Growing What Works

Lessons Learned from Pennsylvania's Nurse-Family Partnership Initiative

Jennifer Collins Stavrakos and Geri Summerville with Laura E. Johnson

P/PV Public/Private Ventures
INNOVATION. RESEARCH. ACTION.

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Introduction

Each year, federal, state and local governments, as well as private funders, pour billions of dollars into intervention services for high-risk children and youth, such as special education, foster care and juvenile detention. While there may always be a need for such services, most people can agree that preventing costly problems, when possible, is the best approach. Similarly, while innovation and experimentation are critical to developing new and better programs, the use—and strategic expansion—of evidence-based models ensures that precious resources are not wasted reinventing the wheel. This approach is especially critical in times of economic distress, when funds for social programs are scarce. Implementing proven programs with fidelity to the established model can reproduce the positive results achieved in original research trials—and ensure a solid return on investment. In the realm of social policy, this level of certainty is a rare commodity.

In the late 1990s, the Commonwealth of Pennsylvania made a strategic decision to direct funds into research-based programming to provide a comprehensive system of proven prevention and intervention services targeting its most vulnerable citizens. As part of this plan, in 2001 the Commonwealth made a $20 million, four-year investment to replicate Nurse-Family Partnership—one of the nation's best-tested social programs. Nurse-Family Partnership uses trained nurses to conduct one-on-one home visits with low-income first-time mothers. The model has been carefully evaluated through ongoing, longitudinal randomized trials with racially and ethnically diverse families in urban and rural settings, producing impressive results: improved prenatal health, significant reductions in child abuse and neglect, increased intervals between births of subsequent children and—by the time the first child is 15—reductions in arrests of children and convictions of mothers. Public/Private Ventures (P/PV) was engaged by Nurse-Family Partnership to oversee the program's expansion throughout Pennsylvania.

"It was remarkable and unprecedented that a state agency [Pennsylvania Commission on Crime and Delinquency] that was responsible for administering juvenile and criminal justice programming statewide was now overseeing trained nurses working with low-income first-time mothers and their babies as an investment to prevent later costs and impacted lives. No other state in the nation advanced Nurse-Family Partnership with such passion and comprehensive partnerships as Pennsylvania did during this time. In fiscal year 2000–2001, Pennsylvania's investment in evidence-based prevention programs, including Nurse-Family Partnership and Communities That Care, was in excess of $20 million—more than the entire federal government made available for the same programs nationwide."

—Clay Yeager, former executive director, Governor's Partnership for Safe Children

This report draws on P/PV's seven years of experience working with Pennsylvania's Nurse-Family Partnership initiative. Those years have made clear that the replication of evidence-based programs can be an enormous challenge, even for highly defined and effective programs like Nurse-Family Partnership. Replication across many sites simultaneously, and by a common funder, is labor-intensive and comes with high expectations: Local governments and foundations support evidence-based programs because they trust their investment will yield the same outcomes and cost savings demonstrated in research trials. As a result, ensuring fidelity to the established program model, while allowing for local innovation, is paramount to success. This report provides key lessons for policymakers and funders interested in bringing proven models to a statewide scale, emphasizing the importance of capitalizing on the unique advantage of geographic proximity to build a network of sites whose work becomes greater than the sum of their individual parts.

Why Replicate Nurse-Family Partnership?

Background

Nurse-Family Partnership represents a highly refined approach to the long-established service strategy of home visiting. The program is voluntary and open to low-income women who are pregnant for the first time. Nurse-Family Partnership is a relationship-based program: Starting at or before the 28th week of pregnancy, clients are visited at home, one-on-one with a trained nurse; visits continue throughout the pregnancy and the first two years of the child's life. Each full-time nurse home visitor has no more than 25 active clients at one time, ensuring she or he is able to adequately focus on the needs of each client. All implementing agencies are operated by organizations known in their communities for being successful providers of services to low-income families.

Nurse-Family Partnership has three main goals:

1. For mothers: Achieve better pregnancy outcomes (by helping them improve their health behaviors, such as ensuring that they obtain prenatal care and encouraging good nutrition and avoidance of cigarettes, alcohol and illegal drugs).
2. For parents: Improve their child's health and development (by helping them provide more responsible and competent care for their children).
3. For families: Become economically self-sufficient (by working with parents to develop a vision for their own future, plan future pregnancies, continue their education and find jobs).

When mothers and their families become confident and skillful in these areas, it can shape their ability to care for themselves and their children long after the program ends.

> *"We know the dramatic effect good parenting can have on children. When Nurse-Family Partnership empowers these young women with critical skills and knowledge, fragile families learn how to become healthy families."*
>
> *—Estelle Richman, secretary, Pennsylvania Department of Public Welfare*

Three Decades of Clinical Research and Proven Impacts

The Nurse-Family Partnership program began in 1977 in Elmira, NY, as a research study conducted by Dr. David Olds. The Elmira trial compared a random sample of 200 primarily low-income white families bearing first babies who received the model with a control group of the same size and profile who did not. The nurse-visited families showed improved prenatal health, significant reductions in child abuse and neglect, fewer subsequent pregnancies and increased intervals between births.

However, given that the Elmira results were produced with a primarily white sample living in a semirural community, Dr. Olds was concerned that the findings might not apply to minorities living in major urban areas. He decided to raise funds from a variety of federal and private sources to conduct a second study, beginning in 1987, with low-income African Americans living in Memphis, TN, before offering the program for public investment.

In 1993, while the Memphis trial was being conducted, Dr. Olds began a third trial in Denver that tested whether it was necessary to use nurses or if the same effects could be achieved with paraprofessional home visitors. Moreover, the Denver trial registered a large sample of Hispanics, providing an opportunity to examine program effects with the other major minority group in the US. (Ultimately these results would demonstrate that nurses were more effective in the Nurse-Family Partnership model, solidifying this essential element of the program model.)

In 1996, with impressive results from the Elmira and Memphis studies in hand and the Denver study underway, the US Department of Justice invited Dr. Olds to implement the program in six high-crime neighborhoods in major urban areas around the country—the first time the program would be implemented outside of a research context. At this juncture, the positive findings from the first two trials gave him confidence that the program's benefits were reproducible and provided sufficient scientific evidence to support public investment.

Replication

As the replication phase began, Dr. Olds was concerned the program would be watered down as it was expanded. In 1997 he engaged Replication and Program Strategies—now a part of P/PV—to help devise an approach that would increase the likelihood that adopting organizations and communities would implement the program with fidelity to the model tested in the trials.

At the time, there was little guidance available to social programs interested in a systematic approach to replication. Even today, some in the field of social policy are averse to the idea of replication, maintaining that "cookie cutter" approaches to programming ignore the unique traits of individual communities and impose an immutable structure that downplays the importance of local circumstances. However, in P/PV's experience, "replication and adaptation are inextricably linked…There has never been a pure replication, and there never will be…The choice is never between replication and adaptation, but which aspects of a program or organization to replicate with fidelity and which can or should be adaptive."[1]

The most integral part of replicating a proven model, then, is identifying its "essential elements"[2]—ingredients both functional and structural that are central to the program's effectiveness—and then ensuring that these elements are strictly adhered to during implementation. Adaptability, on the other hand, comes into play in decisions about day-to-day operations, such as how to fundraise, carry out local advocacy efforts, and hire and manage staff. These activities are certainly informed by the program's essential elements, but there is—and should be—room for agency staff to make choices, based on local circumstances, that can enhance the program while still remaining faithful to the model.

Nurse-Family Partnership requires adherence to 18 well-defined "Model Elements" to ensure that the outcomes of new programs are comparable to those seen during the research trials. These Elements address issues of client eligibility and enrollment, frequency and content of visits, staff credentials and training, program monitoring and use of data, and expectations of administrative oversight. The full list of Model Elements is provided in Appendix D.

Since the beginning of Pennsylvania's replication of the program, P/PV—in partnership with the Nurse-Family Partnership headquarters, known as the National Service Office (NSO)—has helped sites implement the model and adhere to these

The Fundamentals of Successful Program Replication

Too many programs flounder when they are introduced in new settings. Specific structures and processes are required to effectively replicate a program's good results. In P/PV's experience, the following elements must be well defined before a program considers replication:

- Participant characteristics (demographics, etc.),
- Intensity and duration of programming,
- Content and flexibility of activities,
- Key transition points for participants,
- Presence and types of requirements and incentives for participation,
- Performance expectations for participants and staff,
- Staff qualifications and configuration,
- Characteristics of the organizations that operate the program, and
- The program's relationships with other organizations or agencies.

In addition, it is critical to answer the following questions:

- *Is the program effective?* Has it had a formal evaluation that shows positive results, and is it clear that the program, not other factors, caused the results?
- *Can the program achieve those results in a timely fashion?* Have the essential program components been fully defined and tested, and is the necessary program material in place to fully explain successful implementation to new program sites to allow for quick start-up?
- *Is there standardized training for all program sites?* Will new sites receive the same training to ensure quality implementation?
- *What is the marketing plan?* Is there a plan in place (both strategic and opportunistic) that will get the word out that the program is available and that it works? Additionally, are there specific geographic areas or populations that should be targeted that would benefit the most from the program?
- *What partnerships need to be developed?* Are there coalitions, agencies or organizations with the same mission and goals that can help move the program forward and gain access to public funding streams?
- *Is there a universal data collection system?* Are all program sites collecting the same data—both implementation and outcome data—and can the data be used to make a case for new or continued funding?

More information can be found in *Capturing the Essential Elements* (2004) and *Laying a Solid Foundation: Strategies for Effective Program Replication* (2009), both available at www.ppv.org.

established Elements. P/PV currently works in this capacity in the northeastern United States, managing not only Pennsylvania's statewide initiative but a large urban initiative in New York City as well as 10 other sites spread across Maryland, New Jersey and upstate New York. In addition, P/PV continues to develop new sites across the region. While our work in all of these locations has produced important lessons about successful replication of evidence-based programs, the Pennsylvania initiative is particularly instructive, as it is one of the first—and largest—statewide replications of the Nurse-Family Partnership model.

Bringing Nurse-Family Partnership to Scale in Pennsylvania

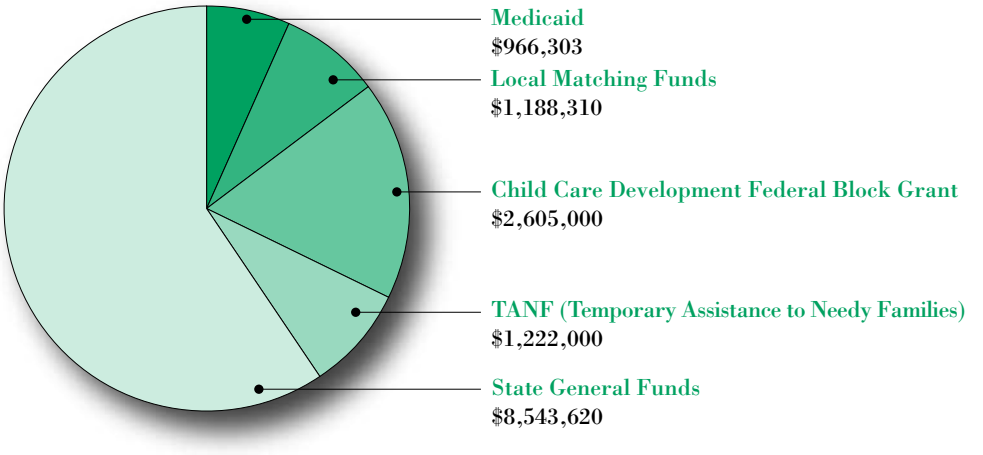
When Pennsylvania Governor Tom Ridge took office in 1995, one of his primary goals was to "get smart on crime." Instead of focusing solely on deterrence and prosecution, the Ridge administration was committed to using evidence-based programs to prevent delinquent and criminal behavior. As part of this commitment, the Pennsylvania Commission on Crime and Delinquency (PCCD) issued a request for proposals (RFP) using a new, designated state funding stream known as Research-Based Violence Prevention Funds, designed to help communities identify and implement proven prevention programs that reduce youth violence, delinquency and other problem behaviors.

Because of Nurse-Family Partnership's proven outcomes related to reducing violence by and against children, then Secretary of the Department of Public Welfare Feather Houstoun, a strong and outspoken advocate for evaluation and research-based programs, offered to make a one-time transfer of TANF (Temporary Assistance for Needy Families) funds from her department to PCCD to replicate the program across the state. The funding, $20 million over four years, enabled PCCD to release an RFP exclusively for the creation of new Nurse-Family Partnership sites.

> *"The Nurse-Family Partnership program was undoubtedly one of the most effective—if not the most effective—of the myriad of prevention efforts undertaken by Pennsylvania state government to ensure healthy and positive futures for Pennsylvania's at-risk children."*
>
> *—Ruth Williams, former deputy director of PCCD's Office of Juvenile Justice and Delinquency Prevention*

Nurse-Family Partnership has been successfully embraced by two administrations since its inception in Pennsylvania. In recent years, under the leadership of Governor Edward G. Rendell, the program has seen a continual increase in funding; current Secretary of Public Welfare Estelle Richman and her staff at the Office of Child Development and Early Learning have been strong advocates for program expansion and have worked to diversify and sustain funding sources. Figure 1 presents a snapshot of how Nurse-Family Partnership is funded in Pennsylvania for fiscal year 2009.

Figure 1: Nurse-Family Partnership Funding in Fiscal Year 2009



Currently more than 25 agencies in Pennsylvania are involved in implementing Nurse-Family Partnership. While approximately two thirds of the agencies are local health departments or home health entities, there are also a variety of community-based social service agencies, including a community action agency and a children's advocacy organization, implementing the program. The agencies are diverse in size, scope and mission and are spread across the Commonwealth, targeting Pennsylvanians in urban, suburban, semirural and rural communities. The vast majority of sites are funded to serve 100 to 125 clients each, with several larger sites operating in urban centers or across multiple counties. All of the communities that have received funding since 1999 are still implementing Nurse-Family Partnership today. (Pennsylvania's implementing agencies and partners are listed in Appendix A; a map of the participating counties can be found in Appendix B.)

The successful expansion of Nurse-Family Partnership in Pennsylvania was the direct result of committed, forward-thinking funders and deliberate ongoing technical assistance. The pace and scale of the replication, as well as the longevity of the initiative, have resulted in a number of important lessons for funders and policymakers who seek to replicate evidence-based models; these lessons and recommendations are discussed in detail in the following chapter.

Lessons Learned

The primary risk in replicating research-based programs is that the model will be diluted or only partially implemented in practice—and thus fail to produce the same positive results seen in research trials. Implementing organizations that are not adequately supported from the beginning with high-quality training and technical assistance are at risk of losing focus or compromising crucial program elements to accommodate the desires of other organizations, funders or local communities.

Policymakers in Pennsylvania recognized that their substantial financial and political investment in Nurse-Family Partnership called for an equally significant investment in technical assistance to help both the state and the sites meet their short- and long-term goals. Thus, the state engaged P/PV to provide support for implementing agencies to ensure adherence to the model while allowing for individual differences and enhancements that contribute to local success.

The large-scale expansion of the program in Pennsylvania also meant that more than 100 nurses would attend training together and 13 agencies were going to begin implementing the model simultaneously. Therefore, P/PV's role was not only to ensure that program expansion occurred with fidelity to the model, but also to create opportunities to build an informed and passionate group of individuals and agencies that could learn from one another and advocate for ongoing sustainability and growth.

A number of important lessons emerged from this work, which we hope will be instructive for other states considering broad-scale expansion of evidence-based models.

1. Choose the Right Implementing Agencies

When large-scale replications begin, funders often want to know how soon new sites can be up and running—with the goal of seeing positive outcomes quickly to justify their investment. However, sites must be chosen carefully to ensure they have the organizational capacity and service-delivery experience to implement the model with fidelity. Significant effort must also be expended to be certain that new sites will not be duplicating existing services already available in their communities.

One way P/PV reconciled these competing goals was by working with PCCD and the NSO to tailor the state's standard RFP to include questions designed to assess

known indicators of quality for potential Nurse-Family Partnership implementing agencies. Key indicators include:

- An established community need for the program;
- Organizational capacity to implement the model with fidelity;
- Adequate community linkages for referrals and resources;
- Ability to recruit and retain qualified home visitors; and
- Demonstrated commitment to sustainability.

Technical Assistance in Support of Successful Replication

P/PV and the Nurse-Family Partnership National Service Office (NSO) collaborate to provide technical assistance to the sites in Pennsylvania. The NSO provides professional development services, including the content and delivery of nurse-home-visitor education sessions, as well as data reporting and analysis to every site in the country.

P/PV partners with NSO to provide:

- *Site development.* The goal of site development is to identify appropriate implementing agencies and work with them throughout the application process to ensure that the agency is well situated financially, culturally and within its community to successfully implement the model. In a statewide initiative such as Pennsylvania's, site development also includes creating and maintaining key relationships across the state to make sure the political and financial climate remains conducive to the program's ongoing sustainability and, as needed, expansion.
- *Site management.* Upon approval of an organization's application, P/PV works to ensure the site receives the support it needs to perform optimally and with fidelity to the program model—and has the funding it needs to continue operations.

As part of the site development and management, P/PV provides:

- Monthly consultation calls with each site;
- Biannual visits to each site;
- Biannual administrators' meetings;
- Annual regional meetings for clinical staff (beginning in Year 2);
- Annual statewide conferences (beginning in Year 3); and
- Monthly meetings with state officials to provide implementation updates.

In addition to these basic structured activities, which may be applicable to most social programs, P/PV has developed several approaches tailored to the sites' needs. Most significantly, P/PV recognized the importance of a dedicated staff member who could focus on helping local staff identify and address clinically controllable influences on the quality and performance of the program. Thus, P/PV made it a priority to hire a clinical nurse supervisor and, in Year 3 of the statewide initiative, to bring on a full-time clinical consultant to focus on nursing practice and quality improvement issues.

In addition, the state allowed representatives from the NSO and P/PV to conduct site visits with each applicant to discuss critical pieces of their proposals before final decisions were made. When this type of evaluative work is done up front by knowledgeable program staff, it can result not only in choosing stronger agencies but in selecting those well prepared to begin the start-up process upon receipt of funding.

2. Ensure the Program Is Well Received and Integrated into Local Communities

Although Pennsylvania's Nurse-Family Partnership program is primarily a state-funded effort, without a strong network of local support most implementing agencies would be destined to fail. By establishing relationships with community members and organizations, programs are not only better able to reach and maintain capacity —by boosting referrals or building partnerships with other programs that can provide clients with ancillary services—they also increase awareness and cultivate feelings of goodwill toward their work and their agency.

Avoiding Duplication of Services

While Nurse-Family Partnership nationally makes a concerted effort to avoid implementing the program where it is not needed or duplicative, there are often other home-visiting programs serving similar populations in each community. For example, a community may choose to add Nurse-Family Partnership to its continuum of services because there are not enough programs to meet the needs of its population or because it is seeking a more intensive intervention for higher-risk families. Sometimes there will be little to no overlap—for example, a program might only serve parenting mothers rather than, like Nurse-Family Partnership, initiating contact while the mother is pregnant.

However, when an existing program does enroll clients during pregnancy, collaboration is crucial to determine the best way to avoid confusing referral agencies and causing duplication of services. Where this has worked best, providers have been able to engage in an open dialogue and create a system for referrals that is mutually beneficial. Doing this as early in the start-up phase as possible cuts down on the sense of territorialism that can often present barriers to enrolling women and connecting them with the resources they need.

Maximizing Impact Through Networks

In every community there are a variety of boards and coordinating councils related to health and social services. Participating in their meetings has helped new implementing agencies establish themselves as a critical part of a community's network of social supports. In Pennsylvania, new sites were required to show a relationship with their local Communities That Care collaborating board, which brought together the majority of local human service providers. The affiliation with these boards helped lend legitimacy to the program in its early days and facilitated access to referrals and resources that enabled many sites to get off to a running start.

Generating Interest and Support

Promoting awareness of the program in local communities through the media and outreach to key organizations that provide financial and in-kind support also proved crucial to Nurse-Family Partnership's success in Pennsylvania. From the start of implementation, sites were asked to create opportunities to raise the program's profile and communicate its value to the community.

To achieve this goal, many sites maintained databases of key stakeholders, whom they reached out to on a regular basis with newsletters, announcements and invitations to events, such as birthday parties and graduations. The leaders of each site were also encouraged to identify nurses who could speak knowledgeably and passionately about the program to the media or at program-related events; nurses, in turn, were asked to name clients who had compelling stories that could illustrate the importance of Nurse-Family Partnership.

"There is so much more to Nurse-Family Partnership than just implementing the model. That's the easy part. The challenge is bringing a new way of thinking (prevention strategies) to communities where they are less than receptive or think they are already doing similar things. You must be constantly speaking to everyone you meet about the program, knowing your audience and their mutual concerns, stressing the savings down the road and sharing stories of how it works, with case examples."

—Lisa Ritchey, RN, BSN, director, Nurse-Family Partnership of Blair, Cambria, Centre and Huntingdon counties

While P/PV and the NSO provided guidance and materials to assist with these advocacy and communication efforts, they believed that those closest to the ground were the most powerful advocates for the program. Involving them in these efforts also served to boost morale and, especially for the clients, build self-esteem.

3. Create a Community of Practice

The existence of a critical mass of sites in geographic proximity does not necessarily mean they will share information or seek assistance from one another. While there may be an instinctual feeling of goodwill or interest, it is easy—and natural—to get mired in the day-to-day operations of program implementation. Therefore, it is critical to establish well-structured, deliberate opportunities for sites to build relationships—so they will not only interact when they are brought together but will seek each other out informally to problem-solve and provide support. Ensuring that all sites are operating with the same type of ongoing support also facilitates the clear communication of expectations across the initiative and eases the burden of the funding organization.

Encourage Experienced Sites to Support Newer Ones

When wide-scale implementation began in 2001, there were already six agencies implementing Nurse-Family Partnership in Pennsylvania. When P/PV held the first statewide supervisors' conference in December of that year, the seasoned site supervisors invited new staff to visit their program and speak with their nurses; many took advantage of this opportunity. Not only did these visits provide an invaluable educational opportunity for the new nurses, they also boosted feelings of competence among existing sites. In 2002, when three new Pennsylvania sites opened their doors, more mature sites jumped at the chance to support them. As new sites have begun operations in other states—including New York and New Jersey—Pennsylvania sites have continued to host new nurses and share their best practices.

Establish Structured Opportunities for Skills Training and Team-Building

To become a Nurse-Family Partnership implementing agency, staff must:

- *Complete education sessions offered by the NSO.* Core training consists of both face-to-face and distance learning. It provides nurse home visitors with an understanding of the program design and theory along with the fundamentals

of Nurse-Family Partnership's nursing practice, including interventions to build self-efficacy, the stages of behavioral change, building therapeutic relationships and reflective practice.

- *Be trained to use the national, web-based Clinical Information System (CIS).* The CIS provides a common platform for every site to collect the same data and supplies them with the information needed to monitor the quality of implementation and the progress of enrolled families toward attaining program goals.

While this initial training gives each nurse home visitor the skills necessary to implement the model, P/PV recognized the need to provide ongoing opportunities to network, tackle common challenges and update clinical skills. In response, P/PV initiated regional meetings for nurse supervisors and home visitors one year after statewide implementation began. The meetings, which are now held annually, provide an opportunity to focus on statewide trends, promote quality improvement and facilitate group problem-solving that would not be possible in the context of individual site visits.

Based on the success of the regional meetings, the first statewide Nurse-Family Partnership conference was held in Pennsylvania one year after the initiation of the regional meetings. These conferences are now attended annually by every nurse home visitor, supervisor and administrator in the state. They provide an opportunity to supplement the required NSO training with additional topics relevant to their practice, as well as to celebrate accomplishments and build camaraderie.

"The PA statewide conferences are always looked forward to by my team. They have offered us the opportunity to listen to knowledgeable speakers and to incorporate new ideas into what we teach. Of course, one thing we always look forward to is seeing all of the other teams and feeling the great pride that comes from being a part of this wonderful state initiative."

—Sara Klingner, MA, BSN, nurse supervisor, Visiting Nurse Association of St. Luke's

Building these relationships has led sites to see themselves as part of a larger team and become strong advocates for the sustainability of the program across the state rather than competitors at a local level for funding. Over the years, Pennsylvania

sites have testified in front of the state legislature, participated in federal advocacy events on Capitol Hill, worked collaboratively on media opportunities and successfully applied for joint funding from regional foundations.

4. Closely Monitor Program Results to Promote Quality

The goal of program replication is to ensure that outcomes are comparable to those found in the original program; as such, it is critical that each local site implements the model with a high degree of fidelity and quality. Without effective data collection and monitoring, sites will be unable to assess how well they are implementing the program and whether their results are in line with those of the proven model.

To help measure performance across sites, the Nurse-Family Partnership NSO developed national performance objectives based on a combination of outcomes from the research trials, site performance in replication and measures set forth in Healthy People 2010.[3] These standards provide a basis for assessing the performance of both individual implementing agencies and the state as a whole. To help monitor program quality, sites have real-time access to their own program data, including client enrollment rates and number of completed visits; client demographics; and risk and outcome indicators related to pregnancy health, birth outcomes, child health and development, and maternal life course development. The NSO provides quarterly updates and annual analysis on the statewide effort to the state funding agency and to local sites. To supplement these updates, P/PV also developed trend reports to help agencies see more clearly where they were making steady improvements and where they needed to place more emphasis on quality improvement.

The Nurse-Family Partnership is an effective model, but it can be complicated to implement well—with intensive education sessions and program guidelines, a comprehensive data-entry system, staff and client recruitment, and the development of a network of community resources. It takes time for an implementing agency and clinical staff to become proficient in delivering the model. To help sites reach this goal, staff are asked to monitor their performance and outcomes regularly, to identify challenges as they occur and to work within their team and with support from P/PV's program and clinical staff to resolve those challenges and continue to improve performance.

5. Engage Local Administrators

It is likely that any large-scale program replication will involve local agency administrators who oversee the program but also manage a variety of other projects. While these individuals have many competing priorities, they are critical to the program's success. In Nurse-Family Partnership's case, these individuals are typically program supervisors, department heads or executive directors designated to oversee operations within local implementing agencies. Given the diversity of these agencies, the administrators' backgrounds, levels of experience and duties within their individual organizations also vary widely. Additionally, most of them do not have any of their salary covered by the Nurse-Family Partnership grant—and many have competing responsibilities managing their larger organizations, with Nurse-Family Partnership only representing a small part of their overall workload.

Recognizing the important role administrators play in successful program implementation, P/PV set out to provide structured opportunities for them to learn about the model, the activities involved in program start-up and, most importantly, the expectation of continued technical assistance and support. This structure is not common; most state and local agencies adopt programs either by creating something new or simply borrowing methods and materials from existing programs in other locations. Yet, successful implementation of evidence-based programming requires a more rigorous approach—one that emphasizes adherence to the program's essential elements, quality-assurance mechanisms and, in the case of Nurse-Family Partnership, specific clinical competencies.

To support the successful launch of Nurse-Family Partnership by new agencies, P/PV held a statewide administrators' meeting in October 2001, immediately after the state notified agencies of their grant awards. A key factor in securing participation was to ensure there was no cost to the agencies for their attendance. By covering the meeting costs, including mileage reimbursement and hotel accommodations, P/PV sent the message that administrators' participation was valued and important, without placing undue burden on their program or agency budgets.

Based on the success of the first meeting, P/PV continued to convene administrators on a biannual basis to review statewide outcomes, address changes and updates to program materials, and discuss program sustainability and national replication and advocacy efforts. In addition to keeping administrators connected

to implementation, frequent meetings also helped address staffing changes: Unlike the nurse home visitors, who are specifically hired for Nurse-Family Partnership, new administrators often inherit Nurse-Family Partnership and other programs as part of organizational changes or staff turnover within their agency. New administrators benefit from orientation and support from experienced peers in other agencies implementing Nurse-Family Partnership.

"P/PV is always there to support us. They serve as a communication conduit between programs and between us and other resources. Their work enables this program to grow in the community, which in turn helps us grow the people in the community."

—Elizabeth Walls, MSN, MBA, RN, CNA, director, Personal Health Services, Chester County Health Department and Nurse-Family Partnership Administrator

6. Invest in Local Evaluation

With more than 30 years of randomized controlled research trials behind the program, it might seem that further evaluation is unnecessary. However, an evaluation that focuses on specific local priorities (e.g., out-of-home placement, child abuse, birth outcomes) can help make the case for further investment. With increasingly scarce resources, a well-thought-out evaluation, particularly one that includes a cost-benefit analysis, can help states and communities make smart choices with their limited dollars. In addition to demonstrating the effectiveness of prevention and early intervention, cost-benefit analysis "can also be used to translate the impact of early education and care into the language of business and economics."[4]

Over the last five years, RAND Corporation[5] and the Washington State Institute for Public Policy[6] have each performed independent cost-benefit studies on Nurse-Family Partnership; both found that the program had significant benefits to society. In 2008, The Prevention Research Center for the Promotion of Human Development at the Pennsylvania State University released *The Economic Return on PCCD's Investment in Research-Based Programs: A Cost-Benefit Assessment of Delinquency Prevention in Pennsylvania.* The report examines the "return on investment" for seven evidence-based programs operating in Pennsylvania, including Nurse-Family Partnership. Researchers estimated that this strategic use of

resources has returned more than $317 million to the Commonwealth in reduced spending on criminal justice, mental health and substance abuse, welfare and social service programs, and increased tax revenues.[7]

The analysis further estimates that each community that has implemented the Nurse-Family Partnership program in the past decade has seen an economic benefit of approximately $10 million[8]—in addition to the non-financial benefits of reductions in crime and delinquency, substance abuse, and child abuse and neglect. While many programs do not last years, let alone a decade, this evaluation has laid a new and powerful foundation not only for sustained investment in Nurse-Family Partnership but for its continued expansion to every community that could benefit.

Conclusion

In 2003, P/PV published an article in the *Nonprofit & Voluntary Sector Quarterly* urging the field to become "more effective at consolidating its gains. It cannot thrive solely on the celebration of differences, especially not when communities have problems and challenges in common. If credible and effective ways have been found to solve those problems and meet those challenges, then replicating those ways should meet the test of common sense."[9] Encouragingly, in recent years policymakers have become increasingly interested in doing just that. The creation of the White House's Social Innovation Fund is but one example of new policy efforts designed to identify and replicate the most effective social programs.

Despite the surge in interest, however, there has been little discussion about how to ensure that evidence-based programs continue to produce positive results in diverse settings. In *Laying a Solid Foundation*, P/PV notes that even the most well-intentioned programs may be tempted to pursue fast and cheap approaches to replication, such as making detailed program documents widely available to prospective sites and allowing site staff to drive local adaptations. However, without a dedicated team or national program office charged with supporting and monitoring consistent implementation and outcomes, this approach often results in weakened local efforts, undermining the case for continued investment.[10]

P/PV's experience in Pennsylvania demonstrates that successful replication requires a high degree of deliberate support—which includes monthly consultation calls, biannual site visits and structured meetings with administrators, nurses and supervisors—to help sites adhere to the model and simultaneously build a community of practice. Intermediary organizations with site development and capacity-building experience may have an important role to play in helping sites use data to improve program performance and meet national benchmarks as well as to create and maintain a structured statewide network of geographically dispersed implementing agencies. While these services come at a cost—in this case, paid for by the state—they can be critical to the success of large-scale expansion efforts.

Over the years, individuals across the country representing states, local communities, foundations and nonprofits have asked how Pennsylvania can afford to invest in prevention. However, research has shown that the decision to spend limited resources on *evidence-based* prevention programs was well worth the significant cost: Over the past 10 years, it has netted the Commonwealth a savings of approximately

$317 million, with $119 million resulting directly from the $20 million investment in Nurse-Family Partnership. Thus, with the successful impact of these initiatives, one wonders how we can afford *not* to invest in them.

> *"While I was governor, we invested in proven approaches to address crime and delinquency. I am proud of the investment we made in the Nurse-Family Partnership program—an exceptional evidence-based program that helped more than 10,000 at-risk families and saved taxpayers an estimated $119 million over five years. That kind of public investment makes sense, and it is why Nurse-Family Partnership remains a valuable program in Pennsylvania."*
>
> *—Tom Ridge, former governor of Pennsylvania*

We hope the lessons learned from managing this statewide expansion will help others—including policymakers at federal, state and community levels—who seek to replicate evidence-based models and in turn foster solutions to some of our most challenging social problems.

Endnotes

1. Racine, David. "Dissolving Dualities: The Case for Commonsense Replication." *Nonprofit and Voluntary Sector Quarterly*, 32 (2), 307–314.

2. The Nurse-Family Partnership "Model Elements" are presented in Appendix D.

3. Office of Disease Prevention and Health Promotion, US Department of Health and Human Services. Healthy People 2010 was designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. The two overarching goals are: 1) to increase quality and years of healthy life and 2) to eliminate health disparities.

4. Heckman, James, Rob Grunewald and Arthur Reynolds. "The Dollars and Cents of Investing Early: Cost-Benefit Analysis in Early Care and Education." *Zero to Three*, July 2006, 10–17.

5. Karoly, L., M. Kilburn and J. Cannon. 2005. *Early Childhood Interventions: Proven Results, Future Promise.* Santa Monica, CA: RAND Corporation.

6. Aos, Steve, Roxanne Lieb, Jim Mayfield, Marna Miller and Annie Pennucci. 2004. *Benefits and Costs of Prevention and Early Intervention Programs for Youth.* Olympia, WA: Washington State Institute for Public Policy.

7. Jones, Damon, Brian K. Bumbarger, Mark T. Greenberg, Peter Greenwood and Sandee Kyler. 2008. *The Economic Return on Investment in Research-Based Programs: A Cost-Benefit Assessment of Delinquency Prevention in Pennsylvania.* University Park, PA: The Prevention Research Center for the Promotion of Human Development, the Pennsylvania State University.

8. Ibid.

9. Racine, "Dissolving Dualities," 314.

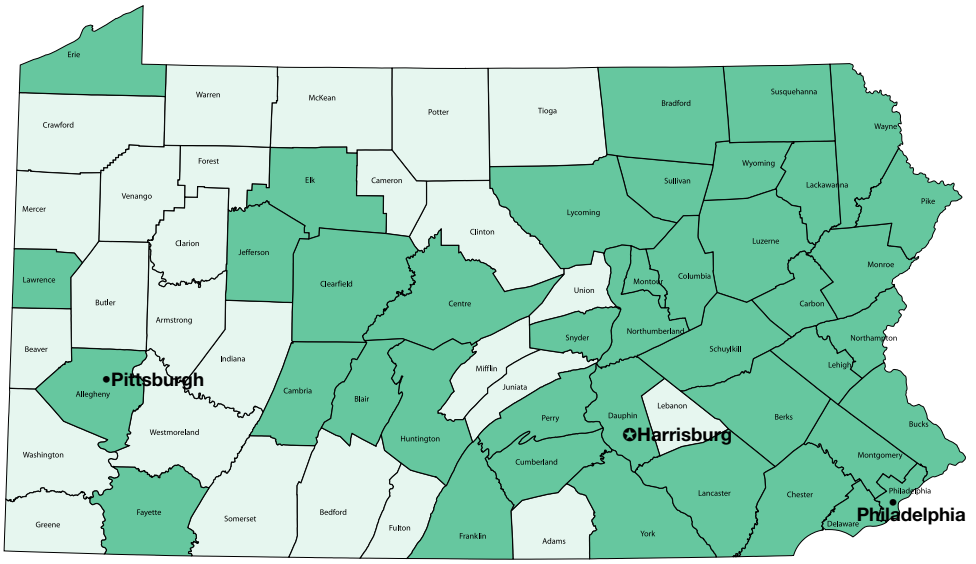
10. Summerville, Geri with Becca Raley. 2009. *Laying a Solid Foundation: Strategies for Effective Program Replication.* Philadelphia, PA: Public/Private Ventures.

Appendices

Appendix A: Nurse-Family Partnership Implementing Agencies and Partners in Pennsylvania

11th Street Family Health Services of Drexel University
Allegheny County Health Department
Behavioral Health Services of Wyoming Valley
Central Susquehanna Community Foundation
Chester County Health Department
Children's Advocacy Center of Lawrence County, Inc.
Columbia Montour Home Health Services/Visiting Nurses Association, Inc.
Community Prevention Partnership of Berks County
The Consortium for Public Education
Crozer-Keystone Women and Children's Health Services
Erie County Department of Health
Family First Health
Fayette County Community Action Agency, Inc.
Home Nursing Agency
Lancaster General Hospital
Lutheran Children and Family Service
Maternal & Family Health Services, Inc.
Montgomery County Health Department
National Nursing Centers Consortium
Peritech Home Health Associates, Inc.
PinnacleHealth Community Health Center
Pocono Medical Center
Sadler Health Center Corporation
Schuylkill County Drug & Alcohol Executive Commission
Susquehanna Home Care and Hospice
Temple University Department of Nursing, CAHP
United Way of Lancaster County
Visiting Nurse Association of St. Luke's
Wyoming County Department of Human Services

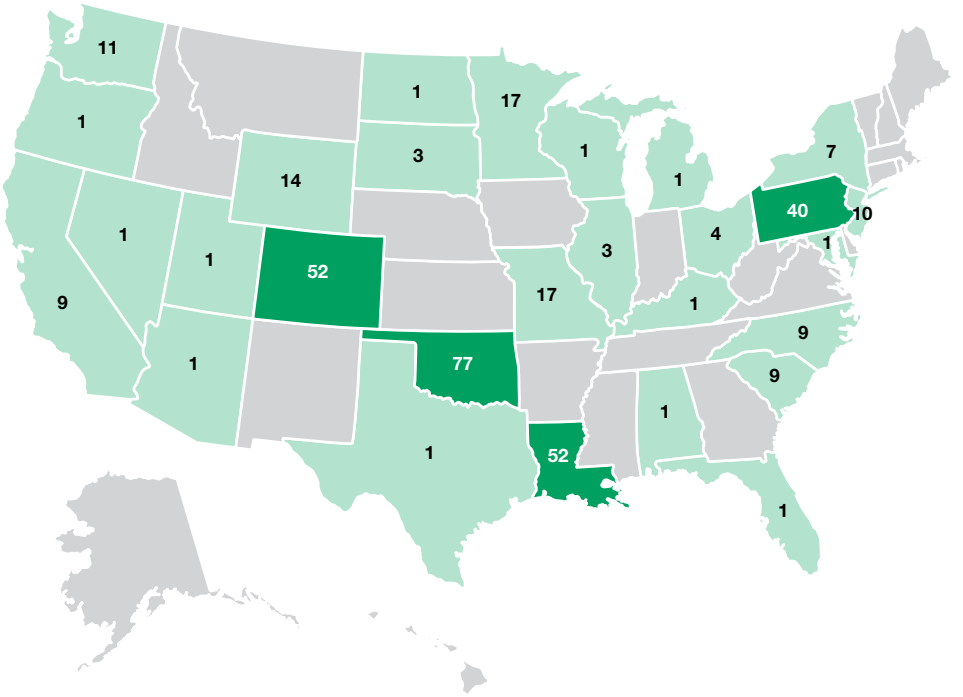
Appendix B:
Counties Served by Nurse-Family Partnership in Pennsylvania



Counties served by Nurse-Family Partnership

Source: Public/Private Ventures, July 2009

Appendix C:
Nurse-Family Partnership National Map



States that Nurse-Family Partnership serves
States where Nurse-Family Partnership is a state initiative

Note: Numbers indicate how many Nurse-Family Partnership programs are operating in each state.

Source: Retrieved July 1, 2009, from www.nursefamilypartnership.org

Appendix D:
Nurse-Family Partnership Model Elements

Before becoming a Nurse-Family Partnership implementing agency, there must be assurance by the agency of its intention to deliver the program with fidelity to the model tested. Such fidelity requires adherence to all of the Nurse-Family Partnership Model Elements.

The 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 reasonably 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.

Clients

Element 1
Client participates voluntarily in the Nurse-Family Partnership program.

Element 2
Client is a first-time mother.

Element 3
Client meets low-income criteria at intake.

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.

Intervention Context

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

Element 6
Client is visited in her home.

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.

Expectations of the Nurses and Supervisors

Element 8

Nurse home visitors and nursing supervisors are registered professional nurses with a minimum of a baccalaureate degree in nursing.

Element 9

Nurse home visitors and nursing supervisors complete core educational sessions required by the NSO and deliver the intervention with fidelity to the model.

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.

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.

Element 12

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

Reflection and Clinical Supervision

Element 13

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

Element 14

Nursing supervisors provide nurse home visitors with 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 1:1 clinical supervision, case conferences, team meetings and field supervision.

Program Monitoring and Use of Data

Element 15

Nurse home visitors and nursing supervisors collect data as specified by the NSO and use these reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality and demonstrate program fidelity.

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.

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 to the program and to promote program quality and sustainability.

Element 18

Adequate support and structure shall be in place to support nurse home visitors and nursing supervisors to implement the program and to ensure that data is accurately entered into the database in a timely manner.

Note: These Model Elements were retrieved from www.nursefamilypartnership.org/content/index.cfm?fuseaction=showContent&contentID=37&navID=37 on August 20, 2009.

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