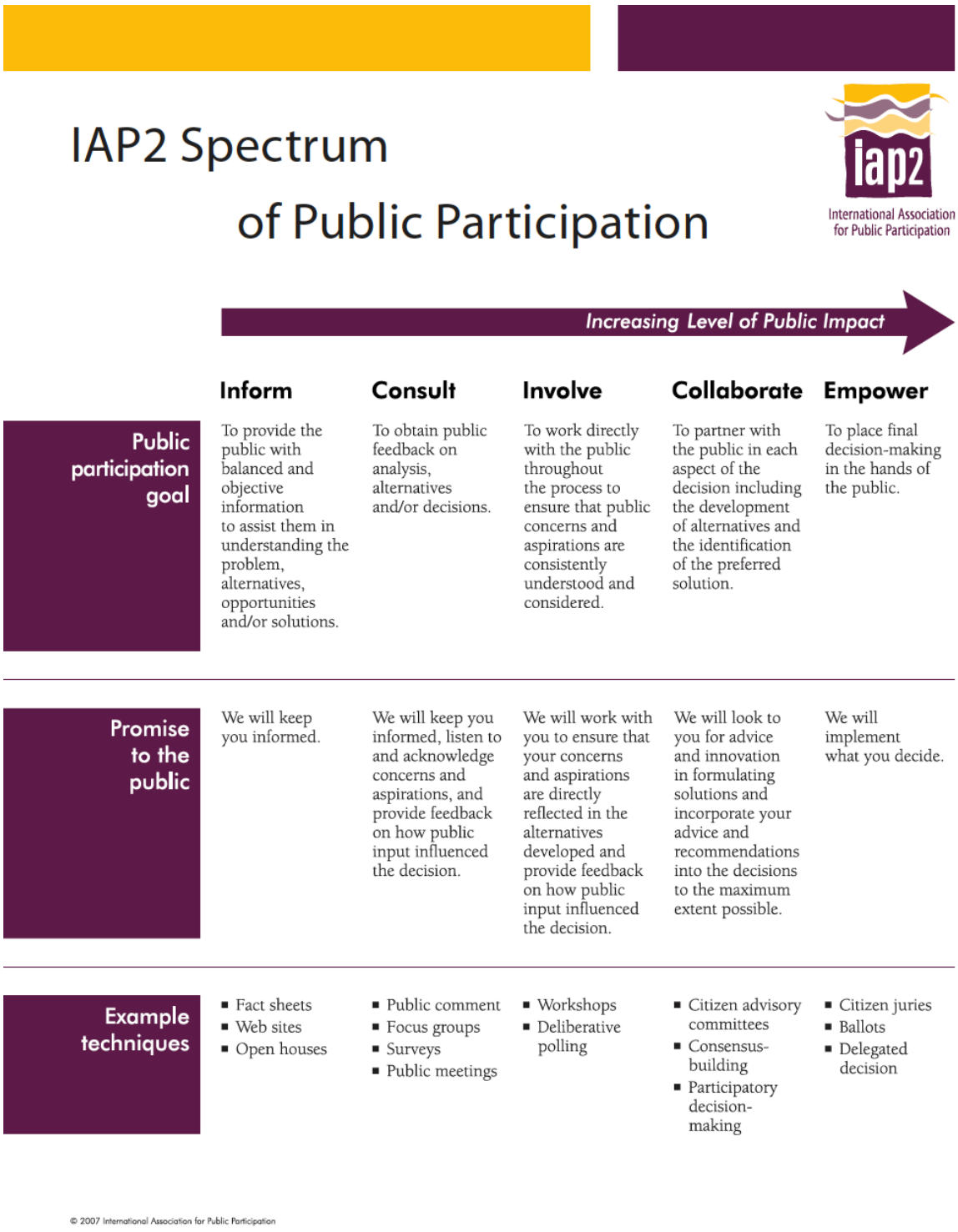

Figure 3: IAP Spectrum of Participation and Core Values (IAP2, 2007). Reprinted from Appendix 3: IAP2 Spectrum and Core Values by IAP2, 2007. Retrieved from http://iap2canada.ca/Resources/Documents/IAP2%20Spectrum_vertical.pdf. Copyright 2007 by International Association for Public Participation.

5.2.2. Infrastructure to support ongoing engagement

Evaluation requires a major investment of time and resources from multiple stakeholders, some of whom may not consider evaluation to be a priority (Maclellan-Wright *et al.,* 2007). Using participatory methods and PE can create additional time and resource burden compared to non-participatory methods. Furthermore, decision makers are often sceptical of the evidence to justify funding PE activities; therefore direct patient care is almost always prioritized over PE (Sarrami-Foroushani *et al.,* 2014a). As PE is frequently misunderstood or undervalued, the infrastructure required to support meaningful engagement is often underestimated, resulting in adequate resource allocation to carry out and sustain such processes (Sarrami-Foroushani *et al.* 2014b).

In the case of HBP, if I were not doing this project on my own time as part of my graduate studies, I would have not had sufficient time in my regular work hours to plan and carry out the ESW meetings. However, the PH manager was supportive of dedicating HBP staff time and her own time to participate in ESW meetings, facility space and of covering a portion of the food cost and patient advisor honorarium. The supervisors of the partners were also supportive of partners attending some of the meetings, but work related conflicts often trumped attendance to ESW meetings and only one partner was able to attend all three meetings.

In terms of engaging patient advisors, being able to provide childcare would have been extremely beneficial for the advisor who participated and also to allow the participation of others that were excluded from participating at all. Although patient advisors were provided with cash honorariums, it may have been inadequate for pay for the amount of childcare that would have been required to attend meetings. HBP does not have dedicated child-minding staff or spaces at present so supporting the participation of moms with young children would require a creative solution.

Chapter 6. Conclusion and next steps

6.1. Self-reflection on dual role as coordinator/evaluator

During the process of logic model creation, I played a dual role. Although I tried to wear my evaluator hat and to be completely open to input and feedback from the ESW, there were times when I wore my coordinator hat for example, to justify why certain elements were necessary in the logic model. In doing so, I had to be aware the potential impact of my contributions and take steps to prevent swaying the discussion to fit with my preconceived ideas.

I acknowledge the possibility that power dynamics between myself, as a coordinator, and some of the ESW members may have impacted outcomes. Since I am the supervisor of some of the ESW members, and the gatekeeper for client entry to HBP, my perceived power may have influenced ESW members' comfort level in disagreeing with me or providing criticism. I tried to mitigate this by showing appreciation for participation from all ESW members and recognizing each of them as subject matter experts. At the same time, I emphasized my newness to the field and my desire to learn from the ESW members. I also paid special attention to highlight the value of having patient voice at the table to bring the lived experience insight that is often overlooked by service providers.

Similarly, power dynamics may have influenced the survey results. Results may have been positively skewed if ESW members' answers were biased because people were concerned about the ramifications of giving negative responses, or because they wanted help me succeed. I did let ESW members know that there were no "grades" attached to the outcomes of this project for me, and that I encouraged constructive criticism so that I could improve the process in the future

On the positive side, being the program coordinator gave me certain benefits similar to those observed by Lin et al., including access to internal information and resources the ability to leverage pre-existing relationships with staff and partners (2010). Furthermore, it contained costs that would have been required for an external evaluator, which had not been budgeted for. Lastly, my ability to influence decisions for HBP will likely ensure that the evaluation continues according to plan.

6.2. Towards the future

HBP is a worthwhile program serving a crucial niche in public health. Given its longstanding history and many innovations through the years, returning to the logic model to understand the current framework for linking inputs to outcomes was an important step in preparing for a major evaluation. The ESW meetings accomplished more than their intended goal of creating a program logic model for HBP. They helped clarify misconceptions among stakeholders, provided key insights to inform future stages of evaluation planning, and strengthen partnership and capacity among all parties involved. The benefits of the exercise were immeasurable, contributing to a product far superior than if I had created it on my own.

The logic model will form the basis of the evaluation plan. Next steps will include determining evaluation questions, indicators and data collection methods, based on the aspects of the logic model. Master's of Public Health students will be engaged in data collection and analysis going forward, as they are likely able to provide more objectivity than myself in these steps of the evaluation and can act somewhat as "external" evaluators.

Specific tasks resulting from the participatory process described in this document will include developing new tools such as a post-discharge survey when children of clients turn two years old, and an exit survey when clients are discharged (including clients who disengage from service). Additionally, steps will be taken to improve data quality such as revising current methods of survey data collection to make surveys more anonymous, as well as translating surveys into different languages to increase response rate. Furthermore a graphic designer is being sought to create a more visual, user-

friendly version of the logic model, incorporating ideas from the patient advisor depictions. The new graphic will likely be used as an advertising tool for HBP.

Securing additional funds or a reallocation of existing resources will be necessary to support a continuation of participatory processes for the duration of the evaluation and associated knowledge translation activities. Sustaining ongoing participation of ESW members may prove to be a major challenge. However, despite this challenge, 71% of survey respondents said they would be interested in participating in future planning stages. Collaboratively planning meeting times and locations, reimbursing patient advisors, and being as time efficient as possible will be key to sustaining ESW engagement.

As ESW members spread the word of their positive experience to friends and colleagues it is my hope that participatory practices and PE will continue to garner support to grow and flourish within VCH.

AFTERWARDS- Self-assessment of MPH competencies

Prior to entering the MPH program at SFU, I was the program coordinator of a health promotion program, funded by the Aboriginal Diabetes Initiative (ADI). ADI funding for all off-reserve programs across Canada was cut in 2013, and I was not able to secure another major grant substantial enough to continue the program. Consequently, the community lost a great program and others and myself lost our jobs. When this happened, I questioned my program planning skills and my grant writing skills and partially blamed myself for the loss of the program.

One of my goals in returning to school to do an MPH was to gain formal training in program planning and health promotion, since my prior experience had been mainly on the job and self-taught. I accomplished this by taking classes such as HSCI 855 (Health Promotion in the Canadian Context) and HSCI 826 (Program Planning and Evaluation). By focusing the capstone on the creation of a program logic model as an early step of evaluation, this paper attempted to demonstrate my competence in:

> Core Competency 8 - Policy and Program Planning, Implementation and Evaluation: Identify program and policy options relevant to population and public health issues, design and implement population and public health programs, and develop appropriate methods of monitoring and evaluation.
>
> Population Health 2 - Develop additional expertise in areas of population and public health applications, including one or more of the following: health promotion, program planning and evaluation, advocacy and communication, and population health policy.

Additionally, prior to beginning my MPH career, I developed a keen interest in community engagement. This interest stemmed from working with the Indigenous community in the DTES, and learning about effective ways to work with clients that were deemed “hard to engage” by mainstream healthcare. I learned that the best way to engage the community was by having them involved in every aspect of the program from planning to delivery. Although this concept is emerging in the literature and gaining some traction within the western medical community, it is still highly underutilized and

undervalued. I further explored the evidence around the benefits and challenges of community engagement through my MPH courses, particularly HSCI 827, and HSCI 880, practicum with Community Engagement at VCH.

My practicum project was to complete a process evaluation examining the use of patient advisors on VCH committees from the perspectives of both committee chairs and patient advisors. Based on this evaluation also I helped create a manual titled, *How to Engage Patient and Public Advisors: A Guide for Staff* (2015). Utilizing the Evaluation Stakeholder Workgroup (ESW) in my capstone project allowed me to apply the teachings from the courses mentioned as well as the practicum. Assembling an ESW and effectively working with them to help improve services for a marginalized population demonstrates my competencies in the following areas:

> Core Competency 7 - Communication: Demonstrate effective communication with and mobilization of individuals, families, groups, communities, and colleagues to improve population and public health.
>
> Core Competency 6. Partnerships, Professionalism, Collaboration and Advocacy: Identify appropriate partners in addressing population and public health issues; identify and analyze ethical considerations in public health programs; and devise appropriate strategies for mobilizing communities around a public health issue.

Finally, another key learning during my MPH was enhancing my knowledge of quantitative and quantitative research methods through courses such as HSCI 801 (Biostatistics), 802 (Epidemiology) and 803 (Qualitative and Survey Research Methods). Although academic research was not a keen interest or aspiration of mine, I learned the value of applying aspects of qualitative and quantitative research to inform decision making and advocating for health promotion programs and policies. In this capstone I reviewed strengths and weaknesses in the current qualitative data available to HBP. I also utilized qualitative and survey techniques in working with the ESW. Additionally the ESW had preliminary discussions on how we could improve indicators and data collection methods thereby improving data quality for HBP. Including these aspects in the capstone demonstrates my competence in:

CC3. *Methods of Population and Public Health Assessment, Diagnosis, and Analysis*: Determine population and public health concerns through analysis and diagnosis of communities and populations using a variety of quantitative and qualitative methodologies.

There are many other new skills, knowledge and experiences I will take away from the MPH program. The capstone paper highlights those competencies, which are currently the most useful in my work as a program coordinator. The MPH program has enabled me to meet my learning and my professional goals. It has inspired me to keep learning and has humbled me to never consider myself a “Master” of anything. I am grateful for being given the opportunity to study at the Faculty of Health Sciences at Simon Fraser University.

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Appendix A: HBP Prenatal Survey

Healthiest Babies Possible Program Feedback Survey - Prenatal

* 1. Today's Date:

Today's Date — DD / MM / YYYY

* 2. How would you rate the services and/or supports of the Healthiest Babies Possible Program?

◯ Poor ◯ Fair ◯ Good ◯ Excellent ◯ No Answer

* 3. What services did you receive from the Healthiest Babies Possible Program?

- ☐ One to one support
- ☐ Good Food Bag Program
- ☐ Clothing exchange / donations
- ☐ Prenatal drop-in
- ☐ Vitamin supplements
- ☐ No Answer
- ☐ Gift cards
- ☐ Bus tickets

Other (please specify)

* 4. Has the program helped you learn more about how to care for:

	Yes	No	No Answer
Yourself?	◯	◯	◯
Your Baby?	◯	◯	◯

If yes, what did you learn?

* 5. Have you made friends with other women by coming to our program?

◯ Yes ◯ No ◯ N/A ◯ No answer

6. If yes, do you see the friends you made in the program, outside of program time?

◯ Yes ◯ No ◯ No Answer ◯ N/A

* 7. Did you learn about new resources in your community by coming to our program?

◯ Yes ◯ No ◯ No answer

* 8. Have you tried / accessed new resources in your community by coming to our program?

◯ Yes ◯ No ◯ No Answer

If yes, which resources?

* 9. Did you experience any physical, emotional or sexual abuse in your pregnancy?

	Yes	No	Not Applicable	No Answer
From your partner?	◯	◯	◯	◯
From someone else?	◯	◯	◯	◯
Did you ask for help?	◯	◯	◯	◯

If you answered yes to from someone else, could you share who?

10. How has the Healthiest Babies Possible Program has made a difference in your life?

11. Do you have any suggestions to improve our program? Any other comments?

* 12. Would you recommend this program to a friend or family member?

◯ Yes ◯ No ◯ Not sure ◯ No answer

If no or unsure, why?

Staff Only Section

* 13. # of times has been an HBP client?

1 time ◯ 2 - 3 times ◯ 3 + times ◯ Unknown

* 14. How many visits/contacts did the client have to the program in this pregnancy? (include 1-1 & group)

less than 3 ◯ 3 - 6 ◯ 6 - 9 ◯ 10 + ◯ Unknown

* 15. How many weeks gestation was the client on your first visit?

* 16. On the first visit, the client's gestational weight gain was?

☐ Within recommended range ☐ Over recommended range

☐ Under recommended range ☐ Unknown

* 17. The client's gestational weight gain for the whole pregnancy was?

☐ Within recommended range ☐ Over recommended range

☐ Under recommended range ☐ Unknown

18. Client had improved nutritional intake since coming to the program?

Yes ◯ No ◯ Unknown

If unknown, please explain.

* 19. Tobacco Use

	Yes	No	Not Applicable	No Answer
Did your client smoke in her pregnancy?	◯	◯	◯	◯
If yes, did she quit?	◯	◯	◯	◯
If she didn't quit, did she cut down?	◯	◯	◯	◯

* 20. Alcohol Use

	Yes	No	Not Applicable	No Answer
Did your client drink in her pregnancy?	○	○	○	○
If yes, did she stop?	○	○	○	○
If she didn't stop, did she cut down?	○	○	○	○

* 21. Recreational Drug Use (e.g. Marijuana, Cocaine, Heroin, etc)

	Yes	No	Not Applicable	No Answer
Did your client use drugs in her pregnancy?	○	○	○	○
If yes, did she stop?	○	○	○	○
If she didn't stop, did she cut down?	○	○	○	○

If she did use drugs, what type of drugs did/does she use?

Appendix B - Invitation to Participate in the ESW

Thank you for considering participating in the Evaluation Stakeholder Working Group for Phase 1 of the Healthiest Babies Possible Program Evaluation.

Purpose of Phase 1:

To collaboratively create a planning tool called a logic model, which will visually display what the Healthiest Babies Possible program does, how it works and what it hopes to accomplish. The logic model will identify key objectives, which will be the basis of what we will try to measure in the program evaluation. The program evaluation will occur from April 1, 2017 – March 31st 2018.

Your role:

In putting together this working group, I considered all the populations and organizations that are affected by our program. With the help of our staff, I selected working group members to represent different segments of our stakeholders, namely: program staff, funders, partner agencies, and most importantly clients.

As a working group member, I hope that you will be able to:

- Share information and insight about your experience about working with/living as a pregnant woman facing challenging circumstances, in a way that others can learn from it
- See beyond your personal experience to the greater global concern about perinatal support for socially vulnerable women in Vancouver/ Richmond
- Listen to and respect other's perspectives
- Interact well with different kinds of people
- Speak comfortably in a group
- Work in a partnership with others
- Bring a positive outlook and sense of humor
- Have the availability to participate

If you have any questions or concerns about your potential participation please email me or call me.

Meeting times/Location:

12:30 – 2:30 on October 7th (Friday), 12th (Wednesday), and 21st (Friday)
Room 226, 2nd floor of Robert and Lily Lee Family Community Health Centre
1669 E. Broadway, Vancouver.

Additional details:

Lunch will be served and parking and/or transit fare will be reimbursed. Additionally patient advisors will receive $15 each session. Please let me know about food allergies, intolerances and cultural food practices.

Please RSVP by September 30th to Sandra Bodenhamer

Appendix C – Facilitation Guide for ESW Meeting 1

Healthiest Babies Possible Evaluation Stakeholder Workgroup –

Meeting 1: Understanding the goal

Date: October 7 **Time:** 12:30 – 2:30

Location: Robert and Lily Lee Family Community Health Centre, Room 226

Equipment: Nametags, Flip chart, stickee notes, paper plates, napkins, cutlery, tea cups, tea kettle, tea bags, honorarium, bus tickets, bathroom keys, pens, felt pens, pens

Set-up: Overhead, laptop, table, food table in corner, phone with speaker function in middle

Handout: Pre-questionnaire

Agenda:

(12:00 – Room and AV set up, set up GoTo Meeting)

12:30 – 12:40 pm – Arrival and getting lunch

12:40 – 12:45 pm - Welcome (slides 1 – 3) *Ask for permission to record the session*

12:45 – 1:00 pm - Icebreaker – (slide 4 - 7)

1:00 – 1:15pm– Background of HBP (slides 9 - 15)

1:15 – 1:20 pm – Brainstorm: Do you have any questions about HBP that would be useful to evaluate?

1:20 – 1:50 – Introduction to Evaluation (slides 17 – 28)

Discussion questions: (slide 18)

5 minutes discussion (in partners):

- Did you ever have an idea that sounded great in theory, but didn't work out so well?
- How did you know it didn't work out well?
- What did you do as a result?
- What skills did you have to use?

Slide 19: 5 minutes reporting back: Does anyone from your pair want to share their example?

Type on Screen: What evaluation skills do we have in this room?

Probe: Were there any other skills that were discussed to add to this list in the example that wasn't shared?

1:45 – 2:20 – Overview of Logic models (slides 30 – 41)

Slide 32 – Brainstorm:

1) What would it look like if a woman facing challenging circumstances in her pregnancy was well supported? (5 minutes) .
2) Which of those things can HBP influence? (5 minutes)

Slide 34 – Discussion (10 minutes):

Is it useful for us to evaluate longer-term outcomes with out clients?

Probe Do you think it is reasonable to look at impact for women after they leave the program?

Final question: What do we want women to walk away with after they leave this program? (Long-term outcomes)

2:20 – 2:30- Wrap up (slides 40 – 41)

Confirm attendance for next meeting

Honorariums

Appendix D – Facilitation Guide for ESW Meeting 2

Healthiest Babies Possible Evaluation Stakeholder Workgroup –

Meeting 2: Creating the logic model

Date: October 12 **Time:** 12:30 – 2:30

Location: Robert and Lily Lee Family Community Health Centre, Room 226

Equipment: Nametags, Flip chart, paper plates, napkins, cutlery, honorarium, bus tickets, bathroom keys, pens, felt pens, pens,

Set-up: Overhead, laptop, table, food table in corner

Handout: 4 copies of each of Activities, outputs, outcomes on coloured paper; 12 copies of Outcome Rating Sheets

Agenda:

11:30 – order sushi

noon – Room set up

12:30 – 12:40 pm – Arrival and getting lunch

12:40 – 12:55 pm – Welcome and icebreaker (Slides 1 – 5)

- *Ask for permission to take pictures*

12:55 – 1:10 – Review of last meeting (slides 6 – 15)

1:10 – 1:25 – Round 1: Rating Outcomes: In groups of 3 or more, using worksheet review short, medium or long-term outcomes

1:25 – 1:50 - Round 2: Each group look at a different set of outcomes: use the worksheet to review outcomes

1:50 – 2:20 – Report Back and Discussion

Probe: Report back if anything should be eliminated/changed (edit document while discussion is happening as displayed on projector)

2:20 – 2:30 – Wrap up: Explain next meeting, honorarium

Appendix E – Facilitation Guide for ESW Meeting 3

Healthiest Babies Possible Evaluation Stakeholder Workgroup –

Meeting 3: Confirming the logic model

Date: October 19 **Time:** 12:30 – 2:30

Location: Robert and Lily Lee Family Community Health Centre, Room 226

Equipment: Paper plates, napkins, cutlery, honorarium, bus tickets, bathroom keys, pens, felt pens, pens,

Set-up: Overhead, laptop, table, food table in corner,

Handout: Logic model, laminated, overhead markers

Agenda:

noon – Room set up

12:30 – 12:40 pm – Arrival and getting lunch

12:40 – 12:55 pm – Welcome and introductions (Slides 1 – 5) **(*Ask permission to take photos)***

12:55 – 1:20 – Review of last meeting, redefining important concepts (slides 6 – 11)

Discussion (10 minutes): Is it HBP's Role to do this?

- Increase awareness of best practices in working with the at risk pregnant and parenting population
- Influencing roles for best practices
- Advocacy

1:20 – 1:35 – Round 1 of review – Drawing linkages between outcomes in logic model

- In groups of 3 or more, using worksheet
- 10 minutes to work on it, 5 minutes to report back if any thing hits a dead end

1:35 – 1:50 – Round 2 of review – anything that HBP does not influence?

8 minutes to work on it, 7 minutes to report back and discuss

1:50 – 2:05 – Round 3 of reviews – Anything missing from logic model?

8 minutes to review, 7 minutes to report back and discuss

2:05 – Do we agree on this logic model? (slide 15) - Discussion (10 minutes)

2:10 – Next Steps

2:15 – 2:30 – Check out

Remind clients that I will email and evaluation and to please email back within 1 week.

Appendix F – ESW Pre-questionnaire with Answers

Evaluation Stakeholder Workgroup Pre-questionnaire

Please answer the following questions in **one sentence**. There are no right or wrong answers. Please complete these questions on your own without consulting others;

1) Who would you refer to Healthiest Babies Possible?

- Responses: Single mothers (3), low income (3), Someone needing nutrition support (3), pregnant women living in Vancouver and Richmond, any woman under 24, socially isolated, new Immigrants, struggling, friends, family, Youth

2) What would you say about the program to encourage them to come?

- Responses: Get gift cards (4), free food/food access (4), support (2), dietitian/nutrition counselling (4), prenatal classes, doula, meet other moms

3) Who would you NOT refer to Healthiest Babies Possible?

- Responses: financially stable (2), women with good support, women with "normal" pregnancies

4) What would you expect someone to get out of attending the program?

- Responses: food access, a normal birth weight baby, prenatal information, how to take care of your baby, advice from the dietitian, friends, how to feed yourself and your baby, access to other services

Appendix G –Outcomes Reviewed at Meeting 2

SHORT TERM OUTCOMES (learning: awareness, knowledge, skills, and motivations)

1. **Clients increase awareness of support services such as:**

Food Security Programs

Prenatal Classes and other Group programs

Health care services

Community services

2. **Clients increase knowledge of health recommendations in pregnancy such as:**

Nutrition in pregnancy

Harm reduction practices

Medical follow-up

3. **Client increase knowledge of health recommendations post-partum such as:**

Infant feeding (including breastfeeding)

Infant care

4. **Clients gain skills and confidence in:**

Food preparation

Self-care practices

Navigating the healthcare system

5. **Community partners:**

Increase awareness of best practices in working with the at risk pregnant and parenting population

MEDIUM TERM OUTCOMES (behavior, practice, decisions, policies):

1. **Clients increase their access to resources and support**

Women access food security programs

Women access to healthcare and community sources

Women increase their social support network (friends etc.)

2. **Clients practice healthy behaviours in pregnancy:**

Pregnant clients improve their nutritional intake

Participants reduce fetal exposure to drugs, alcohol and nicotine

3. **Clients practice healthy behaviours postpartum**

Women follow recommended infant feeding guidelines (including breastfeeding)

Women follow recommended infant care guidelines

Participants use family planning strategies

4. Community Support

Community partners apply best practices in working with at risk pregnant and parenting population

LONG TERM OUTCOMES consequences: social, economic, environmental etc.

(when baby is 2 years old):

1. Participants sustain social support network

2. Participants and their children remain connected with the healthcare services

3. Participants sustain healthy behaviours as related to: diet choices, decreasing substance use, positive self-care practices, parenting practices.

4. Client feels increased confidence in their abilities to manage their (and their families) needs including health, social, financial.

5.Children of participants reach developmental milestones, or if not are referred to appropriate services for early intervention

6.Women successfully transition to other community programs that meet their needs as appropriate

ULTIMATE GOALS:

Healthy women of childbearing age (self-reported)

Healthy children

Well supported women and families

Appendix H - Outcomes Checklist Worksheet

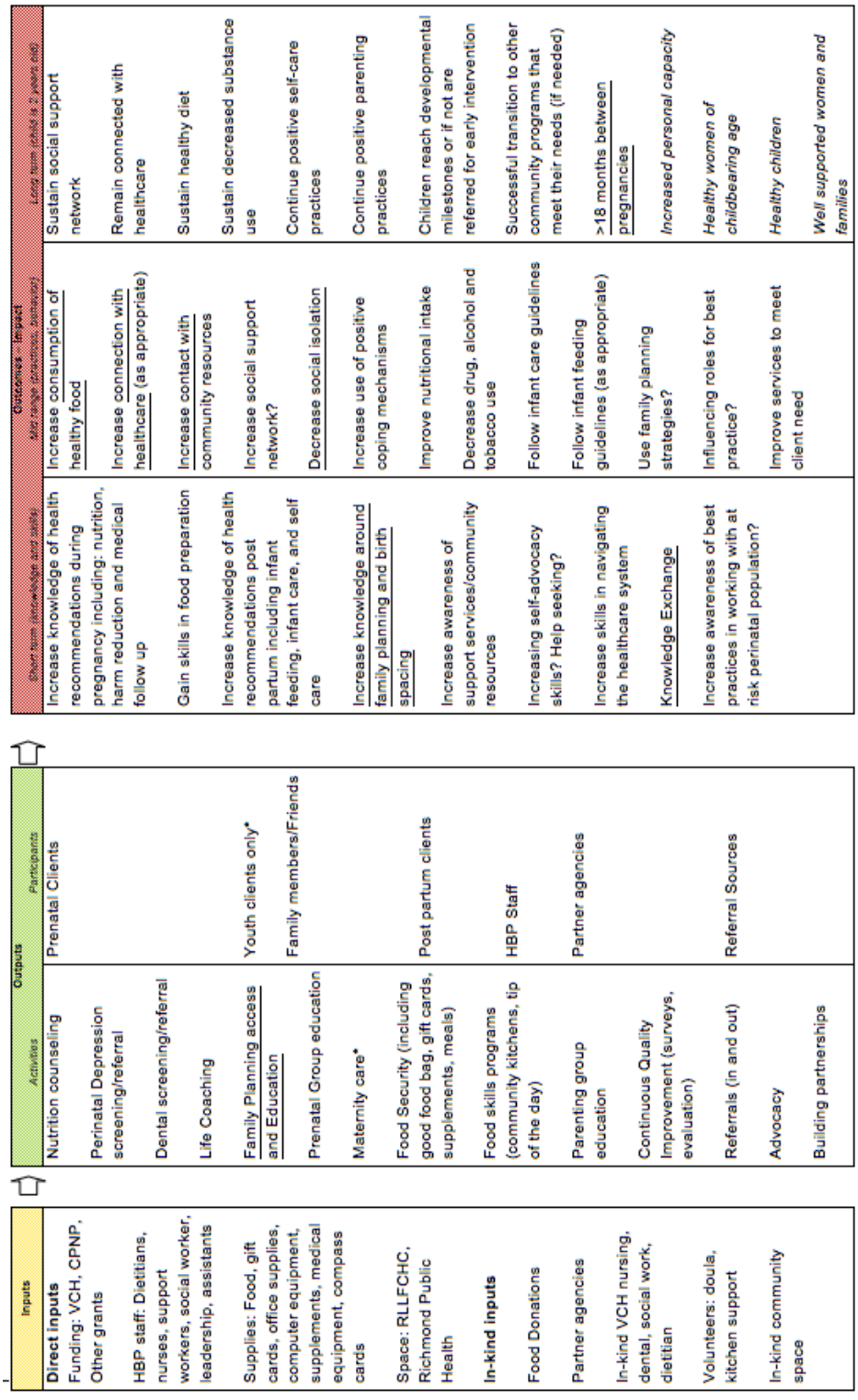
OUTCOMES CHECKLIST WORKSHEET

Program/initiative: _____

OUTCOMES	IMPORTANT? Does the end outcome represent important change or improvement valued by participant and key stakeholders?	REASONABLE? Are the outcomes connected in logical order and connected to the program activities?	REALISTIC? Is the outcome achievable given resources, the situation?	ANY POSSIBLE NEGATIVE EFFECTS? What else might happen?
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Ask others to review your outcomes.

Appendix I – Draft Logic Model Reviewed at Meeting 3



Appendix J: ESW Phase 1 Meeting Evaluation Survey

Evaluation Stakeholder Workgroup - Phase 1 Meetings Evaluation

1. What is your relationship to Healthiest Babies Possible?

2. Please select all meetings that you attended

- [ ] Meeting 1, October 7th
- [ ] Meeting 2, October 12th
- [ ] Meeting 3, October 19th

3. What did you think about the number of:

	Too few	Just Right	Too many
Meetings	○	○	○
People at each meeting	○	○	○
Patient advisors at each meeting	○	○	○
Healthiest Babies Possible staff at each meeting	○	○	○
Partners at each meeting	○	○	○

4. What did you think about the use of time at the meetings?

	Too Short	Just Right	Too Long
Overall length of the meeting	○	○	○
Time for discussion	○	○	○
Time for educational/background component	○	○	○
Time for group work	○	○	○

5. Please rate the following

	Poor	Fair	Avereage	Good	Excellent
Meeting Accessibility (in person or GoTo meeting)	○	○	○	○	○
Room Set-up	○	○	○	○	○
Meeting time slot (12:30 - 2:30)	○	○	○	○	○
Facilitator's communication	○	○	○	○	○
Facilitator's preparedness for meetings	○	○	○	○	○
Facilitator's facilitation skills	○	○	○	○	○

6. What benefit(s) did you get from attending the meeting? (Please check all that apply, if any)

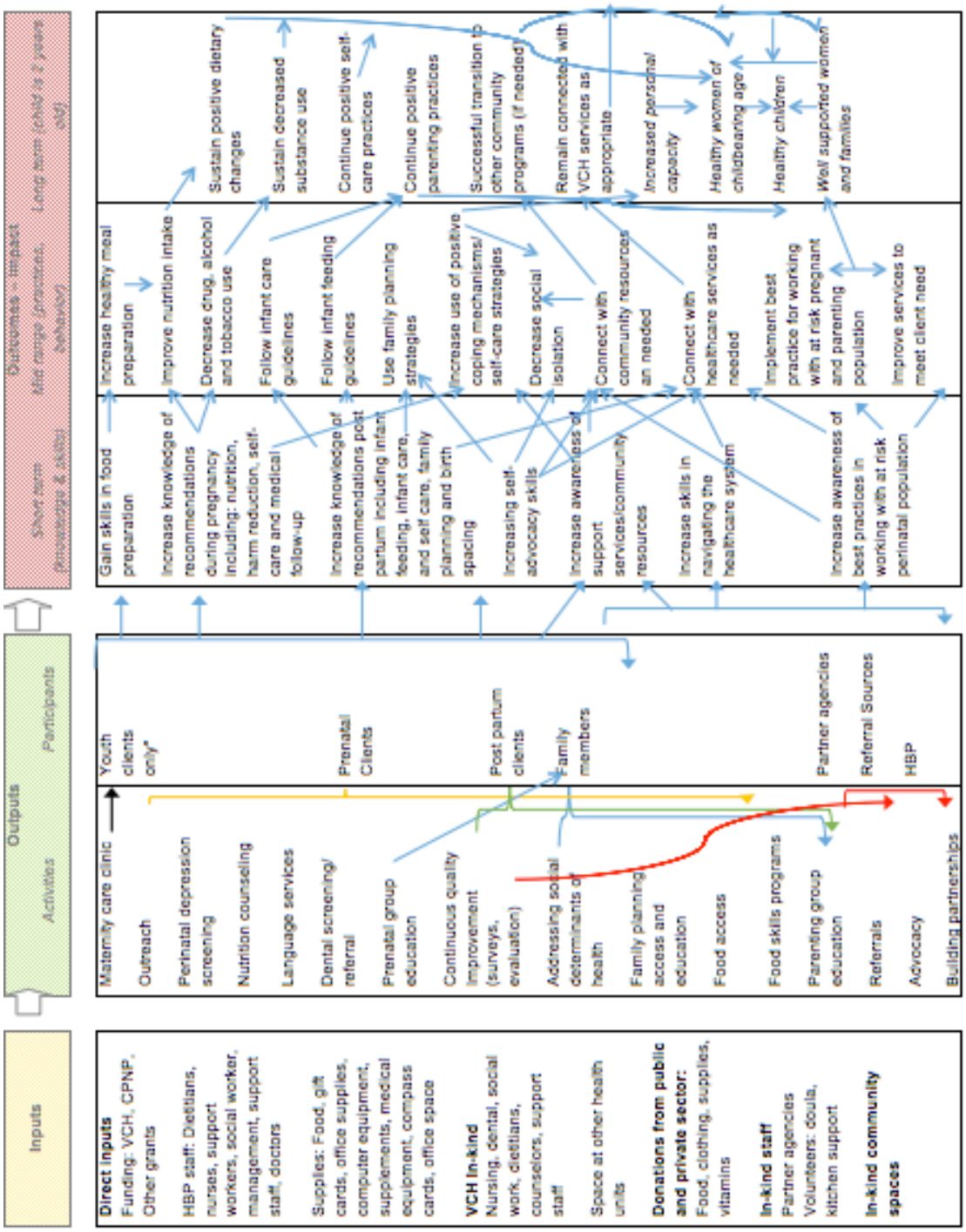
- ☐ An opportunity to expand my network by meeting new people
- ☐ New knowledge about evaluation and/or logic models
- ☐ New skills in evaluation and/or logic models
- ☐ New understanding about Healthiest Babies Possible
- ☐ A chance to contribute to a process that will help women and families

7. Overall, I feel that

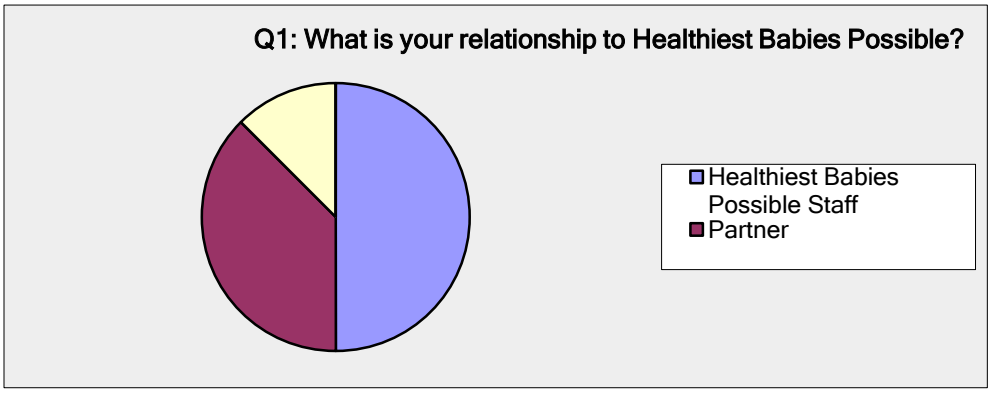
	No	Unsure	Yes	N/A
My voice was heard	○	○	○	○
My opinion was reflected in the logic model	○	○	○	○
I would like to participate in future stages of evaluation planning with Healthiest Babies Possible	○	○	○	○
I would like to participate in collaborative planning meetings in other areas of healthcare	○	○	○	○
I would recommend working in collaborative groups (with staff, partners, leaders and patients) to a friend or colleague	○	○	○	○

8. Do you have any other comments about the Evaluation Stakeholder Workgroup Phase 1 meetings?

Appendix K – Draft Logic Model 2



Appendix L – Summary of Evaluation Results



Q2: Please select all meetings that you attended

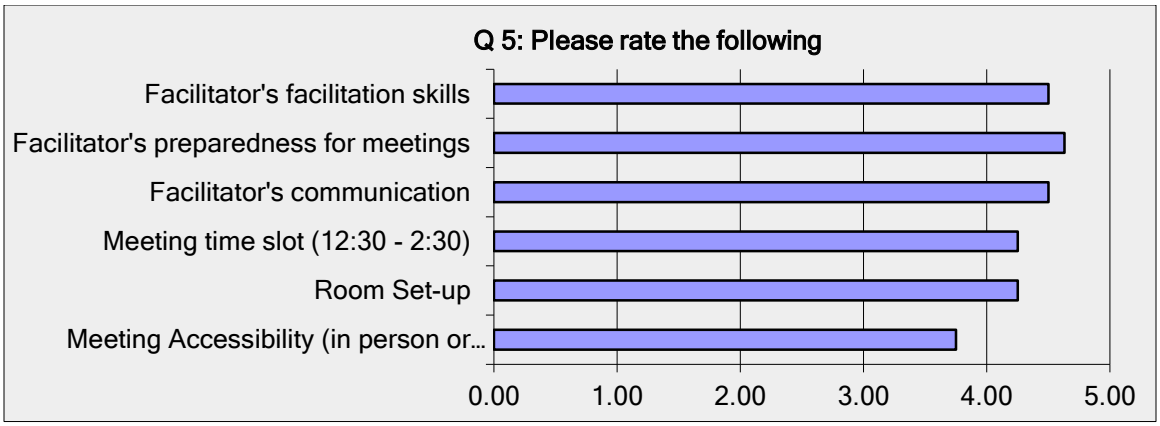
Answer Options	Response Percent	Response Count
Meeting 1, October 7th	100.0%	8
Meeting 2, October 12th	100.0%	8
Meeting 3, October 19th	62.5%	5
answered question		8
skipped question		0

Q3. What did you think about the number of:

Answer Options	Too few	Just Right	Too many	Response Count
Meetings	0	8	0	8
People at each meeting	1	7	0	8
Patient advisors at each meeting	6	2	0	8
Healthiest Babies Possible staff at each meeting	0	8	0	8
Partners at each meeting	2	5	1	8
answered question				8
skipped question				0

Q4: What did you think about the use of time at the meetings?

Answer Options	Too Short	Just Right	Too Long	Response Count
Overall length of the meeting	0	8	0	8
Time for discussion	3	5	0	8
Time for educational/background component	0	6	2	8
Time for group work	1	7	0	8
answered question				8
skipped question				0



	Response Percent	
anding about Healthiest Babies Possible		

Q 8: Do you have any other comments about the Evaluation Stakeholder Workgroup Phase 1 meetings?

Answers Given

1. More dietitians in the grouop, less social workers. Otherwise an enjoyable group of meetings
2. I think it will be important to have logic model in a format that is engaging and easy to understand for sharing
3. It was a great learning and networking opportunity with consumer participation
answered question 3

answered question 5

Appendix M – Healthiest Babies Possible Flyer

Vancouver Coastal Health

Healthiest Babies Possible

Healthiest Babies Possible (HBP) is a **free** prenatal outreach program for women who need extra support during their pregnancy.

HBP provides nutrition and prenatal lifestyle counseling to promote a healthy pregnancy and reduce the incidence of low birth weight babies among high risk pregnancies in Vancouver and Richmond. Our team includes Dietitians, Public Health Nurses and Support Workers fluent in 13 different languages.

Our Services Include:

- ✓ Nutrition counseling to gain a healthy weight
- ✓ Meet other moms at our drop in support groups
- ✓ Lifestyle education on tobacco, drugs or alcohol
- ✓ Weekly prenatal group(Vancouver)
- ✓ Biweekly prenatal group (Richmond)
- ✓ Dental health education
- ✓ Food supplement and prenatal vitamins
- ✓ Referrals to community resources
- ✓ Support and advocacy

Visit our facebook page at: www.facebook.com/healthiestbabiespossible

Email: HBP@vch.ca

Call 604-675-3982, and press extension:

- → 0 for English
- → 1 for Spanish
- → 2 for Punjabi/Hindi/Urdu/Swahili
- → 3 for Cantonese/Mandarin/Vietnamese (Vancouver)
- → 4 for Farsi/Dari/Russian
- → 5 for Somali
- → 6 for Cantonese/Mandarin (Richmond)
- → 7 for Punjabi/Hindi/Urdu (Richmond)

Robert & Lily Lee Family CHC | 1669 E. Broadway, 2nd floor | www.vch.ca