

Building the NFP at Scale in Multiple States
BluePrints Conference 2010
Working Together to Ensure Healthier Families

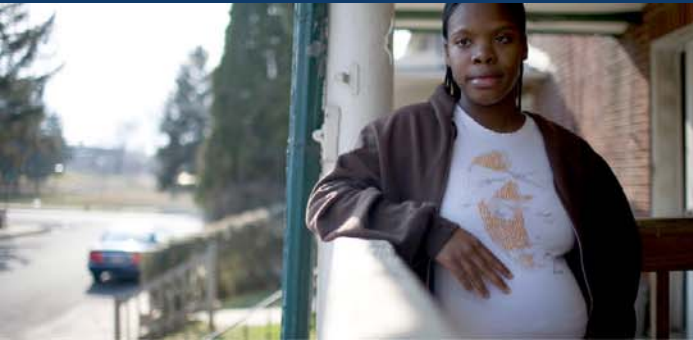


Nurse-Family Partnership is...

- 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 registered nurse

Every dollar invested in Nurse-Family Partnership can yield **more than five dollars in return.**





Program Goals

- Improve pregnancy outcomes
- Improve child health and development
- Improve parents' economic self-sufficiency

Key Program Components

- First-time, at-risk mothers
- Registered nurses
- Intensive services (intensity, duration)
- Focus on behavior
- Program fidelity (Clinical Information System)

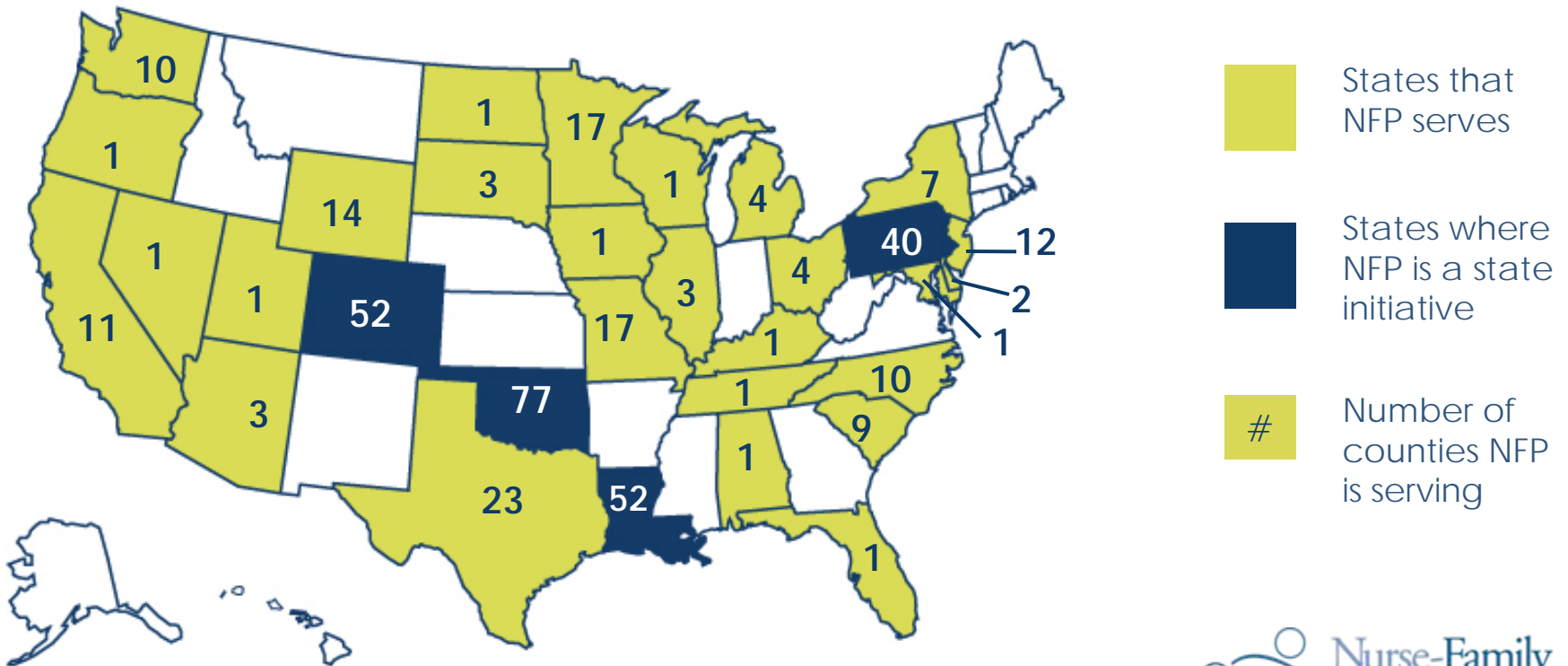
Why Nurses?

- Knowledge, judgment and skills
- High level of trust, low stigma
- Credibility and perceived authority
- Nursing theory and practice at core of original model





Nurse-Family Partnership is a growing, national program



Even State Level Work is Ultimately Community by Community

- Each NFP Implementing Agency (IA) is responsible for their own funding
- Most IA's are county health departments (some hospitals and CBOs)
- Our goal is a state partner of some kind and one common funding stream
 - It is very slow (although possible) to scale a state without a common stream or a partner
- Additional funding streams are still needed
- Varied sources for all funding
 - Medicaid, TANF/Public Welfare, Title V/Maternal and Child Health Initiatives, Child Abuse Prevention Juvenile Justice/Delinquency Prevention, Substance Abuse and Mental Health, Tobacco Settlement, United Way, State, City and County General Funds, Private Philanthropy, School Readiness



Scale is a *very* relative term

- One 8 Nurse Home Visitor team serves up to 200 families (25 ea)
- Ideally start substantially and grow
 - one or two teams (in the largest cities) and building to 10 or more
 - Put teams in many counties across a state and build out each one to capacity based on population
 - reach 50% of eligible pop is penetration for us right now
 - Remember- Enrolling in NFP is only available to a woman for a few weeks of her entire life
- We have achieved this kind of scale in a few cities and some states
- Hundreds of families in a state is an accomplishment
- Thousands per state would get community wide change and maybe even population based change



With Regard to scale, in all its facets, we are moving

From

“Let it Happen”

Through

“Help it Happen”

Aiming now for

“Make it Happen”



Infrastructure prior to scale up:

- Prefer to install **basic functions**

Advocacy and Community

Administration and Management

Clinical Expertise and Oversight

Prior to scaling

- a substantial dependency:

availability of potential partners + degree of local groundswell

↑ groundswell and ↓ partners = grow **w/out** infrastructure
(WA and CA)



Contrasting Examples of “Helping it Happen”

Texas

- Landscape:
 - Heavy Private/non-profit advocacy
 - limited Public Health Infrastructure
 - Limited groundswell
- Result:
 - Legislation with FTE and placement
 - (Lightly) implementation informed RFP
 - Speed (good and bad)

North Carolina

- Landscape:
 - Heavy Philanthropic advocacy
 - Public Health Infrastructure
 - Moderate groundswell
- Result:
 - Strong local support in communities
 - Less Structured process (good and bad)
 - Incremental infrastructure



Texas

- Private sector advocacy starting in 2005 - SB 156 was passed in 2007
- Statutory authority places NFP in the Health and Human Services Commission
- General Revenue and TANF funding for up to 2,000 families
- Big Growth
 - 2006 half a team (4 NHV & 1 Sup)
 - March 2010: 72 NHV and 11 Nurse Supervisors on HHS (plus the first team in Dallas from 2006)
- Funding for the 2010-11 biennium is \$17.8 million
 - the administrative infrastructure cost (HHSC) for TNFP is @ 2% of the total budget or \$200,000 of the yearly \$8.9 million.

North Carolina

- 2000 - Initial team in Greensboro - constant advocacy efforts at state and national level for years
- 2005 - The Duke Endowment and Prevent Child Abuse NC began conversations to coalesce support
- 2008 \$21M committed over seven years for 6 locations
 - 2 of the 6 sites are funded by the NC Division of Public Health and their funding is in perpetuity
- 2010 - 8 NFP locations serving almost 800 moms across 10 counties.
- Pew Center on the States recipient – studying how can we get to 25% penetration in NC
- Heavy Philanthropy plus partners
 - The Duke Endowment; Kate B. Reynolds Charitable Trust; Blue Cross Blue Shield of NC Foundation; NC Division of Public Health; local health departments.
- Mecklenburg County developing plan for 25% penetration in the county
 - funding by Social Venture Partners
- Currently Administrative Infrastructure sits with PCA-NC and the funders support one .75 position to coordinate
 - Hopeful that funders will soon announce support for 1 additional FTE to Administrative Infrastructure



Lessons Learned and Mediating Risk

- Arkansas – single champion and inadequate local support
- Strong Champions and Statewide Funds can = local complacency
- Federal Funding Stream presents this risk as well
- Some aspects of quality appear to be community and agency based
- How do we understand and then assure key features



Scaling EBP is like cooking dinner for 50, instead of 5

You have to think of everything x10

But you can't just multiply everything x 10

Its too expensive and everything is either bland or too salty.

New, different approaches to everything

from sourcing materials and support
to cleaning up the mess

have to be applied, tried, changed and tried again.

"There is a magic window during pregnancy...it's a time when the desire to be a good mother and raise a healthy, happy child creates motivation to overcome incredible obstacles including poverty, instability or abuse with the help of a well-trained nurse."

David Olds, PhD, Founder,
Nurse-Family Partnership





For More Information

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