

Name of Program/Strategy: Nurse-Family Partnership

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1. Overview and description

Nurse-Family Partnership (NFP) is a prenatal and infancy nurse home visitation program that aims to improve the health, well-being, and self-sufficiency of low-income, first-time parents and their children. NFP was founded on concepts of human ecology, self-efficacy, and human attachment. Its program activities are designed to link families with needed health and human services, promote good decision-making about personal development, assist families in making healthy choices during pregnancy and providing proper care to their children, and help women build supportive relationships with families and friends. Nurses follow a detailed, visit-by-visit guide that provides information on tracking dietary intake; reducing cigarette, alcohol, and illegal drug use; identifying symptoms of pregnancy complications and signs of children's illnesses; communicating with health care professionals; promoting parent-child interactions; creating safe households; and considering educational and career options. Program objectives include decreased substance use, improved maternal economic self-sufficiency, fewer subsequent unintended pregnancies, reduced child abuse and neglect, and improved school readiness of the children. Individual programs serve a minimum of 100-200 families and are supported by 4-8 trained registered nurse home visitors (each carrying a caseload of 25 families), a nurse supervisor, and administrative support. Nurse home visits begin early in pregnancy and continue until the child's second birthday. The frequency of home visits changes with the stages of pregnancy and infancy and is adapted to the mother's needs, with a maximum of 13 visits occurring during pregnancy and 47 occurring after the child's birth.

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2. Implementation considerations (if available)

3. Descriptive Information

Areas of Interest	Mental health promotion Substance abuse prevention
Outcomes	1: Maternal prenatal health 2: Childhood injuries and maltreatment 3: Number of subsequent pregnancies and birth intervals 4: Maternal self-sufficiency 5: School readiness
Outcome Categories	Education Employment Tobacco Trauma/injuries Violence
Ages	0-5 (Early childhood) 13-17 (Adolescent) 18-25 (Young adult) 26-55 (Adult)
Genders	Female
Races/Ethnicities	Asian Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	Home
Geographic Locations	Urban Suburban Rural and/or frontier
Implementation History	The Nurse-Family Partnership program has been implemented and evaluated in randomized controlled trials in Elmira, New York (1977), Memphis, Tennessee (1988), and Denver, Colorado (1994). Today, the program is being widely replicated in urban,

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	<p>suburban, and rural communities with diverse racial/ethnic populations.</p> <p>NFP is currently serving approximately 21,000 families a day in more than 380 counties in 31 States across the Nation. The program serves large numbers of families in Colorado, Oklahoma, Louisiana, and Pennsylvania, and expansions and new implementations are underway in several States. Outside the United States, implementation efforts and formative evaluations are underway in Australia, England, Germany, and Holland.</p>
NIH Funding/CER Studies	<p>Partially/fully funded by National Institutes of Health: Yes</p> <p>Evaluated in comparative effectiveness research studies: Yes</p>
Adaptations	No population- or culture-specific adaptations were identified by the applicant
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the applicant.
IOM Prevention Categories	Selective

4. Outcomes

Outcome 1: Maternal prenatal health

Description of Measures	<p>Measures of maternal prenatal health included smoking habits and the rate of pregnancy-induced hypertension (PIH). To assess smoking habits, the number of cigarettes smoked per day was measured at baseline and 32 weeks, and cotinine levels were measured at baseline and 36 weeks. Incidences of PIH, including preeclampsia, eclampsia, and toxemia, were extracted from intra-partum and postpartum medical records.</p>
Key Findings	<p>Smoking habits were measured in two separate study populations. In one study, nurse-visited smokers had greater reductions in cotinine levels from intake to the end of pregnancy than smokers in the control group, who did not receive nurse home visits (259.00 vs. 12.32 ng/mL; $p < .01$). In a second study, nurse-visited smokers reported greater reductions in the number of cigarettes smoked during the course of pregnancy than smokers in the control group, who did not receive nurse home visits. This reduction led to a 4-cigarette-per-day difference at the end of pregnancy ($p < .001$).</p> <p>In a third study, nurse-visited women had lower rates of PIH than</p>

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	women in the control group, who did not receive nurse home visits (13% vs. 20%; $p < .01$). Among women with PIH, nurse-visited women had a mean arterial blood pressure during labor that was 4.6 points lower than that of control group women ($p < .01$).
Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental
Quality of Research Rating	3.5 (0.0-4.0 scale)

Outcome 2: Childhood injuries and maltreatment

Description of Measures	<p>Several measures of childhood injuries and maltreatment were used over a period from birth to 15 years. Measures included:</p> <ul style="list-style-type: none"> • Incidence of injuries and harmful ingestions, extracted from physician records • Number of emergency room visits, extracted from hospital records • Substantiated reports of child abuse and neglect involving either the mother or the first child, taken from State Child Protective Service records • Maternal beliefs associated with child abuse, assessed using the Adult-Adolescent Parenting Inventory • Mother's avoidance of restriction and punishment, assessed using the Caldwell Home Observation Checklist • Child's exposure to hazards in the home, collected during home visit observations
Key Findings	<p>Two studies assessed the incidence of injuries and harmful ingestions as reported in physician records. One study found that during the first 2 years of life, children of nurse-visited mothers had fewer total health care encounters (i.e., outpatient visits, emergency room visits, hospitalizations) in which injuries and ingestions were detected compared with children in the control group, whose mothers did not receive nurse home visits ($p < .05$). This difference was accounted for primarily by a reduction in outpatient visits. A second study showed that between 25 and 50 months of life, children of nurse-visited mothers had 40% fewer notations of injuries and ingestions in physician records compared with children in the control group ($p < .05$).</p> <p>One of these studies reported that children of nurse-visited</p>

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	<p>mothers had fewer total emergency room visits during the first year of life ($p < .05$), the second year of life ($p < .01$), and between 25 and 50 months of life ($p < .05$) compared with children whose mothers did not receive nurse home visits. During the second year of life, the children of nurse-visited mothers presented to the emergency room with fewer accidents and poisonings compared with their control group counterparts ($p < .05$). This same study also examined reports of child abuse and neglect. Compared with their control group counterparts, mothers who received nurse home visits during pregnancy and the first 2 years of the child's life were identified as perpetrators of child abuse and neglect in fewer verified reports over the 15-year period ($p < .001$). The effect of the nurse visitation program was especially robust for the 4- to 15-year period after the birth of the child.</p> <p>The same two studies assessed mothers' beliefs associated with child abuse and avoidance of punishment and children's exposure to hazards in the home. One study found that by the 24th month of the child's life, compared with their control group counterparts, nurse-visited mothers reported fewer beliefs about child-rearing that are associated with child abuse and neglect, including a lack of empathy, belief in physical punishment, and unrealistic expectations for infants ($p < .01$). Similar findings were reported in the second study for a subset of mothers identified as unmarried and from a low socioeconomic status (SES) household.</p> <p>Specifically, among poor, unmarried women, those who received home visits less frequently punished and restricted their children at 10 ($p < .01$) and 22 months ($p < .05$) of age compared with mothers who did not receive nurse home visits. In addition, follow-up observations conducted at 34 months ($p < .05$) and 46 months ($p < .01$) showed that the homes of all nurse-visited families had fewer child hazards (e.g., flaking paint, sharp objects, danger of burns) compared with the homes of control families.</p>
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Experimental
Quality of Research Rating	3.5 (0.0-4.0 scale)

Outcome 3: Number of subsequent pregnancies and birth intervals

Description of Measures	The number of subsequent pregnancies and the number of months between births were reported by mothers at intervals across a 15-year period beginning with the birth of the first child.
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<p>Key Findings</p>	<p>In three studies, the number of subsequent pregnancies was lower and the interval between the birth of the first child and second child was greater for mothers receiving nurse home visits compared with mothers in a control group, who did not receive nurse home visits.</p> <p>One study showed that by 24 months postpartum, nurse-visited mothers reported having fewer second pregnancies than did mothers in the control group (36% vs. 47%; $p < .01$). The difference in rates of second pregnancies remained significant at 54 months ($p < .05$) and 72 months ($p = .01$) postpartum. The finding at 72 months was associated with a small effect size (Cohen's $d = 0.22$). Compared with their control group counterparts, nurse-visited mothers also reported longer intervals between the births of their first and second child at both 54 months ($p < .01$) and 72 months ($p = .01$) postpartum. The effect size for the 72-month finding was small (Cohen's $d = 0.26$).</p> <p>A second study reported similar findings at 24 and 48 months postpartum. Compared with mothers in the control group, mothers who received nurse home visits were less likely to have had a subsequent pregnancy 24 months after the delivery of their first child (41% vs. 29%; $p < .05$). By 48 months postpartum, they also reported greater intervals between the births of their first and second child when a second birth occurred (20.39 vs. 24.51 months; $p = .01$). The effect size for this finding was small (Cohen's $d = 0.32$).</p> <p>A third study that conducted follow-up interviews with mothers 15 years after the birth of their first child reported the same results for a subsample identified as unmarried and from low SES households. Specifically, mothers receiving nurse home visits reported having fewer subsequent pregnancies compared with control group mothers (1.5 vs. 2.2 pregnancies; $p < .05$) and a greater interval between first and second births (64.8 vs. 37.3 months; $p = .001$).</p>
<p>Studies Measuring Outcome</p>	<p>Study 1, Study 2, Study 3</p>
<p>Study Designs</p>	<p>Experimental</p>
<p>Quality of Research Rating</p>	<p>3.3 (0.0-4.0 scale)</p>

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Outcome 4: Maternal self-sufficiency

<p>Description of Measures</p>	<p>Measures of maternal self-sufficiency included the number of months receiving Aid to Families With Dependent Children (AFDC), the number of months receiving food stamps, and the number of months participating in the workforce. Maternal self-sufficiency was measured at intervals across a 15-year period beginning with the birth of the first child. Data were obtained from State administrative records and self-reports.</p>
<p>Key Findings</p>	<p>One study found that mothers receiving nurse home visits received fewer months of AFDC and food stamps, based on State administrative records, compared with mothers in the control group, who did not receive nurse home visits. Specifically, by 54 months postpartum, nurse-visited mothers had received fewer months of AFDC assistance (32.55 vs. 36.19; $p = .01$) and fewer months of food stamps (41.57 vs. 45.04; $p < .01$) than their control group counterparts. Similarly, at 72 months postpartum, nurse-visited mothers reported receiving AFDC assistance ($p = .01$) and food stamps ($p < .01$) for significantly fewer months between 54 and 72 months postpartum compared with control group mothers. These differences were associated with small effect sizes (Cohen's $d = 0.22$ for AFDC and 0.24 for food stamps).</p> <p>In a second study, mothers were asked to estimate the number of months they received AFDC or food stamps from the birth of their first child to the child's 15th birthday. Significant differences were found for the subset of mothers identified as unmarried and from a low SES household. Specifically, among this group, nurse-visited mothers reported receiving AFDC ($p < .01$) and food stamps ($p = .001$) fewer months than did mothers in the control group, who did not receive nurse home visits. Mothers in the intervention group reported receiving AFDC and food stamps an average of 60.4 and 46.7 months, respectively, while mothers in the control group reported receiving these subsidies an average of 90.3 and 83.5 months, respectively.</p> <p>A third study measured the number of months mothers participated in the workforce during the first 12 months and the second 12 months postpartum. Nurse-visited mothers reported being employed for longer periods of time the second year after the birth of their first child compared with mothers who did not receive nurse home visits (6.87 vs. 5.73 months; $p < .05$).</p>

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Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental
Quality of Research Rating	3.2 (0.0-4.0 scale)

Outcome 5: School readiness

Description of Measures	<p>School readiness was measured through standardized cognitive and language assessment batteries.</p> <p>Assessments included the Mental Development Index (MDI), Zimmerman's Preschool Language Scale, and the Kaufman Assessment Battery for Children (KABC), the Peabody Picture Vocabulary Test (PPVT- III), and a series of cognitive attention and inhibitory control tests analyzed as a single composite index of executive functioning. Children were assessed at approximately 2, 4, and 6 years of age.</p>
Key Findings	<p>Two studies showed that children of nurse-visited mothers performed better on mental processing, vocabulary, arithmetic, language, and executive functioning tasks than children of mothers in the control group, who did not receive home visits. Differences were greater in (or in some cases, limited to) children born to mothers with low psychological resources, meaning those who scored lower on tests measuring the mother's intelligence, mental health, and sense of mastery at baseline.</p> <p>One study measured children's language development at 21 months and mental development at 24 months. Among children born to women with low psychological resources, the children of nurse- visited mothers had better language skills ($p = .02$) and mental development ($p = .05$) relative to their control group counterparts. Follow-up assessments conducted at 48 months showed that, within this sample, children in the intervention group had greater executive functioning relative to control group children ($p < .01$), a difference associated with a small effect size (Cohen's $d = 0.47$). No differences were found between children in the intervention and control groups when the whole study population was analyzed.</p> <p>In the second study, children of nurse-visited mothers had higher scores on tests of intellectual functioning ($p < .05$) and receptive vocabulary ($p < .05$) compared with children of mothers who did not receive nurse home visits. These differences translated into very small effect sizes (Cohen's $d = 0.18$ and 0.17, respectively).</p>

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	Separate analyses of child outcomes conducted for the sample of children born to mothers with low levels of psychological resources indicated a similar difference between intervention children and their control group counterparts with respect to intellectual functioning ($p < .05$), a difference associated with a small effect size (Cohen's $d = 0.25$). In addition, within this sample, children of nurse-visited mothers had higher arithmetic achievement scores relative to children in the control group ($p < .05$). The effect size for this finding was small (Cohen's $d = 0.25$).
Studies Measuring Outcome	Study 2, Study 3
Study Designs	Experimental
Quality of Research Rating	3.4 (0.0-4.0 scale)

5. Cost effectiveness report (Washington State Institute of Public Policy – if available)

<p>Benefits minus cost, per participant</p> <p>Return on Investment: Evidence-Based Options to Improve Statewide Outcomes - July 2011 Update. Washington State Institute for Public Policy, http://www.wsipp.wa.gov/rptfiles/11-07-1201.pdf.</p> <p>Costs and Benefits of Prevention and Early Intervention Programs for At-Risk Youth: Interim Report – 2003. Washington State Institute for Public Policy, http://www.wsipp.wa.gov/pub.asp?docid=03-12-3901.</p>	<p>According to the WSIPP study, this program strategy returns</p> <p><u>\$20,905</u></p> <p>in savings that would otherwise be associated with education, substance abuse, teen pregnancy, child abuse and neglect, or criminal justice system.</p>
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6. Washington State results (from Performance Based Prevention System (PBPS) – if available)

7. Where is this program/strategy being used (if available)?

Washington Counties	Oregon Counties

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8. Study Populations

The studies reviewed for this intervention included the following populations, as reported by the study authors.

Study	Age	Gender	Race/Ethnicity
Study 1	0-5 (Early childhood) 13-17 (Adolescent) 18-25 (Young adult) 26-55 (Adult)	100% Female	88.5% White 11.3% Black or African American 0.3% Asian
Study 2	0-5 (Early childhood) 13-17 (Adolescent) 18-25 (Young adult) 26-55 (Adult)	100% Female	92% Black or African American 8% Race/ethnicity unspecified
Study 3	0-5 (Early childhood) 13-17 (Adolescent) 18-25 (Young adult) 26-55 (Adult)	100% Female	45% Hispanic or Latino 35.6% White 16.3% Black or African American 3% Race/ethnicity unspecified

9. Quality of Research

The documents below were reviewed for Quality of Research. Other materials may be available. For more information, contact the developer(s).

Study 1

Olds, D. L., Eckenrode, J., Henderson, C. R., Jr., Kitzman, H., Powers, J., Cole, R., et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association*, 278(8), 637-643.

Olds, D. L., Henderson, C. R., Jr., Chamberlin, R., & Tatelbaum, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*, 78(1), 65-78.

Olds, D. L., Henderson, C. R., Jr., & Kitzman, H. (1994). Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental care giving and child health at 25 to 50 months of life? *Pediatrics*, 93(1), 89-98.

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Olds, D. L., Henderson, C. R., Jr., Tatelbaum, R., & Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics*, 77(1), 16-28.

Study 2

Kitzman, H., Olds, D. L., Henderson, C. R., Jr., Hanks, C., Cole, R., Tatelbaum, R., et al. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: A randomized controlled trial. *Journal of the American Medical Association*, 278(8), 644-652.

Kitzman, H., Olds, D. L., Sidora, K., Henderson, C. R., Jr., Hanks, C., Cole, R., et al. (2000). Enduring effects of nurse home visitation on maternal life course: A 3-year follow-up of a randomized trial. *Journal of the American Medical Association*, 283(15), 1983-1989.

Olds, D. L., Kitman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D. W., et al. (2004). Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. *Pediatrics*, 114(6), 1550-1559.

Study 3

Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., Jr., et al. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics*, 110(3), 486-496.

Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., et al. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. *Pediatrics*, 114(6), 1560-1568.

Supplementary Materials

Olds, D. L., Hill, P. L., O'Brien, R., Racine, D., & Moritz, P. (2003). Taking preventive intervention to scale: The Nurse-Family Partnership. *Cognitive and Behavioral Practice*, 10, 278-290.

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

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Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Maternal prenatal health	3.3	3.8	3.3	3.5	3.0	3.8	3.5
2: Childhood injuries and maltreatment	3.7	3.2	3.3	3.8	3.3	3.8	3.5
3: Number of subsequent pregnancies and birth intervals	3.2	3.0	3.3	3.2	3.5	3.7	3.3
4: Maternal self-sufficiency	3.0	3.2	3.3	3.2	3.0	3.7	3.2
5: School readiness	3.5	3.5	3.3	3.5	3.0	3.5	3.4

Study Strengths

The use of biochemical markers, record reviews, and observational protocols to supplement or validate self-report data increases confidence in the study findings. The KABC and PPVT-III have been shown to have high internal consistency, high test-retest reliability, and acceptable concurrent and construct validity. Zimmerman's Preschool Language Scale has been shown by its authors to have acceptable to high reliability and construct validity. Nurse home visitors were trained by program staff to use visit-by-visit guidelines, and detailed recordkeeping and regular case reviews were used to measure adherence to the program protocols. The tailored approach used to match the specific needs of the target population to the protocols encouraged adherence to these protocols while allowing the nurses to respond to real-world situations. Attrition rates across studies were generally acceptable; in some cases, they were exceptionally low. Randomization of participants to study conditions and the use of multiple measures to assess key outcomes increase confidence in the findings. In some cases, deviations from the initial random assignment strategies were addressed in several ways that allow for causal inferences between the intervention and outcomes reported. Appropriate statistical analyses were conducted.

Study Weaknesses

Variability in services delivered and limited information on other services participants may have used outside the program raise some concerns about potential confounding variables.

10. Readiness for Dissemination

The documents below were reviewed for Readiness for Dissemination. Other materials may be available. For more information, contact the developer(s).

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Dissemination Materials

- Flory, M. (2007). Nurse-Family Partnership implementation logic model. Denver, CO: Nurse-Family Partnership.
- Nurse-Family Partnership. (2006). Data collection, reports, and the clinical information system. Denver, CO.
- Nurse-Family Partnership. (2006). Example agency evaluation report 3: Program initiation (program initiation date) through April 30, 2007. Denver, CO.
- Nurse-Family Partnership. (2006). Instructions for use of the Nurse-Family Partnership Web CIS CD-ROM tutorial and the online exercise. Denver, CO.
- Nurse-Family Partnership. (2006). Quality improvement program. Denver, CO.
- Nurse-Family Partnership. (2006). Sample site budget: 100 families, 2007-2008-2009. Denver, CO.
- Nurse-Family Partnership. (2007). CIS data collection manual. Denver, CO.
- Nurse-Family Partnership. (2007). Implementation application. Denver, CO.
- Nurse-Family Partnership. (2007). Key events check list. Denver, CO.
- Nurse-Family Partnership. (2007). Nurse-Family Partnership application review process. Denver, CO.
- Nurse-Family Partnership. (2007). Nurse-Family Partnership data summary table example. Denver, CO.
- Nurse-Family Partnership. (2007). Nursing practice unit 1. Denver, CO.
- Nurse-Family Partnership. (2007). Nursing practice unit 2. Denver, CO.
- Nurse-Family Partnership. (2007). Nursing practice unit 2: Supervisor session. Denver, CO.
- Nurse-Family Partnership. (2007). Nursing practice unit 3. Denver, CO.
- Nurse-Family Partnership. (2007). Nursing practice unit 3: Supervisor session. Denver, CO.
- Nurse-Family Partnership. (2008). Nurse-Family Partnership implementing agency orientation packet: Winter/spring 2008. Denver, CO.
- Nurse-Family Partnership. (n.d.). Communications packet. Denver, CO.
- Nurse-Family Partnership. (n.d.). Guidelines for interpretation and use of Web-based operational reports. Denver, CO.
- Nurse-Family Partnership. (n.d.). Kim's case conference: Pregnancy [VHS]. Denver, CO.
- Nurse-Family Partnership. (n.d.). Making the decision to expand Nurse-Family Partnership. Denver, CO.
- Nurse-Family Partnership. (n.d.). NFP services: From inquiry to excellence. Denver, CO.
- Nurse-Family Partnership. (n.d.). Nurse-Family Partnership CIS tutorial [CD-ROM]. Denver, CO.

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Nurse-Family Partnership. (n.d.). Nurse-Family Partnership site planning guide: Module 1, overview. Denver, CO.

Nurse-Family Partnership. (n.d.). Nurse-Family Partnership site planning guide: Module 2, essential background information. Denver, CO.

Nurse-Family Partnership. (n.d.). Nurse-Family Partnership site planning guide: Module 3, guidance for communities. Denver, CO.

Nurse-Family Partnership. (n.d.). Nurse-Family Partnership site planning guide: Module 4, guidance for States. Denver, CO.

Nurse-Family Partnership. (n.d.). Program implementation evaluation project. Denver, CO.

O'Brien, R. (n.d.). Nurse-Family Partnership logic model. Denver, CO: Nurse-Family Partnership. Program Web site, <http://www.nursefamilypartnership.org>

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, [see Readiness for Dissemination](#).

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.5	4.0	3.5	3.7

Dissemination Strengths

Program materials are comprehensive and guide every step of implementation. A complete training program uses comprehensive materials to cover a logically sequenced and specifically timed series of self-study, face-to-face instruction, and online distance education for both nurse clinicians and their supervisors. Thorough support materials are provided for supervisors to guide each facet of the supervisory process. This program's data collection system, reporting forms, and other quality assurance tools set a high standard for the field.

Dissemination Weaknesses

Some implementation and quality assurance materials are difficult to navigate.

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11. Costs

The information below was provided by the developer and may have changed since the time of review. For detailed information on implementation costs (e.g., staffing, space, equipment, materials shipping and handling), contact the developer.

Item Description	Cost	Required by Program Developer
Nurse education materials and home visit guidelines	\$502 each	Yes
Nurse home visitor training	\$3,950	Yes
Nurse supervisor training	\$4,663	Yes
First-year program development start-up support	\$4,070 per site	Yes
Annual ongoing education beginning in second year of implementation	\$1,526 per nursing team	Yes
Annual quality improvement and technical assistance services	\$8,816 per nursing team	Yes
Web-based data system	\$1,424	Yes
Nursing Child Assessment Satellite Training (University of Washington), Partners In Parenting Education, Ages and Stages Questionnaire, and dyadic measurement tools	\$6,826	Yes

Additional Information

NFP costs approximately \$4,500 per family per year with a range of \$2,914 to \$6,463 per family per year.

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12. Contacts

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Learn More by Visiting: <http://www.nursefamilypartnership.org>