Working Together to Ensure Healthier Families
Nurse-Family Partnership Overview

- An evidence-based, community health program
- Transforming lives of vulnerable first-time mothers living in poverty
- Improving prenatal care, quality of parenting and life prospects for mothers by partnering them with a public health nurse

Every dollar invested in Nurse-Family Partnership can yield up to five dollars in return.

Home Visit Overview
- Personal Health: Maternal Role, Health Maintenance Practices, Substance Use, Mental Health Functioning
- Environmental Health: Home, Work, School, and Neighborhood
- Life Course Development: Family Planning, Education and Livelihood

Research
- Maternal Role: Mothering Role, Physical Care, Behavioral and Emotional Care
- Family and Friends: Personal network, Relationships, Assistance with Childcare
- Health and Human Services: Service Utilization

There is a magic window during pregnancy...it’s a time when the desire to be a good mother and raise a healthy, happy...David Olds, PhD, Founder, Nurse-Family Partnership
Research

Where we work

California NFP Client Demographics

- Approximately 9,000 women have been enrolled in the program since inception
- Clients' median age: 18 years
- Median household income is $13,500
- 85% of clients were unmarried at program entry
- 37% of clients completed high school
- 64% Hispanic, 14% Non-Hispanic White, 13% African American/Black, 4% Asian, 4% Multi-Racial, 1% Native American

Data through March 31, 2010

California NFP Outcomes

- 18% reduction in cigarette smoking among NFP moms during pregnancy
- 97% of NFP children received all recommended immunizations by age two, higher than the immunization rates for the state
- 85% of NFP mothers report breast feeding at birth and nearly 35% continue to breast feed at 6 months
- 42% of mothers who completed the program and who did not have a diploma/GED at intake earned their diploma/GED; 25% continue to work toward a diploma/GED; 16% were pursuing education beyond high school
- 92% of mothers were born full term compared to the CA rate of 89%

Data through March 31, 2010

How It Works

How It Works

For More Information

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NURSE-FAMILY PARTNERSHIP IN CALIFORNIA

Nurse-Family Partnership® (NFP) is an evidence-based, community health program that helps transform the lives of vulnerable mothers pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child’s second birthday. Independent research proves that communities benefit from this relationship — every dollar invested in Nurse-Family Partnership can yield more than five dollars in return.

NURSE-FAMILY PARTNERSHIP GOALS
1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets, and reducing their use of cigarettes, alcohol and illegal substances;
2. Improve child health and development by helping parents provide responsible and competent care; and
3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Positive Outcomes for Clients Served by California’s Nurse-Family Partnership

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>92% of babies were born full term and 93% were born at a healthy weight - at or above 2500 g (5.5 lbs)</td>
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<tr>
<td>91% of children received all recommended immunizations by 24 months</td>
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<tr>
<td>42% of mothers who completed the program and who did not have a diploma/GED at intake earned their diploma/GED</td>
<td>• 25% continue to work toward obtaining one • 16% were pursuing education beyond high school</td>
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<tr>
<td>88% of mothers initiated breastfeeding and 35% continue to breastfeed at child age 6 months</td>
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CLIENT DEMOGRAPHICS
At intake
- Median age: 18
- 85% Unmarried
- 73% Medicaid recipients
- 64% Hispanic
- 14% Non-Hispanic White
- 13% African American
- 4% Multiracial/other
- 4% Asian
- 1% Native American

Data as of March 2010
In California, Nurse-Family Partnership (NFP) programs are implemented by county public health departments serving families in 11 counties: Fresno, Humboldt, Kern, Los Angeles, Orange, Riverside, Sacramento, San Diego (El Cajon and South Region sites), San Luis Obispo, Solano and Tulare.

IMPLEMENTING AGENCY CONTEXT

The first California Nurse-Family Partnership Implementing Agencies were launched in 1998 in Fresno, Los Angeles, and Alameda Counties using the Department of Justice’s Weed and Seed strategy funding. The successful implementation of these initial NFP pilot sites demonstrated to other California communities that it was possible to replicate a scientific-based health strategy while also tailoring the program to meet the needs of each community.

FUNDING AND POLITICAL CONTEXT

Funding for the California Nurse-Family Partnership comes from an array of sources including: Medicaid (TCM), Prop 10, Prop 63, Realignment, County General Funds, Maternal & Child Health funds (MCH), Healthy Start, Federal Financial Participation (FFP), Agency for Children and Families (ACF), United Healthcare/PaciﬁCare, The California Wellness Foundation, and PIMCO.

PUBLIC HEALTH PROGRAM WITH PROVEN AND MEASURABLE RESULTS

Societal Benefits

Nurse-Family Partnership is one of the only community health programs that is based on evidence from randomized, controlled trials – 30 years of research proves that it works. This evidence shows our clients — eligible first-time mothers — that if they follow the program and work with their nurse, they can transform their lives and the lives of their children. Moreover, independent policy research makes clear that every public health dollar policymakers and communities invest in Nurse-Family Partnership could realize more than five dollars in return.

National Recognition

The Washington State Institute for Public Policy, The RAND Corporation and The Brookings Institution have concluded that investments in Nurse-Family Partnership lead to significant returns to society and government, giving taxpayers a $2.88-$5.70 return per dollar invested in the program.

The Office of Juvenile Justice & Delinquency Prevention (OJJDP) recognizes Nurse-Family Partnership as an Exemplary Model Program.

The Partnership for America’s Economic Success finds investments in early childhood programs, such as Nurse-Family Partnership, to be stronger investments than state business subsidies when viewed from a long-term, national perspective.

The Center for the Study and Prevention of Violence reviewed over 650 programs with published research in peer-reviewed literature. Nurse-Family Partnership is one of only 6% of the programs that clearly work, or even appear promising. The Center fully supports and endorses NFP as one of its “Blueprints” programs.

The non-profit, non-partisan Coalition for Evidence-Based Policy finds “strong evidence of effects on life outcomes of children and mothers” by Nurse-Family Partnership – findings that are consistent with the results of an authoritative evidence review recently published in The Lancet, one of the top medical journals.
The Nurse-Family Partnership model is a unique community health program that is based on evidence from randomized, controlled trials that proves that it works. Moreover, independent analyses based on the outcomes of these trials suggest that when communities adopt the Nurse-Family Partnership model, they are making a smart investment. For every dollar invested, a community can see a return of more than five dollars.

DISTINGUISHING PROGRAM FEATURES

Nurse-Family Partnership focuses on first-time mothers. It is during a first pregnancy that the best chance exists to promote and teach positive health and development behaviors between a mother and her baby.

The Nurse-Family Partnership program is delivered by registered nurses who are perceived as trusted and competent professionals, fostering a powerful bond between nurse and mother.

Nurse-Family Partnership has sufficient duration. Typically, a client begins to work with her nurse home visitor during her first trimester and continues through the child’s second birthday. This early intervention during pregnancy allows for any critical behavioral changes needed to improve the health of the mother and child.

Nurse-Family Partnership also has sufficient intensity, combining relevant content valued by the mother with a therapeutic relationship focused on self-efficacy.

The Nurse-Family Partnership National Service Office provides intensive education for nurse home visitors who utilize Visit-to-Visit Guidelines, clinical consultation and intervention resources to translate the program’s theoretical foundations and content into practice in a way that is adaptable to each family.

Nurse-Family Partnership implementing agencies enter data from each visit into the national web-based Clinical Information System. This data is monitored to ensure that the program is being implemented with fidelity to the model as tested in the original randomized, controlled trials, so that comparable results are achieved.

NURSE-FAMILY PARTNERSHIP GOALS

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets, and reducing their use of cigarettes, alcohol and illegal substances
2. Improve child health and development by helping parents provide responsible and competent care
3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work
A PROVEN SUCCESS

Nurse-Family Partnership is at the forefront of community health programs because it is evidence-based. This makes it easier for communities to choose to adopt the program because 30 years of research from randomized, controlled trials prove it works — delivering multi-generational outcomes that benefit communities and eliminate the costs of long-term social service programs. For example, the following outcomes have been observed among participants in at least one of the trials of the program:

- 48% reduction in child abuse and neglect
- 56% reduction in emergency room visits for accidents and poisonings
- 59% reduction in arrests at child age 15
- 67% reduction in behavioral and intellectual problems at child age six
- 72% fewer convictions of mothers at child age 15

THE ORIGINS OF NURSE-FAMILY PARTNERSHIP

The origins of the Nurse-Family Partnership model began more than 30 years ago when its founder, Dr. David Olds, began the first of three randomized, controlled trials in Elmira, New York. His vision and commitment were a result of his early experience working in an inner city day care center. He saw the need for care early in a young mother’s pregnancy and through the first two years of her child’s life if social problems like child abuse and neglect were to be reduced. A recent report from the Center on the Developing Child at Harvard University shows the extent to which early childhood experiences influence later learning, behavior and health. (See graph below.) The report provides a framework for a variety of informed policy choices, one of which is early and intensive support by skilled home visitors for vulnerable families expecting their first child.

Human Brain Development

Synapse formation dependent on early experiences

As the chart above shows, during the first 30 months of a child’s life, basic brain functions related to vision, hearing and language develop. It is during this window of opportunity that experienced registered nurses can have a huge impact on the future of both mother and child.

Home visits weekly the first month following program enrollment, then every other week until birth of infant. Nurses address:

- Effects of smoking, alcohol & illicit drugs on fetal growth, and assist women in identifying goals & plans for reducing cigarette smoking, etc.;
- Nutritional & exercise requirements during pregnancy & monitor & promote adequate weight gain;
- Other risk factors for pre-term delivery/low birth weight, e.g., genitourinary tract infections, pre-eclampsia;
- Preparation for labor & delivery/childbirth education;
- Basics of newborn care & newborn states;
- Family planning/birth control following delivery of infant;
- Adequate use of office-based prenatal care; and
- Referrals to other health & human services as needed.

Pregnant women display improved health behaviors.

↓ cigarette smoking
↓ pregnancy-induced hypertension
↑ use of community resources

Newborns are ≥37 weeks gestation & weigh 2500 grams or more.

↓ pre-term delivery among smokers
↑ birth weight among young teens (<17 years)
↓ neurodevelopmental impairment

Parents demonstrate sensitive and competent caregiving for infants & toddlers.

↓ childrearing beliefs associated with child maltreatment (Bavolek AAPI)
↓ verified cases of child abuse & neglect
↑ stimulating home environments, i.e., increase in appropriate play materials (HOME Inventory)

Child displays age & gender appropriate development.

↓ language & cognitive/mental delays
More responsive in interactions with mothers (NCAST)/less distress to fear stimuli

Parents have developed plans for economic self-sufficiency.

↓ subsequent pregnancies
↓ interval between 1st & 2nd child
↓ number of months women employed during child’s 2nd year
↓ months on welfare
↓ father involvement in child care & support

Parents have developed plans for economic self-sufficiency.

↓ subsequent pregnancies
↓ interval between 1st & 2nd child
↓ number of months women employed during child’s 2nd year
↓ months on welfare
↓ father involvement in child care & support

Home visits weekly postpartum period, every 2 weeks until toddler is 21 months, monthly until child is 2 years. Nurses:

- Educate parent on infant/toddler nutrition, health, growth & development, & environmental safety;
- Role model PIPE activities to promote sensitive parent-child interactions facilitative of developmental progress;
- Assess parent-child interaction, using NCAST sleeping & teaching scales, & provide guidance as needed;
- Assess infant/toddler’s developmental progress at selected intervals, using Ages and Stages Questionnaire or DDI, & provide guidance as needed;
- Promote adequate use of well-child care;
- Guidance to new parents in building & fostering social support networks;
- Guidance assessing safety of potential/actual child care arrangements; and
- Referrals to other health & human services as needed.

Parents have developed plans for economic self-sufficiency.

↓ subsequent pregnancies
↓ interval between 1st & 2nd child
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Home visits weekly during postpartum period, every 2 weeks until toddler is 21 months, monthly until child is 2 years. Nurses:

- Facilitate decision-making re: planning of future children & selection of birth control to achieve goals;
- Assist parents to set realistic goals for education & work, & identify strategies for attaining goals;
- Coaching parents in building & fostering relationships with other community services;
- Parents’ family planning, education & work goals; and
- Referrals to other health & human services as needed.

Parents have developed plans for economic self-sufficiency.

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IMPROVE outcomes of pregnancy by helping women improve prenatal health

IMPROVE children’s health & development by helping parents provide sensitive & competent caregiving

IMPROVE parental life-course by helping parents develop vision for future & plan, subsequent pregnancies, complete educations, & find work

Theory of Change Logic Model

Developed by Ruth O’Brien, Ph.D, RN
through a grant from the Harvard University Family Research Project - Home Visit Forum
What is a logic model?

A logic model provides a visual depiction of a program’s “theory of change” - the way in which a set of services to a particular population are linked to expected outcomes of the program. The articulation of a program’s theory of change can help program staff and families stay focused on the outcome goals rather than just focusing on program activities and services. A logic model is also a tool to assist program stakeholders in gathering data to facilitate effective program implementation and evaluation.

This model flows from left to right, as depicted by arrows, and shows how program goals are translated into home visit activities with families, which in turn, facilitate families to create change needed to attain program outcomes. The theory behind a logic model is a series of “If…then” statements. For example, If women who are smokers at entry into the program quit smoking, then they are more likely to have a full-term infant weighing greater than 2500 Grams.

What are the major elements of the Nurse-Family Partnership logic model?

The major elements of the logic model include the program’s goals, activities, and outcomes.

Program Goals are broad statements of expected outcomes for the problem(s) that the program is attempting to prevent or reduce. The program goals are color coded to illustrate how they correspond to program activities and outcomes.

Activities are interventions designed to facilitate change in families’ attitude, knowledge and skills in order to help them attain the intended program results.

Short-term Outcomes are changes that occur by completion of the program. The specific outcomes delineated are those observed in the three randomized clinical trials in Elmira, NY, Memphis, TN and Denver, CO.

Intermediate Outcomes are changes that result over time from short-term outcomes and are measurable at a later timeframe, usually within 2-6 years following completion of the program. The specific outcomes delineated are those observed in the 4-year and 6-year follow-ups of families from the randomized clinical trials in Elmira, NY, Memphis, TN and Denver, CO.

Long-term Outcomes refer to changes that have a greater community impact and require a greater time to measure, often 10 or more years following program completion. The specific outcomes delineated are those observed in the 15-year follow-up of families who participated in the trial conducted in Elmira, NY.

Who does Nurse-Family Partnership serve?

Nurse-Family Partnership serves low-income, first-time mothers and their children, by providing nurse home visitation services beginning early in pregnancy and continuing through the first two years of the child’s life. Women voluntarily enroll as early as possible in pregnancy, but no later than the 28th week of gestation.

The majority of participants are unmarried women with less than a high school education. The focus on women who have had no previous live births stems from the belief that individuals undergoing a major role change are more likely to seek information and support from others than are women who have already given birth. Moreover, the skills first-time mothers learn through the program, will help them provide better care for subsequent children, generating even broader salutary effects.

Other family members are invited and encouraged to participate if the mother wants them to be present.

How does Nurse-Family Partnership work?

Central to the successful implementation of Nurse-Family Partnership is the establishment of a trusting relationship with the family. Registered Nurse Home Visitors, work together with their clients, engaging them in activities associated with the three Nurse-Family Partnership goals during each home visit. These goals are:

- Improve pregnancy outcomes;
- Improve child health and development; and
- Improve families’ economic self-sufficiency.

These goals are achieved by helping women engage in good preventive health practices, including obtaining thorough prenatal care from their healthcare providers, improving their diet, and reducing their use of cigarettes, alcohol and illegal substances; child health and development is improved by helping parents provide responsible and competent care for their children; and families’ economic self-sufficiency is improved by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Nurse Home Visitors utilize a strength-based approach directed toward optimizing the family’s sense of efficacy; and are guided in their work through detailed visit-by-visit guidelines that reflect the challenges parents are likely to confront during pregnancy and the first two years of the child’s life. Within this framework, however, nurses use their professional judgment to address areas where needs are greatest.

Guided by the above principals, and implemented with fidelity to the program model which has undergone extensive research over the past three decades, Nurse-Family Partnership is transforming lives through the power of relationships.
NURSES AND MOTHERS

NURSE-FAMILY PARTNERSHIP BUILDS A TRANSFORMATIONAL RELATIONSHIP THAT BENEFITS MULTIPLE GENERATIONS

The transition to motherhood can be particularly challenging for many low-income, first-time mothers. Many are socially isolated or are experiencing severe adversity and nurse home visits can prove extremely helpful.

WHY A NURSE INTERVENTION?

The expertise and experience that registered nurses bring to this intervention is key in gaining the confidence of a new mother. A nurse’s expertise helps guide first-time mothers through the emotional, social and physical challenges they face as they prepare for a healthy birth. Prenatal support is the starting point, but the nurse continues to serve her client after she delivers her child, teaching parenting and life skills that foster positive growth for both mother and child.

The original model developed by Dr. David Olds was heavily influenced by nursing theory and practice and remains at the core of the model and nurse education today. In a sense, the Nurse-Family Partnership model was developed in partnership by nurses for nurses.

NURSE-FAMILY PARTNERSHIP MOTHERS

Nurse-Family Partnership focuses on low-income, first-time mothers—a vulnerable population segment that sometimes has limited access to good parenting role-models. Women voluntarily enroll as early as possible with nurse home visits, beginning ideally by the 16th week of pregnancy.

Race/Ethnicity of NFP clients

- 39% Caucasian
- 25% Hispanic
- 25% African-American
- 6% Multiracial/Other
- 4% Native American
- 2% Asian

The NFP Mother at a Glance

- MEDIAN AGE: 19
- MARITAL STATUS: Unmarried (84%)
- EDUCATION LEVEL: High school (50% completed)
- ANNUAL HOUSEHOLD INCOME (MEDIAN): $13,500

At program intake 2007-2008
A RELATIONSHIP YOU CAN COUNT ON

Nurse-Family Partnership can help break the cycle of poverty—empowered, confident mothers become knowledgeable parents who are able to prepare their children for successful futures. Nurse home visitors and their clients make a two-and-one-half year commitment to each other, with 64 planned home visits. This intensive level of support has been proven to improve outcomes relating to:

- Preventive health and prenatal practices for the mother—helping her find appropriate prenatal care from healthcare providers, improve her diet, and reduce her use of cigarettes, alcohol and illegal substances. Nurses also help the mother prepare emotionally for the arrival of the baby by educating her on the birth process and the immediate challenges of the first few weeks after delivery, e.g., breastfeeding and potential postpartum depression.

- Health and development education and care for both mother and child—providing individualized parent coaching aimed at increasing awareness of specific child development milestones and behaviors, and encouraging parents to use praise and other nonviolent techniques.

- Life coaching for the mother and her family—enabling economic self-sufficiency among mothers by encouraging them to develop a vision for their own futures, stay in school, find employment and plan future pregnancies. The partnership can extend beyond the mother and nurse to involve the mother’s family members, the baby’s father and friends.

CHARACTERISTICS OF THE NURSE/MOTHER RELATIONSHIP

Client-Centered means the nurse is constantly adapting to ensure the visit and materials are relevant and valued by the parent. Supporting the client’s growth and needs is the focus.

Relational means that the relationship between the nurse and the client is the primary tool used for learning and growth in each family served.

Strengths-Based means that the intervention is based on solid adult learning and behavior change theory. Adults and adolescents make changes most successfully when they are building on their own knowledge, strengths and successes.

Multi-Dimensional means that the life of each program participant is viewed holistically, and what the program offers is tied to multiple aspects of personal and family functioning: personal and environmental health, parenting, life course development, relationships with family and friends, and community connections.

FIDELITY TO THE MODEL

Nurses chart and enter data from each visit into the Nurse-Family Partnership national database. The data is monitored to ensure that the program is being implemented with fidelity to the model as tested in the original randomized, controlled trials, so that comparable results are achieved. The NFP Model Elements are supported by evidence of effectiveness based on research, expert opinion, field lessons and/or theoretical rationales. The Elements can viewed at www.nursefamilypartnership.org (NFP Sites/Fidelity to the Model).
WHY INVEST PUBLIC RESOURCES?
Nurse-Family Partnership (NFP) is an evidence-based, public health program that helps transform the lives of low-income mothers pregnant with their first child. Each mother served by this national program is partnered with a registered nurse early in her pregnancy and receives ongoing support and guidance through her child’s second birthday.

This partnership can help break the cycle of poverty by empowering mothers to become confident, skilled parents able to prepare their children for successful futures. More than 30 years of research from randomized, controlled trials conducted in three diverse settings demonstrate that when first-time mothers receive the guidance and support they need, both mother and child benefit. Examples of specific outcomes include:

- 48% reduction in child abuse and neglect
- 56% reduction in emergency room visits for accidents and poisonings
- 32% reduction in subsequent pregnancies
- 67% reduction in behavioral and intellectual problems at child age six
- 59% reduction in arrests at child age 15
- 83% increase in labor force participation

MULTIPLE PUBLIC FUNDING SOURCES SUPPORT NURSE-FAMILY PARTNERSHIP TODAY
Federal, state and local funds that currently support the program include Medicaid, the Maternal and Child Health Services Block Grant (Title V), Temporary Assistance for Needy Families (TANF), Child Care Development Block Grant, Healthy Start, juvenile justice, child abuse prevention funds through the Administration for Children & Families, tobacco settlement funds, and state and local general revenue funds.

Private support also serves to extend the reach of publicly supported programs. And, private funding often helps establish pilot sites which can be useful in generating the public support needed for broader state-wide implementation. Six of the nation’s leading foundations — the Robert Wood Johnson, Edna McConnell Clark, Bill & Melinda Gates, Kellogg, Picower and Kresge Foundations — made an unprecedented private investment in NFP’s national infrastructure in 2008, allowing public funds allocated in the future to directly support local services for children and families.

EFFECTIVE STATE FUNDING STRATEGIES
Under Republican Governor Tom Ridge’s leadership, Pennsylvania offered communities state support in 2001 to implement NFP or other evidence-based interventions proven to reduce youth violence. A combination of State/County Child Welfare funds, TANF, juvenile justice, Child Care Development Block Grant, and other state and private funds have supported the implementation since then under subsequent Democratic and Republican administrations.

PUBLIC FUNDING
In June 2007, Texas State Senator Florence Shapiro (R-Chair, Education) and State Representative Jerry Madden (R-Chair, Corrections) led statewide NFP legislation (SB 156), authorizing $7.9 M in funding with a combination of TANF and state general funds to serve 2,000 families. Additional sources of funding include a required local match to state/federal funding.

Under the leadership of Mayor Michael Bloomberg and Thomas Frieden, Commissioner of the Department of Health and Mental Hygiene, New York City spearheaded the most ambitious NFP expansion in an urban center to date. Funding sources include Healthy Start, state child abuse prevention and health dollars, NYC Council and other targeted NYC funds, county general funds, and a range of private sources including the Robin Hood Foundation and the United Way, with steps underway to secure Medicaid Targeted Case Management funding.

FEDERAL STRATEGIES TO SERVE GREATER NEEDS

Additional public funding is essential to meet the goal of making Nurse-Family Partnership available to every eligible first-time family. (It is estimated there are approximately 600,000 first-time, low-income mothers each year in the U.S.) To support States’ interest in bringing Nurse-Family Partnership to their communities, NFP has developed federal legislative proposals that support increased investment of public funds based on the best available evidence about what works.

President Obama has recommended a federal funding stream for a national nurse home visitation program that serves first-time, low-income mothers. The President’s support for Nurse-Family Partnership was clear during the presidential campaign, when NFP was included in his candidate platform, and support remains strong in his Administration. In Congress, funding for Nurse-Family Partnership has bi-partisan, bi-cameral support and legislative opportunities exist for allocations to supplement State funding.

In 2007, the Brookings Institution published a series of papers on budget choices that would lead to a balanced federal budget in the next five years. Based on a review of cost-benefit evidence, Brookings proposes a federal investment of $12.5 billion over five years in NFP to cover 80% of program funding, with the remainder funded by states or localities.

WISE LONG-TERM PUBLIC INVESTMENTS FOR SOCIETY

Not only will a public investment in Nurse-Family Partnership profoundly impact families served, but independent research documents that communities also benefit. A 2005 RAND Corporation study found that every dollar invested in NFP for higher-risk families can yield a social return of more than five dollars.

And what about the longer-term economic impacts relative to improving job growth and fiscal health? A recent report by the Partnership for America’s Economic Success finds investments in early childhood programs, such as NFP, to be stronger investments than state business subsidies when viewed from a long-term, national perspective.

Research highlights the need for science-based early childhood initiatives. A 2007 report issued by Harvard University’s Center on the Developing Child says scientists can guide policymakers in choosing the right investment in science-based early childhood policies and programs, such as NFP. The report notes “early experiences determine whether a child’s developing brain architecture provides a strong or weak foundation for all future learning, behavior, and health.”

Legislators have a tremendous opportunity to make investments in prevention programs like NFP that can have a profound long-term impact on both outcomes and budgets. A growing chorus of academic, business, social service, health policy and government leaders are calling for the investment of new dollars in the most proven programs, understanding that policies that promote healthy development throughout the early years create a foundation for school achievement, economic productivity, responsible citizenship and successful parenting.
Nurse-Family Partnership is a public health program that is based on evidence from randomized, controlled trials that proves it works. The evidence shows that first-time mothers working with a Nurse-Family Partnership (NFP) nurse home visitor can transform their lives and the lives of their children. Moreover, independent research proves that for every public health dollar invested in a local Nurse-Family Partnership program, communities can realize more than five dollars in return.

The Nurse-Family Partnership program costs approximately $4,500 per family per year to fund, and can range from $2,914 to $6,463 per family per year. Nurses’ salaries are the primary driver that affects variability of cost, with highest costs typically found in urban centers on either Coast and in hospital-based programs.

Communities choose to invest in Nurse-Family Partnership because it is a wise investment that can yield substantial, quantifiable benefits in the long term — to parents, their children and the communities in which they live.

INDEPENDENT COST-BENEFIT STUDIES

When Medicaid pays for Nurse-Family Partnership services, the Federal government saves more than it spends on the program costs, according to a 2009 analysis conducted by the Pacific Institute for Research and Evaluation (PIRE).

Using data from the 1990 NFP Memphis trial, PIRE noted that Nurse-Family Partnership services resulted in a decrease in the number of women and children enrolled in Medicaid and Food Stamps programs as the nurse-visited families gained academic and employment skills to become economically self-sufficient. According to the analysis, NFP services resulted in lower enrollment in Medicaid and Food Stamps, with a 9% reduction in Medicaid costs and an 11% reduction in Food Stamps costs in the 10 years following the birth of the child. Federal savings will be 154% of costs, yielding a net 54% return on the Federal investment.

A RAND Corporation 2005 analysis found a net benefit to society of $34,148 (in 2003 dollars) per family served, with the bulk of the savings accruing to government, equating to a $5.70 return for every dollar invested in Nurse-Family Partnership (see graph). The analysis also found...
that for the higher-risk families participating in the first trial in Elmira, New York, the community recovered the costs of the program by the time the child reached age four, with additional savings accruing throughout the lives of both mother and child.

In a 2004 study by the Washington State Institute for Public Policy, Nurse-Family Partnership ranked highest in terms of cost return among pre-K, child welfare, youth development, mentoring, youth substance prevention and teen pregnancy prevention programs at $2.88 benefit per dollar of cost.

**LASTING IMPACTS**

Data from the 15-year follow-up study to the Nurse-Family Partnership trial in Elmira, New York, shows positive effects for nurse-visited families more than 12 years after the visits ended. In addition, the following outcomes have been observed among participants in at least one of the three NFP controlled program trials:

- 48% reduction in child abuse and neglect
- 59% reduction in arrests among children
- 72% fewer convictions of mothers
- 56% reduction in emergency room visits for accidents and poisonings
- 67% reduction in behavioral and intellectual problems among children

**NATIONAL SUPPORT**

Nurse-Family Partnership is currently serving clients in 28 states across the country. As the program expands, the NFP national headquarters in Denver, Colorado, works with participating agencies to ensure that they adhere to the tested and proven approach. Agencies are required to input data regarding family characteristics and needs and the services provided during each nurse home visit into the national NFP database. Reports are provided back to the agencies, tracking fidelity to the proven model, and ensuring communities realize comparable outcomes to those documented over the past 30 years.
Nurse-Family Partnership is widely recognized as an exemplary evidence-based program. Thirty years of research from randomized, controlled trials prove Nurse-Family Partnership works, delivering multigenerational improvements in the health, social and economic well-being of participating parents and their children.

Nurse-Family Partnership began with research; the program’s implementation in communities is done with fidelity to the model born out of that research. Independent analysis from some of the country’s most respected organizations and individuals praise Nurse-Family Partnership for its proven, cost-effective results.

The RAND Corporation, 2006
“In the case of early childhood intervention and particularly in the Nurse-Family Partnership program, we actually have solid, rigorous, experimental-based evidence that demonstrates that this is a program that generates not only benefits to participating children and their families…but real economic returns that are a payback to society for making those investments.”

California Secretary of State, Debra Bowen, May, 2005
“It’s one of the best kept secrets in the state. We could save a lot of money for California taxpayers.”

The Brookings Institution, 2007:
“The strong evidence of effectiveness of the Nurse-Family Partnership...makes it a leading candidate for a prudent investment in children and the country.”

Rob Grunewald, Associate Economist, Federal Reserve Bank of Minneapolis, June, 2006
“If communities are truly interested in making sound investments that will yield high public and private gains in both the long and short run, they would fare far better by investing in evidence-based, early child development initiatives, like the Nurse-Family Partnership than in professional sports stadiums or office towers [bricks and mortar].”

California State Senator George Runner
“Nurse-Family Partnership is a program that has strict accountability and proven results.”

Chief Paul Walters, Santa Ana Police Department, Fight Crime: Invest in Kids, 2006
“Fight Crime: Invest In Kids has prioritized this remarkable program for one simple reason...because it keeps kids and their parents from getting in trouble with the law. The single most cost effective way to ensure our streets are safe for our children and grandchildren is to invest now in programs like the Nurse-Family Partnership.”
Mayor Michael Bloomberg, New York City, 2006

“Nurse Family Partnerships, you should know, are a proven success. Last year’s heartening decline in African American and Puerto Rican infant mortality --reported in the recent MMR-- was attributable in part to the success of the pilot NFP program we launched in several communities.”

Dr. Delbert S. Elliott, Director, Center for the Study and Prevention of Violence, University of Colorado, 2006

“It’s unethical and irresponsible for government agencies to promote programs that have never been evaluated or evaluated and found to be ineffective or harmful – particularly when the lives of children and family members are at stake. We fully support and endorse the Nurse-Family Partnership as a model effective program.”

Texas State Representative Jerry Madden, Chairman of the House Committee on Corrections, 2007

“We have been looking at alternative programs that will make great positive changes in our society in Texas and keep us from having a growing criminal class. Of all the programs we have seen, the Nurse-Family Partnership has the history to show it makes the greatest possible difference in reducing family violence, reducing child abuse, improving school performances, and reducing criminal activities of both mother and child. This program will change Texas for the better and this legislation may be looked back on by future generations as the best work in many years of the Texas Legislature.”

California State Treasurer and former Attorney General Bill Lockyer, 2006 NFP Forum

“Studies show that children exposed to violence, either as victims or witnesses, are more likely to become juvenile and adult offenders and that’s why we’re here today – to understand the positive impact Nurse-Family Partnership can have in California.”


“The question, of course, is what can governments do about any of this? The answer is that there are programs that do work to help young and stressed mothers establish healthier attachments…the Nurse-Family Partnership program has produced rigorously examined, impressive results...”


Investments in Nurse-Family Partnership lead to significant returns to society and government, giving taxpayers a $2.88 - 5.70 return per dollar invested in the program.

U.S. Senator Ken Salazar (D-CO) upon introduction of the bipartisan Healthy Children and Families Act (S. 1052), 2008

“The success of the Nurse-Family Partnership is undeniable; this program should be expanded to every community in this country, not just a select few.”