Nurse-Family Partnership

Helping First-Time Parents Succeed®

Implementation Overview & Planning

A guide for prospective Nurse-Family Partnership Implementing Agencies

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Organizational Culture

What is the Nurse-Family Partnership National Service Office mission statement?

The Nurse-Family Partnership® National Service Office (NFP NSO) supports communities in implementing a cost-effective, evidence-based nurse home visitation program to improve pregnancy outcomes, child health and development, and self-sufficiency for eligible, first-time parents. The results benefit multiple generations.

How is this mission accomplished?

Nurse-Family Partnership offers states and communities one of the most promising approaches developed for helping low-income, first-time families succeed. NFP draws its strength from an extensive body of rigorous research conducted over more than thirty years. The research demonstrates that NFP makes significant and sustainable differences in the lives of vulnerable families.

Nurse-Family Partnership engages with and supports states and communities interested in implementing the NFP program. In order to achieve the outcomes that research has proven are possible through this program, agencies must have a commitment to the mission, values and day-to-day processes required to implement the model with fidelity. The implementation planning process provides an avenue for mutual dialogue between the National Service Office staff and the agency. This dialogue helps the agency to understand the requirements of the program. The agency can then better determine the feasibility and advisability of program implementation.

Research-based programs can be diluted or compromised when scaled up in the "real world". The result is a reduction in program effectiveness. Preventing this compromise from occurring as NFP expands is of the highest importance. We believe that each implementing agency must provide a stable, supportive environment for the nursing staff, and so we offer both encouragement and caution about the timing for program start-up. We have learned that it is better to wait until the community and agency are truly ready to support and sustain the program before they begin to serve families.

What services does the National Service Office provide?

The Nurse-Family Partnership provides several services through the National Service Office. These include:

- Planning assistance
- Marketing and communications resources
- Policy, financing and government relations consultation
- Nursing education services and home visit guidelines
- Data collection and reporting system
- Ongoing consultation to support NFP implementation

Each of these resources has evolved over time and improved with input from experienced NFP implementing agencies across the country:

Planning assistance

The NSO provides substantial assistance during the implementation planning process. We hold conference calls and meetings with stakeholders in your community and state to build consensus about the program's value and the best way to implement it locally. We share knowledge from experienced implementing agencies about funding strategies and sources. We provide support in developing and submitting a plan to implement Nurse-Family Partnership. Upon determination of implementation readiness, the NSO prepares the contracts between the NSO and local implementing agencies.

Marketing and communications resources

Generating visibility for and understanding of NFP in your community is crucial to its overall success and sustainability over time. Obviously, there are different avenues to reach different interests. For example, materials used to gain the attention of policy makers will differ from those used for client referral sources. The National Service Office has developed a range of materials appropriate for many audiences for your use. In addition, the Marketing & Communications department can provide strategic counsel.

Policy, financing, and government relations consultation

Your NFP Regional Program Developer can connect you with our Policy and Government Affairs staff as needed. This group is based in New York City and Washington, DC. Their counsel on use of federal funding streams like Medicaid and TANF can be instrumental in building a sustainable financing plan. Further, the NSO can provide counsel on legislative and administrative advocacy that may be important for your program's development.

Nursing education services

Registered nurses bring an abundance of knowledge and experience with them. The NFP Core Education Sessions add to their skills. These extensive education sessions and follow-up consultations make this program unique and highly successful. In addition, the face-to-face sessions provide nurses with the opportunity to interact with colleagues from across the country. This helps nurses develop a shared frame of reference and community of practice.

NFP Core Education for nurse home visitors and supervisors consists of both distance and face- to-face education units. This professional development process is required for nurse home visitors and supervisors prior to enrolling clients. The success of NFP depends on preserving its clinical integrity. This integrity is achieved directly through nurse home visitors who are skilled in establishing therapeutic relationships applying the model.

Full participation in the NFP educational program (completion of all distance and face-to-face offerings) enables nurses to become proficient in the application of the NFP model.

Data collection and performance management system

Nurse home visitors collect data during the course of their visits. Collected data are entered into the Efforts to Outcomes (ETO™) software. Nurse-Family Partnership utilizes a data collection system designed specifically to record and report participating family characteristics, needs, services provided and progress toward accomplishing program goals. This process is fundamental to successful program implementation and beneficial outcomes. The data collection system is also utilized by nurse home visitors and nursing supervisors to guide their

practice, assess and guide program implementation, inform clinical supervision, enhance program quality and demonstrate program fidelity. It is expected that both supervisors and nurse home visitors will review and use their data.

Ongoing support

A member of our consultation team will schedule regular phone calls and periodic site visits with your agency supervisor and administrator. This allows us to support you in learning to operate the program successfully. The NSO helps you learn to manage the organizational, political, and fiscal issues affecting the program's ongoing operation and sustainability.

What is the evidence for NFP's effectiveness?

A cornerstone of Nurse-Family Partnership is the extensive research on the model conducted over the last three decades. Randomized, controlled trials were conducted with three diverse populations beginning in Elmira, New York, 1977. Trials were then initiated in Memphis, Tennessee in 1988 and Denver, Colorado in 1994. Two of the three trials targeted first-time, low-income mothers. Follow-up research continues today to study the long-term outcomes for mothers and children in the three trials.

Research Protocols

Randomized, controlled trials (RCTs) are the most rigorous research method for measuring the effectiveness of an intervention. RCTs require a study group and a comparison control group with random assignment into either the study group or the control group. The random assignment occurs after individuals consent to participate in the study. The groups must be similar demographically and in other ways.

Random group assignment ensures that the effects of the intervention cannot be attributed to some special characteristic of the group. Randomized, controlled trials are the kinds of studies that the Food and Drug Administration requires. These studies are used to determine the effectiveness and safety of new drugs or medical devices before they are made available to the public. Because of their cost and complexity, these kinds of trials are not often used to evaluate complex health and human services.

Consistent Program Effects

The program effects with the strongest evidentiary foundations are those that have been found in at least two of the three trials. They are listed below:

- Improved prenatal health
- Fewer childhood injuries
- Fewer subsequent pregnancies
- Increased intervals between births
- Increased maternal employment
- Improved school readiness for children born to mothers with low psychological resources

Dr. Olds and his research team are located at the Prevention Research Center for Family and Child Health at the University of Colorado Denver. They continue longitudinal follow-ups of all three trials. For instance, the positive program effects measured at child age 15 from the Elmira randomized, controlled trial are on the following page.

- **Lifetime Benefits to Mothers**
  - 61% fewer arrests
  - 72% fewer convictions
  - 98% fewer days in jail

- **Lifetime Benefits to Children**
  - 48% reduction in child abuse and neglect
  - 59% reduction in arrests
  - 90% reduction in adjudications as PINS (person in need of supervision) for incorrigible behavior

For more information on the outcomes from the randomized, controlled trials of NFP, please refer to the Nurse-Family Partnership website: http://www.nursefamilypartnership.org/proven-results

Evidence for Return on Investment

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 research proves that for every public health dollar invested in a local NFP program, communities can realize more than five dollars in return.

In 2009, the Pacific Institute for Research and Evaluation (PIRE) concluded 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. Using data from the NFP Memphis trial, the analysis showed that 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.[1]

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. 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.[2]

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.[3]

[1] Miller,T.R. (2009). *Estimated Medicaid costs and offsetting federal cost-savings of Nurse-Family Partnership*. Calverton, MD: Pacific Institute for Research & Evaluation.
[2] Karoly, L.A., Kilburn, M.R., & Cannon, J.S. (2005). *Early childhood interventions: proven results, future promise*. Santa Monica, CA: Rand.
[3] Aos, et al. (2004). *Benefits and costs of prevention and early intervention programs for youths*. Olympia, WA: Washington State Institute for Public Policy.

What are the model elements?

The NFP Model Elements are supported by evidence of effectiveness based on research, expert opinion, field lessons and/or theoretical rationales. When the program is implemented in accordance with these Model Elements, Implementing Agencies can have a high level of confidence that results will be comparable to those measured in research. Conversely, if implementation does not incorporate these Model Elements, results may be different from research results.

The 18 NFP Model Elements follow:

CLIENTS

Element 1 - Client participates voluntarily in the Nurse-Family Partnership program.
Nurse-Family Partnership services are designed to be supportive and build self-efficacy. Voluntary enrollment promotes building trust between the client and her nurse home visitor. Choosing to participate empowers the client. Involuntary participation is inconsistent with this goal. It is understood that agencies may receive referrals from the legal system that could be experienced by the client as a requirement to participate. It is essential that the decision to participate be between the client and her nurse without any other pressure to enroll.

Element 2 - Client is a first-time mother.
First-time mother is a nulliparous woman, having no live births. Nurse-Family Partnership is designed to take advantage of the ecological transition, the window of opportunity, in a first-time mother's life. At this time of developmental change a woman is feeling vulnerable and more open to support.

Element 3 - Client meets low-income criteria at intake.
The Elmira study was open to women of all socioeconomic backgrounds. The investigators found that higher-income mothers had more resources available to them outside of the program, so they did not get as much benefit from the program. From a cost-benefit and policy standpoint, it's better to focus the program on low-income women. Implementing agencies, with the support of the Nurse-Family Partnership National Service Office, establish a threshold for low-income clients in the context of their own community for their target population.

Element 4 - Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of the 28th week of pregnancy.
A client is considered to be enrolled when she receives her first visit and all necessary forms have been signed. If the client is not enrolled during the initial home visit, the recruitment contact should be recorded in the client file according to agency policy. It is recommended that only one pre-enrollment visit be provided. Early enrollment allows time for the client and nurse home visitor to establish a relationship before the birth of the child, and allows time to address prenatal health behaviors which affect birth outcomes and the child's neurodevelopment. Additionally, program dissemination data show that earlier entry into the program is related to longer stays during the infancy phase, increasing a client's exposure to the program and offering more opportunity for behavior changes.

INTERVENTION CONTEXT

Element 5 - Client is visited one-to-one, one nurse home visitor to one first-time mother/family.

Clients are visited one nurse home visitor to one first-time mother. The mother may choose to have other supporting family members/significant other(s) in attendance during scheduled visits. In particular, fathers are encouraged to be part of visits when possible and appropriate. The nurse home visitor engages in a therapeutic nurse-client relationship focused on promoting the client's abilities and behavior change to protect and promote her own health and the well-being of her child. It is important for nurse home visitors to maintain professional boundaries within the nurse-client relationship.

Some agencies have found it useful to have other nurses on their team at times to accompany the primary nurse home visitor for peer consultation. This helps the client to understand that there is a team of nurse home visitors available and that this second nurse home visitor could fill in if needed. This may reduce client attrition if the first nurse is on leave or leaves the program. Other team members, such as a social worker or mental health specialist, may also accompany nurses on visits as part of the plan of care.

The addition of group activities to enhance the program is allowed, but can not take the place of the individual visits and can not be counted as visits. It is expected that clients will have their own individual visits with their nurse, and not joint visits with other clients.

Element 6 - Client is visited in her home.

The program is delivered in the client's home, which is defined as the place where she is currently residing. Her home can be a shelter or a situation in which she is temporarily living with family or friends for the majority of the time (i.e., she sleeps there at least four nights a week). It is understood that there may be times when the client's living situation or her work/school schedule make it difficult to see the client/child in their home and the visit needs to take place in other settings. But whenever possible, visiting the client and child in their home allows the nurse home visitor a better opportunity to observe, assess and understand the client's context and challenges.

Element 7 - Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current Nurse-Family Partnership Guidelines.

Prenatal visits occur once a week for the first four weeks, then every other week until the baby is born. Postpartum visits occur weekly for the first six weeks and then every other week until the baby is 21 months. From 21-24 months visits are monthly. To meet the needs of the individual family, the nurse home visitor may adjust the frequency of visits and visit in the evening or on weekends. An expectation that a home visitor is available for regular contact with the family over a long period of time, even if families do not use the home visitor to the maximum level recommended, can be a powerful tool for change.

EXPECTATIONS OF THE NURSES AND SUPERVISORS

Element 8 - Nurse home visitors and nurse supervisors are registered professional nurses with a minimum of a Baccalaureate degree in nursing.

When hiring, it is expected that nurse home visitor and nurse supervisor candidates will be evaluated based on the individual nurses' background and levels of knowledge, skills and abilities

taking into consideration the nurses' experience and education. The BSN degree is considered to be the standard educational background for entry into public health and provides background for this kind of work. For nurse supervisors, a Master's degree in nursing is preferred. It is understood that both education and experience are important. Agencies may find it difficult to hire BSN-prepared nurses or may find well prepared nurses that do not have a BSN. In making this decision, agencies need to consider each individual nurses' qualifications, and as needed, provide additional professional development to meet the expectations of the role. Non-BSN nurses should be encouraged and provided support to complete their BSN. Agencies and supervisors can seek consultation on this issue from their nurse consultant.

Element 9 - Nurse home visitors and nurse supervisors complete core educational sessions required by the Nurse-Family Partnership National Service Office and deliver the intervention with fidelity to the NFP Model.

It is the policy of Nurse-Family Partnership National Service Office (NFP NSO) that all nurses employed to provide NFP services will attend and participate in all core NFP education sessions in a timely manner, as is defined by NFP NSO policy and the NFP NSO contract. Nurse home visitors and nurse supervisors will deliver the program with fidelity to the model. Fidelity is the extent to which implementing agencies adhere to the model elements when implementing the program. Implementing these components provides a high level of confidence that the outcomes achieved by families who enroll in the program will be comparable to those achieved by families in the three randomized, controlled trials.

APPLICATION OF THE INTERVENTION

Element 10 - Nurse home visitors, using professional knowledge, judgment and skill, apply the Nurse-Family Partnership Visit Guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.

The NFP Guidelines are tools that guide nurse home visitors in the delivery of program content. Nurse home visitors use strength-based approaches to working with families and individualize the guidelines to meet the client's needs. The domains include:

1) Personal Health (health maintenance practices; nutrition and exercise; substance use; mental health)
2) Environmental Health (home; work; school and neighborhood)
3) Life Course (family planning; education and livelihood)
4) Maternal Role (mothering role; physical care; behavioral and emotional care of child)
5) Friends and Family (personal network relationships; assistance with childcare)
6) Health and Human Services (linking families with needed referrals and services)

Element 11 - Nurse home visitors apply the theoretical framework that underpins the program, emphasizing Self-Efficacy, Human Ecology and Attachment theories, through current clinical methods.

The underlying theories are the basis for the Nurse-Family Partnership Program. The clinical methods that are taught in the education sessions and promoted in the NFP Guidelines are an expression of these theories. These theories provided the framework that guided the development of the NFP Visit Guidelines, Nurse Home Visitor and Supervisor Competencies, and Nurse-Family Partnership Core Education Sessions. They are a constant thread throughout the model and Nurse-Family Partnership clinical nursing practice.

Element 12 - A full-time nurse home visitor carries a caseload of no more than 25 active clients.

Full time is considered a 40-hour work week. Agencies may have a different definition for full time, and should pro-rate the nurse's caseload accordingly. At least half-time employment (20-hour work week) is necessary in order for nurse home visitors to become proficient in the delivery of the program model. Existing teams that already are in place but do not meet these expectations should consult with their nurse consultant.

Active clients are those who are receiving visits in accordance with the NFP Guidelines and the plan established by the client and the nurse. In practice, clients are considered participating if they are having regular visits. Agencies can establish their own policies regarding a timeframe for discharging missing clients. It is expected that supervisors will work with their nurse home visitors to monitor caseloads and utilize the program to serve the number of families they are funded to serve. The contract between the NFP National Service Office and the Implementing Agency states that the Agency will:

1) Ensure enrollment of 23 to 25 first-time mothers per full-time nurse home visitor within nine months of beginning implementation; and
2) Ensure that each nurse home visitor carries a caseload of not more than 25 active families; and
3) Maintain the appropriate visit schedule.

REFLECTION AND CLINICAL SUPERVISION

Element 13 - A full-time nurse supervisor provides supervision to no more than eight individual nurse home visitors.

Full time is considered a 40-hour work week. It is expected that a full-time nurse supervisor can supervise up to eight individual nurse home visitors, given the expectation for one-to-one supervision, program development, referral management and other administrative tasks. It also is assumed that other administrative tasks may be included in time dedicated to NFP, including the supervision of some additional administrative, clerical and interpreter staff. Refer to the sample supervisor job description found in the *Implementing Agency Orientation Packet*. The minimum time for a nurse supervisor is 20 hours a week with a team of no more than four individual nurse home visitors. Though we discourage smaller teams, even teams with less than four nurse home visitors still require at least a half-time supervisor. Existing teams that are already in place but do not meet these expectations should consult with their nurse consultant.

Element 14 - Nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings and field supervision.

To ensure that nurse home visitors are clinically competent and supported to implement the Nurse-Family Partnership Program, nurse supervisors provide clinical supervision with reflection through specific supervisory activities. These activities include:

1) <u>One-to-one clinical supervision</u>: A meeting between a nurse and supervisor in one-to-one weekly, one-hour sessions for the purpose of reflecting on a nurse's work including management of her caseload and quality assurance. Supervisors use the principles of

reflection as outlined in NFP supervisor training. Supervisors who carry a caseload will make arrangements for clinical supervision with reflection from a qualified person other than the nurse home visitors he/she supervises.

2) Case conferences: Meetings with the team dedicated to joint review of cases, ETO data reports and charts using reflection for the purposes of solution finding, problem solving and professional growth. Experts from other disciplines are invited to participate when such input would be helpful. Case conferences reinforce the reflective process. Case conferences are to be held twice a month for 1 ½ to 2 hours per case conference. The Case Presentation Form is in the Unit 2 Supervisors Workbook.

3) Team meetings: Meetings held for administrative purposes, to discuss program implementation issues, and team building twice a month for at least an hour or as needed for team meetings. Team meetings and case conferences alternate weekly so there is one meeting of the team every week.

4) Field supervision: Joint home visits with supervisor and nurse. Every four months the supervisor makes a visit with each nurse to at least one client and additional visits on an as needed basis at the nurse's request or if the supervisor has concerns. At a minimum, time spent should be 2 – 3 hours per nurse every four months. Some supervisors prefer to spend a full day with nurses, enabling them to observe comprehensively the nurse's typical day as well as her home visit, time and case management skills and charting. After joint home visits with a supervisor and nurse, a Visit Implementation Scale is completed and discussed.

PROGRAM MONITORING AND USE OF DATA

Element 15 - Nurse home visitors and nurse supervisors collect data as specified by the Nurse-Family Partnership National Service Office and use NFP reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality and demonstrate program fidelity.

Data are collected, entered into the Efforts to Outcomes (ETO™) software and subsequently used to address practice. Data are utilized to guide improvements in program implementation and demonstrate fidelity. The ETO reports are tools with which nurse home visitors and supervisors assess and manage areas where system, organizational, or operational changes are needed in order to enhance the overall quality of program operations and inform reflective supervision of each nurse. It is expected that both supervisors and nurse home visitors will review and utilize their data.

AGENCY

Element 16 - A Nurse-Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.

An Implementing Agency is an organization committed to providing internal and external advocacy and support for the NFP program. This agency also will provide visible leadership and passion for the program in their community and assure that NFP staff members are provided with all tools necessary to assure program fidelity.

Element 17 - A Nurse-Family Partnership Implementing Agency convenes a long-term Community Advisory Board that meets at least quarterly to promote a community support system for the program and to promote program quality and sustainability.

A Community Advisory Board is a group of committed individuals/organizations who share a passion for the NFP program and whose expertise can advise, support and sustain the program over time. The agency builds and maintains community partnerships that support implementation and provide resources. If an agency can not create a group specifically dedicated to the Nurse-Family Partnership program, and larger groups are in place that have a similar mission and role dedicated to providing services to low-income mothers, children and families, it is acceptable to participate in these groups in place of a NFP dedicated group. It is essential that issues important to the implementation and sustainability of the NFP program are brought forward and addressed as needed.

Element 18 - Adequate support and structure shall be in place to support nurse home visitors and nurse supervisors to implement the program and to assure that data are accurately entered into the database in a timely manner.

Support includes the necessary infrastructure to support and implement the program. This includes the necessary physical space, desks, computers, cell phones, filing cabinets and other infrastructure to carry out the program. Further, this includes employing a person primarily responsible for key administrative support tasks for NFP staff, as well as entering data and maintaining accuracy of ETO reports. This resource is critical to ensuring administrative support and accuracy of data entry, allowing nurse home visitors time to focus on their primary role of providing services to clients. NFP Implementing Agencies shall employ at least one 0.5 FTE general administrative staff member per 100 clients to support the nurse home visitors and nurse supervisors and to accurately enter data into ETO on a timely basis. The Agency has the option to have their nurses enter the data, but the expectation of a 0.5 FTE support staff remains.

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What forms the framework of the Nurse-Family Partnership model?

The NFP model draws from three distinct strands of theory: human ecology, self-efficacy and attachment. These theoretical strands, woven together within a professional nursing framework, produce a unique program of great depth, breadth and vitality.

Human ecology theory

This theory holds that parents' care of their babies is influenced by the larger social context in which they live. This includes relationships with other family members, friendship networks, neighborhoods, communities, and cultures. The NFP model acknowledges the impact of these various elements while helping parents negotiate and regulate their environments.

Self-efficacy theory

This theory is rooted in the notion that people are more likely to engage in a desirable behavior if they believe the behavior will produce a desired outcome. They must also believe they can successfully carry out that behavior to achieve the outcome. The NFP model helps parents set realistic goals. It bolsters parents' confidence in their ability to reach those goals. Examples include avoiding or stopping risky behaviors, engaging in healthy behaviors, and/or coping with challenging situations.

Attachment theory

This theory proposes that children who receive sensitive and responsive parenting are more likely to grow up to become sensitive and responsive parents themselves. The NFP model promotes nurturing parenting through a variety of direct teaching methods. Learning is further enhanced by the supportive and caring relationships nurse home visitors establish with parents.

Why do we ask about commitment and motivation of mid-level and senior leadership to NFP?

Experience tells us that informed and committed mid-level and senior-level leadership is essential to the success of the program. Programs are more successful when mid- to upper-level managers are committed to understanding the challenges of this unique program. These committed leaders are able to encourage and support the nurses, understand the needs and circumstances of clients, advocate in the community, and anticipate and plan for threats to funding or political sustainability. We also know that programs are more likely to thrive when there is broad support across the agency and within the community. Building this support takes considerable time and focused networking.

Many stakeholders are involved in assuring the requirements of NFP are met. However, primary responsibility for NFP success lies with local administrators of the program. Administrators are crucial to creating an organizational environment that supports NFP implementation within the agency. Administrators also promote the benefits of the program to the wider community and to state policymakers and funders who invest in the program's development.

Administrators and nurse supervisors need specialized knowledge and skills to effectively manage an NFP implementing agency. They need to give themselves time to understand the program. They can then determine what will be required for a successful program implementation. NFP may require

modification of an organization's current practices (e.g., allowing for flexible work schedules) in order to be a sustainable success.

This ability to effectively lead and support needed organizational change in the interest of assuring NFP's success is the difference between a vulnerable NFP and a strong one. Mid-level and senior level leadership's approach to change is a significant leverage point in bolstering (rather than just accommodating) an evidenced-based and intensive program like NFP. The most successful Nurse-Family Partnership programs are in organizations that recognize both the value of past experience and the ongoing vital role of true openness to seeing things through a new lens.

Organizational Capacity

How do the theories on which NFP is based affect leadership?

The theories of human ecology, self-efficacy and attachment provide the framework for nurses' understanding of NFP – both its values and its methods. In successful programs, this understanding is reinforced by the larger environment in which nurses operate. NFP works best when program theories are reflected in program administration in the following ways:

Program administrators help ensure supportive work conditions and professional relationships for NFP Nurse Home Visitors.

Nurse home visitors work to promote a healthy social context for the clients. Likewise, their success in the implementation of the model is impacted by the environment in which they work.

The work environment is affected by both direct and indirect relationships. Direct relationships include those with supervisors, administrators, other supporting agency departments, NFP referral sources, and community agencies that provide services to program participants. Indirect relationships include agency executives not directly involved in the program, funders, other community home visitation programs, and community opinion leaders.

Administrators ensure that these relationships are managed in ways that enable the program to function as designed. Administrators should thoughtfully introduce the program to the agency so that concerns are not created. Administrators can also help to see that the NFP program is viewed as an exciting opportunity for clients and the agency.

Program administrators reinforce belief in the value of NFP and the agency's ability to implement the model.

The practice environment is a critical factor in the recruitment and retention of registered nurses. NFP is a complex model in which nurses become increasingly proficient over time. It is a dynamic program that continually creates new opportunities for staff to learn and improve performance.

Administrators support the program by cultivating an organizational culture that rewards ongoing learning and growth. The culture should also value effective, efficient, safe and quality nursing services. Further, staff performance expectations should be consistent with a developmental approach to program implementation. All staff members are novices at first, but will gain more and more expertise given time and experience.

Programs are more successful when administrators demonstrate consistent concern for the well-being of NFP Nurse Home Visitors and their NFP Nurse Supervisors. The NFP staff needs consistent, reliable support from the administrators for whom they work. Nurse home visitors and nurse supervisors need to know that administrators recognize the nurses are autonomous, licensed healthcare providers who govern their practice and are empowered to deliver this evidence-based program. The administrator provides leadership in the allocation of human, material, and financial resources as well as in critical thinking, problem-solving, managing conflict, and addressing ethical issues.

Nurse-Family Partnership is a relationship-based organization.

Nurses achieve outcomes through the power of healthy therapeutic relationships. Healthy work relationships give nurses more energy, focus and creativity to bring to their clients. A relationship-based organization is one in which strong, supportive relationships exist among staff and between staff and the families they serve. These relationships form the foundation for all the work that is done in such settings.

Organizational structure, mission and supervisory style all support relationship-building efforts. In our experience, organizations with certain attributes create relationship-based environments. These attributes are:

- **Mutually shared goals**: Combine talents and creativity to achieve client, team and program goals.
- **Commitment to growth and change**: Question the status quo and make growth-enhancing changes.
- **Reflective practice**: Promote learning from experience through self-reflection and mentoring from supervisor and colleagues.
- **Respect for individuals**: Promote acceptance of team members' and clients' strengths and vulnerabilities.
- **Sensitivity to context**: Acknowledge that the environment influences the individual and the individual influences the environment.
- **Open communication**: Value others' thoughts, ideas and feedback.
- **Team standards**: Team members develop standards and norms that promote professional excellence and expertise.

It is challenging for agencies to actually "walk the talk" of a relationship-based organizational culture, but agencies can strive to implement these principles within the NFP team. When teams practice these attributes, the team is more consistent with the culture of NFP and the paradigm for serving clients.

Nurse-Family Partnership culture is unique.

Nurse-Family Partnership is truly client-centered. Clients are "the experts on their own lives" and we focus on the "client's heart's desire." Clients drive the agenda for visits and decide what goals motivate them.

This requires nurses to actively listen, make astute assessments, provide essential and appropriate interventions, negotiate with their clients and be flexible. Sometimes it means supporting a seemingly "silly" or "inconsequential" goal when "bigger and better" things could be on the providers' agenda. We use those small goals as vehicles for teaching and skill-building.

Administrators can support nurses by understanding this concept and the need for flexibility. They can ensure that nurses are not encumbered with rigid extra requirements from outside sources. Administrators can also support the nurses in this principle of "being the expert" on their practice by encouraging nurses to have input on rules, policies, use of physical space, etc. within their agencies.

Low-income, first-time mothers are recruited into the Nurse-Family Partnership. Many of these mothers have highly complex and challenging lives. These are often the clients who experience

the most change through multiple small steps over time. Nurses may feel pressured (externally or internally) to quickly produce grand results similar to the research trials. It is important to understand that health promotion and illness prevention programs produce smaller results initially and more impressive outcomes over time. For example, outcomes related to school success are not seen until children reach school age. Outcomes related to involvement in the legal system are not seen until adolescence.

Consequently, nurses, administrators and funders will see small changes in the child's first two years. As the children grow and families mature, the outcomes grow. For that reason, we say, "only a small change is necessary." A series of small successes builds the confidence to enable the larger changes.

Small successes lead to big successes. Administrators who understand that small changes are linked to impressive long-term outcomes help staff to stay confident and focused.

What is evidence-based policy?

Evidence-based policy refers to fiscal and program decision-making using research evidence to inform conclusions. Evidence-based policy is informed by scientifically-designed studies showing conclusively that an approach is effective. The first clinical trial of the Nurse-Family Partnership model began in 1977 in Elmira, New York. The results were so positive that there was national and international pressure to immediately implement the program in other sites. But the program was not offered for public investment until the evidentiary standards were met in two additional clinical trials. These standards are:

- The program is described in sufficient detail that others can replicate it.
- The program clearly identifies its intended outcomes and they are measured in psychometrically sound ways.
- The program has been tested in well-conducted clinical (randomized, controlled) trials.
- The program consistently has outcomes that are clinically or socially important.
- Effects found in one trial have been replicated in two additional clinical trials, providing confidence that the program can reliably produce positive outcomes.
- The sample tested has been clearly identified and the impact of the program is not generalized beyond the sample characteristics tested in the trials.
- There is evidence that the program developers have a reliable method of ensuring that the program offered for public investment will be conducted with fidelity to the model tested in the trials.

The adherence to these standards and the strong, consistent outcomes across the clinical trials led to Nurse-Family Partnership being recognized as one of the most effective interventions ever implemented. Nurse-Family Partnership's emphasis on controlled, randomized trials is also at the core of the approach promoted by the Coalition for Evidence-Based Policy, a Washington, DC think tank seeking to increase the use of scientific evidence when investing in programs and services. In April 2009 the Coalition concluded that rigorous studies support the effectiveness of the Nurse-Family Partnership. www.evidencebasedprograms.org

How is research put into practice?

Nurse-Family Partnership offers states and communities one of the most promising approaches developed for helping first-time, low-income families succeed. NFP draws its strength from an extensive body of rigorous research conducted over the past thirty years. The research demonstrates that NFP makes significant and sustainable differences in the lives of vulnerable families.

The challenge in implementing NFP is ensuring that this proven research model functions equally well in practice. Research-based programs can be diluted or compromised when scaled up in the "real world." Preventing this compromise from occurring as NFP expands is of the highest importance.

The success of NFP depends on preserving its clinical integrity. This integrity is achieved directly through nurse home visitors. The nurse home visitors are skilled in establishing therapeutic relationships. They use the theories to guide their application of the model. To successfully implement the model, nurse home visitors need:

- Full participation in the NFP educational program (i.e., completion of all online and face-to-face educational offerings)
- Relationship-based clinical supervision
- Ability to use data to monitor and improve program implementation over time
- Administrative and agency support for conducting the program with fidelity to the model
- Community support

What staff positions are critical to the success of Nurse-Family Partnership?

The four critical staff positions needed to operate the Nurse-Family Partnership at the local level are Administrator (state and/or local), Nurse Supervisor, Nurse Home Visitor, and Administrative and Data Entry Support.

Administrator

In most agencies, the Nurse-Family Partnership begins as a relatively small program serving about 200 families. It is often one of several programs for which an administrator is responsible. As the program grows, it may require dedicated program management at a level higher than that of the clinical supervisor.

In general, the administrator plays several critical roles. The first is to create a supportive organizational environment. This enables the nurse home visitors and their supervisor to produce good outcomes with families enrolled in the Nurse-Family Partnership. For example, the administrator should advocate for flexible workplace policies governing hours and days worked. The administrator should also assure that nurse home visitors are fully dedicated to the Nurse-Family Partnership and not required to staff additional programs that make it difficult to manage the required home visit schedule and caseload.

In addition, the administrator is often the person responsible for helping the supervisor monitor program quality. The administrator supports program improvement strategies, helps with staffing issues in the program, and provides support to the supervisor. Further, the administrator must be familiar with the role of the nurse home visitor.

The administrator should help make the Nurse-Family Partnership a highly visible and valued program within the host agency and in the larger community. This involves advocating for funding and other resources needed to keep the program growing. The administrator provides leadership. The administrator may participate in establishing an advisory board that advocates for the program, helps with referrals, and opens doors to resources. Further, the administrator may well relate to county and state government entities concerned with the Nurse-Family Partnership. This includes legislators or other elected officials and leaders of professional associations or other organizations with a stake in the success of the Nurse-Family Partnership.

These responsibilities may sound essentially the same as the management duties associated with supporting the start-up and sustainability of any program. However, upon further review, several distinctions emerge:

- The Nurse-Family Partnership is intensive and complex. There is an intersection of the theoretical underpinnings, evolving clinical methods, an ever more rich evidence base, and the real world challenges of intensive services to vulnerable families. This provides for one of the most dynamic, exciting and challenging efforts in human services and public health today.
- This complexity requires time to mature a practice, followed by time to maintain proficiency. Consequently, administrators need to allow time for visitors and supervisors to learn the model. They must cultivate an organizational climate that rewards ongoing learning, growth and effectiveness. Further, performance expectations should be consistent with the developmental approach to program implementation – modest early on and rising with time and experience.
- Administrators are most successful when they show they care about the NFP staff as individuals. Direct and practically-helpful involvement of administrators is key to the ultimate results the team achieves. This involvement assists NFP teams as they become solutions-focused, reflective practitioners.

Great administrators are anxious to take on new approaches and be leaders in evidence-based practice. When administrators provide supportive leadership to the NFP team, administration can shape the environment and bring the vision to fruition for all.

Nurse Supervisor

Each nurse supervisor in the Nurse-Family Partnership has two critical roles. The first is effective program management. The second is clinical supervision of nurse home visitors. In general, masters-prepared nurses tend to be more effective in understanding the theoretical framework of the program model. They are better able to assist their home visitors in becoming more clinically skilled.

Nurse supervisors need a strong desire to foster the learning of nurses under their supervision. They must use data to inform program management. The success of the Nurse-Family Partnership is largely dependent on strong, relationship-based supervision. Successful nurse supervisors attract and retain capable nurse home visitors. This is critical in achieving good outcomes with families.

The nurse supervisor helps build community partnerships. These partnerships result in referrals, client services, and ongoing program support. Nurse supervisors build strong community partnerships by:

- Fostering community awareness of and ongoing support for NFP through creation of a Community Advisory Board and outreach education.
- Generating and sustaining a steady flow of referrals into the NFP Program.
- Learning about community services and forming relationships with service providers in order to help clients access needed services.

Nurse supervisors must also ensure that nurse home visitors are clinically competent and able to implement the NFP Program. Nursing supervisors provide clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development. This is done through specific supervisory activities, including:

- **One-to-one Supervision**

  These are meetings between a nurse and supervisor in one-to-one weekly, one hour sessions for the purpose of reflecting on a nurse's work. This includes caseload management and quality assurance. Supervisors use the principles of reflection as outlined in NFP supervisor training. Supervisors who carry a caseload will make arrangements for clinical supervision with reflection from a qualified person other than the nurse home visitors he/she supervises.

- **Case Conferences**

  These are team meetings dedicated to joint review of cases and ETO reports. The team uses reflection for the purposes of solution-finding, problem-solving and professional growth. Experts from other disciplines are invited to participate when appropriate. Case conferences reinforce the reflective process. Case conferences are to be held twice a month for 1 ½ to 2 hours per case conference.

- **Team Meetings**

  These are administrative meetings. The time is used to discuss program implementation issues and for team building. Team meetings are held twice a month for at least an hour. Team meetings and case conferences alternate weekly so there is one meeting of the team every week.

- **Field Supervision**

  This is a joint home visit conducted by the nurse supervisor and nurse home visitor. The supervisor should accompany each nurse to at least one client visit every four months. Additional visits may be made at the nurse's request or when the supervisor has concerns. The minimum time required for field supervision is 2-3 hours per nurse every four months. Some supervisors prefer to spend a full day with each nurse. This enables the supervisor to comprehensively observe the nurse's typical day, including home visits, time and case management skills, and charting. After any joint home visit, a Visit Implementation Scale is completed and discussed.

Nurse Home Visitor

Nurse-Family Partnership Nurse Home Visitors have a very challenging job. We strongly prefer that nurses in this role have at least a bachelor's degree. Some experience in obstetrics, maternal and child health, community health nursing, or public health is also beneficial. Further, nurse

home visitors must have a great deal of personal maturity. They need a strong desire to do home-based preventive intervention with young families. They must be willing to develop a therapeutic relationship with each parent in the program. Nurses in this program deal with more than just health. They are required to become expert in assessing status, teaching, making appropriate referrals and nurturing the development of young parents across several domains of functioning. The Nurse-Family Partnership can provide position descriptions and guidance for hiring nurse home visitors who are likely to succeed in this program.

Administrative and Data Entry Support

The NFP model requires a 0.5 FTE administrative or data entry support person per 100 clients. This important role serves to support the nurse home visitors and nursing supervisors. Hiring capable administrative staff will greatly enhance the efficiency of the nursing staff and the ability of supervisors to manage the program.

The administrative support person must take responsibility for efficient, accurate, thorough entry of program and home visit data into the national web-based Efforts to Outcomes (ETO) software. In some locations, nurse home visitors enter their own data. However, the expectation of a 0.5 FTE support staff remains.

Most implementing agencies have found it extremely helpful to have administrative support personnel assist with other organizational functions as well. There are many forms, client resources and visit facilitators that need to be inventoried and kept well-organized and in adequate supply. When this is done by the administrative support person, the nurses can focus on completing visits and charting. In addition, an administrative support person can help with program communications, client correspondence and tracking, filing, organizing community and family events, and other activities that would otherwise fall to the supervisor or nurse home visitors.

Plan to have the Administrative or Data Entry Support person available for work at least 2-3 weeks before program implementation (i.e., enrolling pregnant women into the program).

What support is required for the Nurse-Family Partnership team?

Support is the infrastructure necessary to implement and sustain the program. This includes the physical space, desks, computers, cell phones, filing cabinets and other equipment needed to carry out the program. Further, this includes employing a person primarily responsible for key administrative support tasks for NFP staff, as well as entering data and maintaining accuracy of ETO reports.

It may seem early to be thinking about the practicalities of making space for a new program in each host agency, but many public agencies and community-based non-profits are chronically cramped. It is important to plan ahead! Space considerations should be considered when planning to meet the needs of the host agency and the nursing staff in the Nurse-Family Partnership program.

NFP nurses in existing programs share that there is incredible value in sharing space within the office. This allows them to interact regularly, share concerns, problem-solve together, and inspire each other with best practice ideas and successes. We advise co-locating nurses to provide regular access to each other and the supervisor. Because of the emotional demands of the job, we strongly discourage home-officing.

There are many ways to configure an efficient Nurse-Family Partnership program. The best set up for each agency is dependent upon the nature of the community served, the distances covered by nurse home visitors, and the resources shared with other programs in the host agency.

The NFP NSO is expanding the use of distance learning and web-based communications technologies to support the professional development of nurses in the field. For this reason, the minimum requirement for effective computer support equates to:

- One computer for the supervisor
- One computer for the data entry clerk or administrative assistant
- A minimum of one computer for every two nurse home visitors

To meet their program responsibilities, the nurse supervisor and data entry clerk or administrative assistant need access to computers during all work hours. The data entry clerk or administrative assistant requires secure medical records storage and adequate storage space for equipment. This position also requires highly-organized and accessible sets of the resource materials used by nurse home visitors.

Cell phones are an essential element to ensure the efficiency and safety of nurse home visitors. Supervisors must also have a cell phone in order to be accessible to nurse home visitors in the field.

The team needs access to conference room space for team meetings and case conferences. In addition, there must be space for confidential one-to-one reflective supervision sessions.

What materials and supplies are needed to implement Nurse-Family Partnership?

- Nurse/supervisor workstation requirements
  - Desk with two file drawers (or a cabinet)
  - Chair
  - Office phone
  - Computer
  - Access to copier
  - Bookshelves for approximately 8-10 large, 3-ring binders (for NFP, PIPE, NCAST manuals and additional in-service materials)
  - Supervisors require added bookshelf space for additional manuals
  - Supervisors and nurses need a work area where confidentiality can be maintained
  - Supervisors need an office with a door
- Space needed for medical records and other program materials
  - Locked file drawers for 25 client charts per full-time nurse throughout 2 ½ years. (Note: Some agencies subdivide permanent client record into pregnancy, infancy and toddler sections.)
  - 2-to-3 inch 3-ring binders or sturdy pressboard fastener folders for storing client records. (Ring binders take up more space.)
  - Shared library; a large shelf unit or cabinet for clinical reference books, in-service material, and brochures from other agencies. (A series of cubby holes or racks for brochures are helpful.)

  - Two 5-foot, 5-drawer lateral filing cabinets for NFP visit handouts, facilitators, PIPE topics, ETO forms, Ages & Stages forms, and marketing materials. OR equivalent shelf space.
  - Storage cabinet for client support materials, including educational or support items for the mother and child. This could be books, gifts, etc.
- Data entry (or) administrative assistant workstation requirements
  - Desk
  - Chair
  - Phone
  - Computer
  - Bookshelves
  - Locked drawers for client records
  - Implementing Agency Orientation Packet
- Recommended equipment and supplies

  The following list of equipment is recommended. You may already have some of the necessary items. This list will help you anticipate your budget. The NSO Nurse Consultant is available to assist with questions. Many items, such as family support materials for clients, can be solicited as donations from local stores or agencies.

RECOMMENDED FOR EACH NURSE HOME VISITOR	SHARED NURSE EQUIPMENT	OTHER SUGGESTED ITEMS
• Equipment bag • Blood pressure cuff • Stethoscope • Thermometer and disposable sleeves • Disposable measuring tape • Pregnancy calculator • Carrier for client charts, etc. • Cell phone	• Baby scales and carrier • Batteries for baby scales • Disposable pads for scales • VCR/TV monitor or DVD player • Digital or film camera • Bags of toys appropriate for different developmental stages • PIPE materials • Pediatric measuring device for infant length	• Disposable exam gloves • Disinfectant surface wipes • Alcohol wipes • Family support items such as books, toys, blankets, or other small gifts • Loose-leaf ring binder (1 ½") for clients to hold program materials

How is data collected?

Because Nurse-Family Partnership is an evidence-based program, data collection is essential to program management. The collection and use of data allows each agency to guide clinical practice, assess and guide program implementation, inform clinical supervision, enhance program quality and demonstrate program fidelity.

Nurse-Family Partnership utilizes a data collection system designed specifically to record and report participating family characteristics, needs, services provided and progress toward accomplishing program goals. This process is fundamental to successful program implementation and beneficial outcomes. It is expected that both supervisors and nurse home visitors will review and use the data.

Computer Specifications for accessing ETO:

- **Platform**: Microsoft Windows
- **Browser**: Microsoft Internet Explorer 7.0 or higher
- **Internet Connection**: High speed internet though corporate LAN or Consumer Internet Service Provider
- **Plug-ins**: Acrobat (a link will be provided to download if needed)
- **Cookies**: Enabled
- **Java Script**: Enabled
- **Pop-up Blockers**: Contact your IS staff concerning pop-up blockers; the NFP data collection system login screen is affected by these blockers

What program indicators are tracked?

Agencies implementing the Nurse-Family Partnership program gather information on various indicators addressing program implementation, services provided, client characteristics, and risk and outcome indicators. Information is collected by nurse home visitors during home visits families or through other contacts with Nurse-Family Partnership implementing agencies. The NFP NSO evaluates the information and generates reports based on this data. Implementing agencies can use these reports to assist quality improvement, program management, and demonstration of program services and outcomes. Additional information on the data collected is provided below:

Monitoring Program Implementation

The Nurse-Family Partnership program must be implemented as similarly as possible to the program delivered in the randomized, controlled trials. This makes it possible to produce comparable outcomes for participating families. Following guidelines for program implementation ensures fidelity to the program model. Fidelity indicators include:

- Voluntary participation
- First-time mother status
- Low-income criteria
- Percent of referrals enrolled in the program and referral source
- Gestational age at program enrollment
- Client attrition and reason for attrition
- Number of visits completed
- Length of visits

- Content of visits
- Referrals to other services/agencies
- Nurse home visitors and supervisors are registered nurses
- Clinical staff attends Nurse-Family Partnership training
- Clinical staff employs methods promoted by the program
- Clinical staff FTE status
- Caseload size
- Utilization of the data collection and reporting system
- Appropriate supervision provided
- Presence of team meetings for case conference and multidisciplinary input
- Use of an advisory committee
- Presence of sufficient administrative support staff

Client Characteristics

An important component of program evaluation is to understand the client population. Information collected on client characteristics includes:

- Age
- Education level
- Marital status
- Race/ethnicity
- Employment status
- Maternal mental health
- Household income
- Number of persons in the household
- Household composition
- Government assistance use

Risk and Outcomes Indicators

Nurse-Family Partnership implementing agencies collect data on health indicators and progress of mothers and children in the program. Below is the list of risk and outcome indicators collected by Nurse-Family Partnership programs. Certain client characteristics are also considered indicators of risk with regard to certain outcomes.

- Pregnancy health
  - Gestational age at which prenatal care began
  - Adequate weight gain during pregnancy
  - Substance use (cigarette, alcohol, marijuana, cocaine, other substances) during pregnancy
  - Experience of intimate partner violence during pregnancy
  - Government assistance use during pregnancy
- Birth outcomes
  - Preterm births
  - Low birth weight
  - NICU use

- Child health and development
  - Breastfeeding
  - Immunizations
  - Developmental delay
  - Language development
  - ER visits and hospitalizations for injury and ingestion
- Maternal life course
  - Subsequent pregnancies
  - Participation in education
  - Educational attainment
  - Work force participation
  - Marital status
  - Government assistance use

Nursing Practice

Why do nurses deliver the Nurse-Family Partnership program?

Registered nurses are perceived by the public as holding high standards of ethical practice and honesty. In addition, nursing is widely respected as a caring profession with strong academic preparation in the social, life and caring sciences. Polls of the American public consistently rank nurses at the top of the list of professions when it comes to the values of honesty and ethical standards (Gallup, 2007). Nurses are trusted.

Nurses have unique knowledge that is appealing to a first-time mother. Pregnant women have many questions and concerns about their health and the baby's health. Mothers value the expertise of registered nurses during this critical life transition. NFP nurses are welcomed into clients' homes and in the community.

Registered nurses have an educational background that teaches them to listen, assess, plan, teach, refer, support, challenge and encourage. This makes them ideally prepared to conduct the strengths-focused assessments and deliver the individualized interventions that are part of the NFP program.

How is this important to your agency?

The Denver trial compared outcomes between nurse-visited and paraprofessional-visited groups. The evidence clearly supported the use of registered nurses to implement NFP.

The paraprofessionals in the Denver trial were able to achieve some improved outcomes. However, the nurses' outcomes for clients were generally twice as strong as their paraprofessional counterparts. The nurse-visited group was also able to demonstrate a good return on investment while the paraprofessional-visited group's improvements in outcomes were insufficient to offset the costs of the program.

We know that funders, politicians, and programs look at "Return on Investment." While nursing salaries account for the majority of the expense of the program, the evidence shows that public and private dollars are well spent on nurses. The use of nurses allows agencies to achieve desired outcomes and produce cost return.

Why do we require BSN degree or higher?

A bachelor's degree in nursing (BSN) is considered entry-level for public health. This is partially because degree programs specifically educate nurses in public health. It is also because the academic preparation of BSN better enables nurse home visitors to function in independent settings.

Nurses must integrate the Nurse-Family Partnership interventions and the Standards of Nursing Practice. They must maintain therapeutic relationships, set appropriate boundaries and achieve program outcomes. Nurse-Family Partnership nurses use their clinical knowledge and skills to deliver comprehensive services to complex clients and families. We have found that BSN-prepared nurses are better prepared to meet these responsibilities. Model Element 8 clarifies the importance of a commitment to hiring qualified nursing staff that meet these standards.

How is this important to your agency?

There is a shortage of nurses, particularly in community health. It may be difficult to find baccalaureate-prepared nurses in your community. It is important that you look at salary levels in

your organization to see if you can compete with the market in your community. Because the nature of the challenging, satisfying work of NFP nursing is highly attractive in and of itself, we rarely see serious problems with the initial recruitment of a nursing team. However, careful planning contributes to success!

More information regarding nurse education and demographics can be found in the *National Sample Survey of Registered Nurses* at the U.S. Department of Health & Human Services at: http://bhpr.hrsa.gov/healthworkforce/rnsurvey

What is the work of a nurse who is implementing the Nurse-Family Partnership program?

NFP implementing agencies employ registered nurses who work within the full scope of their licensure to implement the Nurse-Family Partnership model. NFP nurses promote:

- Mothers' personal health
- Mothers' and fathers' care of the child
- Environmental health
- Support of the mother and child from family and friends
- Parents' life course development

Nurses address these domains through assessment, education, promotion of behavioral change, and referral of families for other health and human services. This comprehensive approach requires a skilled nurse with a broad background who is ready to learn.

Nurses develop therapeutic relationships that promote adaptive behavior change such as decreased substance use, development of healthy relationships, and good nutrition. This is done through understanding and supporting the client's goals and dreams. Other examples of nurse activities include referring women for treatment of any identified potential obstetric complications, taking blood pressures and promoting healthy pregnancy practices and family planning.

After the baby is born, NFP nurses monitor child health, development and growth. They support standard pediatric recommendations such as immunizations and routine well-child care. Nurses teach and model consistent and nurturing parenting. NFP nurses refer suspected health and developmental problems to specialists for further evaluation and treatment.

Within the context of NFP, nurses are not required to operate under a physician's orders or those of any other licensed provider. Registered nurses are governed by both federal and state laws and regulations, including licensure requirements

Model Elements 10 and 11 explain how the NFP Guidelines, nurse competencies and core education support the nurse in learning and integrating ways to address the domains and use the underlying theories.

How is this important to your agency?

Successful Nurse-Family Partnership nurses respect and value clients from low-income, diverse populations. These successful nurses are comfortable initiating, working independently, and asking for what they need. They use their challenges and those of their teammates as opportunities for growth. They need a broad background of experience. There will be areas in which they need support and education.

When recruiting staff, it is essential to find the right mix of values and experience. A clear understanding of the values of Nurse-Family Partnership is key to your success. It will allow you to match your staff appropriately. Anticipating and planning for continued professional development – both time and money – is also essential.

What are the Standards of Nursing Practice?

Nurses are accountable to themselves, their clients, their peers and society for their professional actions. The regulation of nursing practice is determined by legal requirements to assure the health, safety, and welfare of the general public and to protect the integrity of the nursing profession.

Standards of Nursing Practice are authoritative statements that describe the responsibilities for which nurses are held accountable. They describe a competent level of behavior in the professional role. These performance measures include quality of practice, education, professional practice evaluation, collegiality, collaboration, ethics, research, resource utilization and leadership. Generally, standards of nursing care include the nursing process. This is a deliberate, problem-solving approach to meet the health care and nursing needs of clients. The nursing process involves assessment, diagnosis/issues, outcome identification, planning, implementation, and evaluation. The practice of nursing in the Nurse-Family Partnership is an art and a science.

Regardless of clinical setting, nurses are expected to practice to the level of nursing specified in the standards. Although standards are not laws, standards of practice are now used to establish and determine quality nursing care by courts and regulatory agencies and clients. The court's use of a community's "accepted" common nursing practice is being replaced by the use of national standards to identify acceptable practice and define therapeutic relationships (Helm, 2003). The ANA Scope and Standards on Practice for Registered Nurses can be found at www.nursingworld.org.

How is this important to your agency?

Nurse-client visits are used to educate. Nurses use the therapeutic relationship as a vehicle for client change. This sometimes results in confusion and interpretation of the Nurse-Family Partnership as a "social" program. However, nurses in the Nurse-Family Partnership practice nursing though assessing, planning, intervening, teaching, and evaluating their care.

Nurses are held to the standards of nursing regardless of the setting. This presents liability implications for agencies and nurses related to obtaining legal consent, mandatory reporting, documentation of visits, etc. Agencies must create policies that allow nurses to incorporate all actions for which they are legally liable into their practice.

For those agencies experienced in working with nursing, there may be few surprises. For those who are new to employing nurses, consultation on the practice of nursing and nursing standards would be valuable.

What is the Nurse Practice Act?

Each state has a Nurse Practice Act. This is a set of laws that define the formal education needed for a particular level of nurse and sets the regulations for licensure. The intent is to protect the public from harm.

Each state's Nurse Practice Act makes provision for a Board of Nursing. The Board of Nursing enforces the regulations that govern nursing, licenses qualified nurses, approves nursing education programs and provides disciplinary actions against nurses that violate the Nurse Practice Act.

The Nurse Practice Act defines the nurse's scope of practice based on formal education and licensure. That is, the scope of practice is different an RN, an LPN/LVN, or a Nurse Practitioner. A nurse may not perform duties outside the scope of practice for his or her license.

How is this important to your agency?

Agencies must confirm that each nurse has a valid nursing license. The state Board of Nursing can guide you on licensing issues.

Leaders and nurses in your agency need to understand the Nurse Practice Act and practice accordingly. Some people erroneously believe that nurses are not held to the same standard when visiting in the home and providing a health promotion/illness prevention model. This is not the case. Nurses are accountable for their actions, must use the nursing process and must complete timely and accurate documentation regardless of the setting or the model of care.

Your agency may have a policy to report exceptional situations and client concerns that could have implications with the Board of Nursing.

How is nursing in the Nurse-Family Partnership unique?

You have read about the values of Nurse-Family Partnership. These values include promoting self-efficacy, honoring the client's "heart's desire," acknowledging that the client is the "expert on her own life," facilitating growth and change through motivation, and promoting emotionally available, responsive parenting. The values help nurses create new opportunity and growth.

One nurse proclaimed, "This is the hardest job I've ever loved!" The expectations and challenges of very complex clients with dynamic lives, the comprehensive knowledge needed, the level of skill to listen, to really hear, to facilitate instead of direct – these are all high-level skills. It takes time and support to build these skills.

Many Nurse-Family Partnership nurses have come to the program highly-skilled and experienced in home visiting and maternal child nursing. Even for these nurses, there is a lot to learn. As one supervisor stated, the learning curve in the first two years is "not a curve, it's straight up!"

How is this important to your agency?

Even highly-skilled and experienced nurses have a huge learning curve in the Nurse-Family Partnership. For this program to succeed, nurses need good preparation, support, and ongoing opportunities for growth. Time to orient and learn is essential.

This may be perceived by leadership or those who fund the program as "non-productive" time. However, when nurses have adequate time to orient and learn, they are better able to move forward with enrolling and retaining their caseload. If they are rushed, they are less able to integrate the concepts. This may lead them to use a more superficial approach while they organize and begin to integrate their new learning. Planning and protecting time for learning is a valuable investment.

How will Nurse-Family Partnership support nurses' skill development?

The Nurse-Family Partnership provides a core education curriculum. It is required for all nurses in the program. This education includes the theories that support the model, visit structure, tools for building self-efficacy, and ways to encourage parents to become emotionally available and responsive parents.

The curriculum is built on competencies (knowledge, attitudes and skills) that result in effectively delivering the model to clients. Education to build these competencies is delivered in various ways, including distance learning and face-to-face education sessions with Nurse-Family Partnership instructors. Skills are refined with the support of the National Service Office Nurse Consultants assigned to each implementing agency.

How does this affect your agency?

All nurses are required to complete the core education. Line items for tuition, travel and food are included in the budget. It is helpful to plan the budget for some attrition in staff, which will result in additional education and travel expenses for the replacement nurses. It is also helpful to consider and plan for any possible challenges in accommodating travel or reimbursement due to agency policy. Model Element 9 explains the commitment each NFP agency makes to ensure quality preparation for all NFP nurses.

What is reflective practice?

Reflection is essential to professional practice in the fields of nursing medicine, social work and teaching. "Reflective practice is about getting into the habit of consciously and deliberately examining situations, actions and responses, and changing practice as a result. Clinical supervision can provide a supportive and safe framework for reflection, helping nurses develop their professional skills" (McDonald & Glover, 2000, p.49). In other words, reflection is a process for learning, professional growth and change.

Reflecting on practice is a valuable process for NFP Nurse Home Visitors. The nurses soon discover that their work with clients is challenging, complex and emotionally demanding. Even nurses with public health and nurse home visiting experience feel uncertain, confused and overwhelmed at times. Nurse-client relationships in this program are affected by the intense visit schedule over two-and-a-half years.

Working with 25 high-risk clients, their infants, and other family members is never easy. NFP nurses visit frequently and spend 1-1 ½ hours per visit with clients. Although this can lead to emotional closeness, it is essential that nurses establish healthy boundaries and maintain them throughout the intervention. Clients often live in difficult situations with tremendous obstacles to overcome. Nurses express frustration about trying to support clients in finding solutions and achieving goals when there are no simple answers.

These are intense situations, and the more intense the work, the more nurses need reflection in their practice. Reflective practice can help nurses establish and maintain healthy boundaries in the therapeutic relationship.

How does this affect your agency?

Nurse supervisors must be prepared to practice reflective supervision. Supervisors help nurses to reflect on their work. This includes caseload management and quality assurance. Supervisors use the principles of reflection as outlined in NFP supervisor training.

Community Linkages

What are community linkages?

Community linkages are the relationships you build between NFP and the referral sources, programs, people and services that will make NFP function as a part of your service system. Building a clear map of these linkages is an important part of your planning and decision-making prior to start-up. We provide planning tools to help in these efforts.

What similar programs exist in your service area for the target population?

In most communities, the need for home visitation services for pregnant women and parents is great. The need often exceeds available program resources. Still, when introducing a new program that appears similar to existing programs, there is a real need for communication, coordination and even collaboration in advance.

Doing careful advance planning to describe how adding NFP will shape your existing service system will:

- Create a clear vision of where NFP will fit among the services currently available to support pregnant women and young families.
- Demonstrate that NFP will not duplicate existing services. Instead, NFP will fill a void within an existing continuum of services or augment existing services in important ways.
- Clarify the strengths of the existing family support service system as well as its vulnerabilities and challenges.
- Help identify individuals and agencies that are important to further planning. These individuals and agencies may be important members of your Community Advisory Board.

Pay close attention to any other home visitation programs that operate in your intended service area. Examples might include federal or state-funded Healthy Start, Early Head Start, Healthy Families America, Parents as Teachers, the Parent Child Home Program, Home Instruction for Parents of Preschool Youth, and unique locally-developed programs designed to support pregnant women and new parents.

Referral Sources

In order for your program to succeed, you will need clients: clients who are eligible for the program, enough clients to fill caseloads, a steady stream of clients so that nurses will be neither overwhelmed nor underutilized, and an appropriate balance of client complexity so that caseloads are manageable. Establishing this referral base is frequently much more challenging to achieve than implementing agencies imagine.

New implementing agencies often struggle at first to get referrals to flow from the agencies that promised to send clients. There are many reasons for this: perhaps the decision maker has failed to inform the staff, the staff has not embraced the program, or they don't know how to make the referral. Maybe referrals get lost or delayed on the way to you.

It is important to think through these issues and plan ahead. With careful preparation, your nursing staff can begin to enroll clients after completing the Denver education session. In addition, they can anticipate a steady flow of well-qualified referrals.

Service Linkages for Clients

Women and families who participate in Nurse-Family Partnership tend to have a wide range of needs and concerns related to their health, environment, economic status, stability, and stress. It is important to plan ahead and become aware of services that will fill these needs – services that are accessible, affordable and supportive.

Sustainability

Why are political champions needed?

Even the strongest, most effective programs cannot survive without political and financial support. That support must come from within the host agency and from the community and/or state within which the program operates. Even programs with ample funding from stable, long-term sources will eventually need to demonstrate their value and make the case for continued support. For many, the need for this advocacy arises sooner than ever imagined.

The agency administrators who once championed the introduction of a program may move on. They may be replaced by leaders with different priorities. Elected officials who supported policies and financing for NFP might lose an election or retire. They could be replaced by others who are simply unfamiliar with what Nurse-Family Partnership is achieving.

Your sustainability plan should describe your current champions. It should also identify who will commit the time and energy to cultivate, maintain, and when necessary rebuild relationships with those on whom your NFP program's survival depends.

You may begin with a single highly effective champion. You should work quickly to develop a team of champions. You need a strong network of individuals and groups that are well-informed about Nurse-Family Partnership's value and ongoing contributions to the community. This network must be able and willing to use their influence on behalf of NFP. These champions will help you maintain NFP's visibility and express gratitude to all those who support you. They can introduce NFP to new leaders who will have a say over whether or not, and how much, funding will be available to you in the future.

Building your team of NFP champions begins while you are engaging important stakeholders in the initial decision about bringing NFP to your community.

How do I identify potential champions?

As you begin to build a network of political champions, you must identify those who can help your agency achieve the goals of Nurse-Family Partnership. Ask yourself this key question:

"If my program's funding was suddenly threatened, which five influential people in the community would and could fight successfully to preserve it?"

You can use the table on the following page to identify important relationships for your sustainability plan.

Critical Relationships for Sustainability			
Power Relationship	**Name(s) and Title(s)**	**Who influences this person?**	**What are my relationships with the person in power and with those who influence him/her?**
Who in the proposed implementing agency has the power to maintain or to close NFP?			
Who in the community has the power to enable NFP to succeed operationally or fail?			
Who determines whether or not NFP continues to get funded?			
Who sets policy that determines whether or not this funding stream continues or at what level it is funded?			
What other groups in the community could be helpful in generating broad support or a powerful 'voice' for the value of NFP?			

Step One

Identify the people you most need to involve in the decision to implement NFP. Determine who should be kept informed and involved in sharing the program's successes. Be sure that they are equipped and motivated to speak on your behalf when you need them to do so.

Step Two

Develop a plan to celebrate program milestones in a public way. Include your supporters in the community. Events like a program opening celebration, a Mothers' Day Reception with your program participants, and Graduation Days let you share news about your program successes.

Women who have benefitted from NFP can tell their stories. This helps people to truly understand the difference NFP makes. Consider developing a Nurse-Family Partnership Newsletter. It can keep the program and its accomplishments visible in the broader community. Offer a variety of ways for people to be involved in supporting the program.

Step Three

Determine what tools and support your advocates need from you. Help them to speak well on your behalf to those who have the power to keep your program funded and strong. The NFP National Service Office will provide you with an array of communications tools (program fact sheets, brochures, videos, etc.) to use in describing the program. However, you will need to create a set of local resources as well. These may include local nurse articles and fact sheets. The local fact sheets could contain information such as:

- Number and characteristics of the women and children enrolled
- Results from early evaluation reports
- Your community partners
- Your funders
- Quotes from women who have benefitted from NFP services
- Photos (with appropriate permissions) of NFP families in your community
- Statements of support from locally influential people
- A brief case statement for NFP in your community: the need, how NFP meets that need, and what you need to build the program to the size and strength it needs to be. The case statement should give your champions the key talking points they need to communicate NFP's value and ask for support in particular ways.

Step Four

Develop a schedule and assignments for visits to people and groups from whom you need support. These may include local county commissioners, members of a board of health, your mayor, your state representatives and senators, or local business leaders. Leaders in the health, education or law enforcement community and members of local civic organizations might also be enlisted to support and advocate for the program.

Recognize that you can't do this alone! You will be more effective if you have a team engaged in outreach and support for your program's sustainability. A Community Advisory Board can be a big help.

What is a Community Advisory Board?

Experience and research has shown that implementing agencies with strong, broad and high-level support from individuals and organizations in their community are stronger. They have more stable funding, a solid referral network, better staff retention and ultimately, a better reputation among

families in the community. One study even demonstrated stronger outcomes for families in the program when the community was more aware and supportive of Nurse-Family Partnership and program participants.

While there are many ways to secure and maintain the support of a community, one of the best is to build a strong community advisory board or coalition. There are four functions with which an advisory board can assist:

- Initial decision-making about bringing NFP to your community
- Supporting program operation
- Advocating for Nurse-Family Partnership
- Advocating for children and families

Initial decision-making

A Community Advisory Board can engage a broad cross-section of the community to assess the need for Nurse-Family Partnership. If the community has a stake in the initial decision to implement NFP, they are more likely to commit to plan for and support the program's operation and nursing staff.

Supporting program operation

Members of the Community Advisory Board can help build a referral system. The referral system brings eligible families into the program, provides interdisciplinary support and case consultation for the nursing staff delivering the program, and eases access to other services Nurse-Family Partnership participants may need.

Advocating for Nurse-Family Partnership

Community Advisory Board members keep those who can provide funding and political support for the program remain well-informed about the program's value and its importance to the community at large. Community Advisory Board members can work with the implementing agency administrator to conduct public awareness events and outreach visits to people you need on your side. They can be of great assistance in cultivating powerful champions.

Advocating for children and families

Community Advisory Board members keep an eye on the broader needs of low-income children and families. They help identify gaps in services that cannot be met by NFP. They help identify the actions necessary to complete a solid spectrum of support and opportunity for all families.

How do I build a Community Advisory Board?

Identify the right people to participate.

Identify 10 – 15 individuals to attend an informational meeting about Nurse-Family Partnership. Identify at least two or three you think would be excellent at fulfilling the four functions above and whose buy-in is important for your initial and ongoing success. Choose people who are passionate about children and families and good at working collaboratively. Identify those who you believe will be motivated and excited to support this new initiative, not just those who 'fit the bill' in a particular category.

Consider people from the following areas:

- Major employers or businesses
- Judicial system
- Law enforcement
- Child care
- Education
- Schools
- Referral sources
- Health care (influential physicians or health plan leaders)
- Home visiting programs
- Community organizers or community development experts
- Press
- Faith-based communities
- Local legislators or other elected officials (be bi-partisan)
- Program graduates (eventually)

Extend the invitation to participate.

Prepare to extend the invitation by developing a clear statement of the purpose of the Community Advisory Board. Describe the requirements and benefits of membership.

Think ahead about who should invite each person to attend. Should you extend the invitation? One of your Board members? One of the Advisory Board members who has already accepted your invitation? Make sure the invitation comes from someone your targeted member knows and respects.

It is important to determine who will have time to devote to establishing your community board. Sometimes the job of establishing and maintaining an effective advisory board falls to the nurse supervisor. This may or may not be appropriate for your program. Remember that during the start up phase (the first 6-9 months) the supervisor will be focusing on establishing a strong referral base, ensuring appropriate enrollments, assisting nurses with building and maintaining caseloads, finding resources for clients, helping nurses integrate new learning and new skills, providing reflective sessions for each nurse, establishing case conferences and in-services programs, and so forth. An agency administrator or Board member may be the best choice to establish and lead your Community Advisory Board.

Take time to plan good meetings.

- Schedule a room for the meeting that is comfortable and centrally located.
- Select a time and date for meetings to allow as many people as possible to participate.
- Schedule the meeting to last no more than two hours.
- Consider providing childcare if your participants have children.
- Provide food and drinks.
- Start and end on time.
- Prepare an agenda and send it out at least a week in advance. The agenda should reflect clear objectives. Stick to the agenda and ensure that discussion items are focused on achieving those objectives.

- Keep and distribute meeting notes.
- Allow time for mingling and building social relationships.

Make participation meaningful and rewarding.

- Assign each member meaningful roles and tasks related to your objectives for the Advisory Board.
- Celebrate accomplishments and express gratitude for member contributions – regularly!
- Check-in with members outside of the meeting and during meetings to assess how they view their involvement and the program. Ask what else you can do to support their involvement.
- Keep the voices of the families you serve prominent. Share their stories; invite Community Advisory Board members to program events; invite nurse home visitors to meetings to talk about their experience in the program.
- If important members find it difficult to attend meetings regularly, consider creating alternate ways to keep them involved. You could ask them to carry out particular tasks or help with time-limited projects that don't require meeting attendance.

Financing

How do I develop a budget for our program?

Developing a well thought-out budget is paramount to the successful implementation of any new Nurse-Family Partnership program. Underestimating the actual start-up and operational costs could undermine the degree to which the agency can maintain model fidelity. Inadequate resources could affect the quality of services delivered to children and families. Inadequate resources can also influence the sustainability of the program itself. Without the necessary tools and support, your NFP team is less able to achieve positive program outcomes and cost benefits.

The Nurse-Family Partnership National Service Office has prepared materials to assist prospective agencies during the budget planning process. Review the sample budget worksheets and accompanying budget narratives provided by the NSO Program Developer. The narrative "maps" to the budget worksheet line by line. It explains in detail the assumptions and parameters used in developing the worksheet, as well as factors that applicants must carefully consider when identifying their own cost figures.

Please note that while these budget planning tools have been based on the experiences of NFP implementing agencies, specific dollar amounts reflect average costs. Several cost components will differ according to the local community, the most variable one being competitive nursing salaries and benefits. Other line items that may vary considerably based on local context and needs include mileage reimbursement for nurse home visitors and costs for additional professional development (as needed based on the experience and background of the nurses hired).

In contrast, some expenses included are fixed for the fiscal years used in the sample budgets and will not change. For example, Nurse Core Education tuition is a fixed expense. Depending on local circumstances, an agency may have some equipment on hand and/or can secure certain items through in-kind donations. The critical thing to remember is to plan carefully and to take site-specific issues and the community context into account when developing an implementation budget.

A Regional Program Developer is available to provide guidance as you think through underlying budget assumptions. The Program Developer can help determine whether projected cost estimates seem reasonable and on target. This helps ensure that the team will have the resources they need to effectively implement the Nurse-Family Partnership program.

What are the financing requirements for the program?

Financing for Nurse-Family Partnership must meet three broad requirements:

1) Financing must be appropriate to the model. That is, none of the requirements associated with receipt of funds should conflict or interfere with the nurses' ability to achieve fidelity to the model.
2) Financing must be adequate to fully support the budget.
3) Financing must be sustainable or replaceable, with an adequate plan and commitment indicated to assure that funding will remain adequate and secure over time.

When submitting an implementation plan to the Nurse-Family Partnership NSO, your agency must provide evidence that a full three years of funding is secure. You must have the first year's funding

in hand. The second and third years of funding must either be in hand or the applicant must show compelling evidence that funders are committed to following through with support in those subsequent years.

We are insistent about secure financing for at least the first full program cycle of enrollment because we are committed to fulfilling the promise we make to support women who agree to participate in the program. When funding fails and programs must be cut back or positions eliminated, we violate the trust of our program participants. When an agency that purports to promote their well-being fails in this trust, members of the community tend to be less willing to participate in similar services in the future.

A compelling plan for sustaining the program should be submitted as part of the implementation plan prior to program launch. Without financial security, nurses may well become anxious about their employment and look for alternative positions in the community. Nurse turnover is costly, in both financial and human terms. The program must pay to recruit and train a replacement nurse. More importantly, when an NFP Nurse Home Visitor leaves the program, she leaves the families with whom she has built relationships. That loss can form a psychological wound that makes it difficult for families to remain engaged in the program. They may not be open to receiving continued services from another nurse. Families count on the stability and commitment of their nurse home visitor. Any gaps in service can lead to disengagement and reduced program impact.

Please bear these factors in mind when you seek funding for Nurse-Family Partnership. Plan to do the public relations and advocacy work necessary to maintain or expand your funding sources over time.

Research

What is the Research and Publication Communication Committee?

The Research and Publication Communication Committee (RAPComm) is a joint committee comprised of members from the following organizations:

- Nurse-Family Partnership National Service Office (NFP NSO)
- Prevention Research Center (PRC)
- Public/Private Ventures (PPV)
- Invest In Kids (IIK)

The RAPComm committee is responsible for approving research and assuring the coordination of research activities that involve Nurse-Family Partnership (NFP) staff and/or data. In this role, the RAPComm committee will:

- Review and assign approval status to all research activities that involve NFP staff and/or NFP data.
- Assure the coordination of NFP-related research activities to minimize unnecessary interference with the nurses' primary responsibility to carry out the program and to prevent contamination of research activities in progress.
- Assure that NFP clients' rights and welfare are protected and that research proposals have been reviewed by the appropriate institutional review board(s).
- Maintain a database of research conducted at Implementing Agencies.
- Facilitate effective communication about research, publications and presentations among NFP Implementing Agencies, NFP NSO, PRC, IIK, PPV and other researchers and stakeholders as requested.
- Establish policies and procedures to carry out its responsibilities.

How do I get approval to conduct NFP-related research?

The Committee meets monthly to review applications. The application may be found on the NFP Community. Researchers who are not employed by an NFP Implementing Agency may request an application via email to: RAPComm@nursefamilypartnership.org.

For researchers requesting access to Implementing Agencies in which to conduct the project, an additional 3 months may be required. This time is used to determine if potential participating agencies are available and to establish a relationship with the researcher to determine their interest in research participation.

The Research and Publication Communication Committee has agreed on the following definitions:

- **Research**
  A systematic investigation, including development, testing, and evaluation designed to develop or contribute to generalizable knowledge. Projects meeting this definition must be reviewed by an institutional review board (IRB).
- **Generalizable Knowledge**
  Generalizable knowledge is held to be knowledge that can be applied to individuals or

populations outside the individuals being studied. That is, a larger group is expected to benefit from the knowledge obtained from the study.

- **Program Evaluation**
  A systematic collection of information about the activities, characteristics and outcomes of a program used to make judgments about the program and improve effectiveness or inform decisions about future programming. IRB approval for program evaluations is required if the project meets the definition of research.
- **Quality Improvement (QI)**
  A system designed to monitor and improve the performance of a program or process. QI is an on-going process designed to measure performance against existing standards, review how well the standards are met, identify possible causes for variation, establish goals to improve performance, design and implement strategies to improve performance and evaluate the outcomes.
- **Scholarly Publications/Presentations**
  Publications such as peer-reviewed journals, research reports, books or book chapters, and presentations at academic or professional conferences.

New implementing agencies should not undertake research studies until their program has reached a stable state of implementation with fidelity.

Timeline

How do I determine an implementation timeline?

There are many factors influencing when your agency can begin implementing Nurse-Family Partnership. Some of your agency's tasks and activities must be reviewed by a team at the NFP NSO prior to initiating subsequent steps. A determination of NFP implementation readiness is contingent on securing appropriate funding for the program and completing an implementation plan. Following this determination, the NSO initiates the completion of a proprietary protection letter and/or contract with the NFP NSO.

Completing an agreement with the National Service Office will prompt a number of other tasks for your agency. The first step is generally to begin recruiting and hiring the nurse supervisor. This could take a number of weeks or months depending on your agency and community. It is recommended that the nurse supervisor interview and hire other team members. The supervisor may also prepare work space, order and organize materials, and develop a referral system. Agency staff can also obtain a log-in for the NFP Community, allowing them access to NFP Education calendars and registration.

The NSO will provide the administrator and nurse supervisor with materials and information needed to complete the tasks that are required prior to NFP education in Denver. This includes: supervisor orientation, selecting and hiring nurse home visiting and administrative support staff, purchasing materials, and completing the initial self-study modules.

The table on the following page shows the initial implementation tasks and dependencies.

Program Implementation Timeline & Tasks

Items shaded in green are Implementing Agency (IA) tasks;
those in white are National Service Office (NSO) tasks that depend upon certain IA tasks being completed