

Charting Nursing's Future

REPORTS THAT CAN INFORM POLICY AND PRACTICE



June 2017 • ISSUE NO. 31

- ▶ Before Birth to Age 3: The Time to Intervene..... 2
- ▶ Improving Birth Outcomes..... 3
- ▶ Changing the Trend of Late Prematurity..... 4
- ▶ Supporting Breastfeeding, Changing Lives..... 4
- ▶ Keeping Young Children Healthy and Safe..... 6
- ▶ Expanding Nurse Home Visiting..... 7
- ▶ Bringing Proven Programs to Scale..... 8

“A vital and productive society with a prosperous and sustainable future is built on a foundation of healthy child development. Health in the earliest years—actually beginning with the future mother’s health before she becomes pregnant—lays the groundwork for a lifetime of well-being.”

—Center on the Developing Child at Harvard University, *The Foundations of Lifelong Health Are Built in Early Childhood*, 2010.

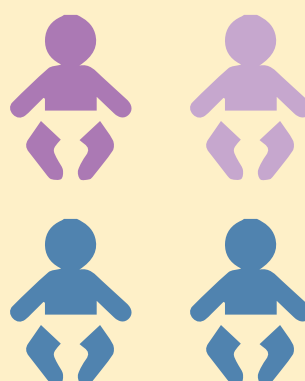
Nursing Interventions at the Start of Life: Laying the Foundation for Lasting Health and Well-Being

Today it seems obvious, but only in recent years have scientists fully understood just how critical the period from conception through age 3 is for preventing illness and promoting health and well-being. During this time, babies’ and toddlers’ brains and bodies are growing rapidly. They are tremendously vulnerable—and receptive—to physical, social, and emotional influences.

Many U.S. newborns, infants, and toddlers grow up in nurturing environments with families who have the resources needed for the best start in life. But many do not. Twenty-three percent of newborns, infants, and toddlers live in poverty—a powerful predictor of health and well-being into adulthood. Differences at the earliest stages of life—exposure to cigarette smoke *in utero* or the opportunity to be born into a stable, safe home—can add up to substantive differences in lifelong health, which in turn affects economic productivity. As a society, we have a choice: Invest in building a Culture of Health that enables all children to thrive, or risk a future in which social inequality and illness threaten to sap the nation’s vitality.

This brief highlights innovative nurse-designed and nurse-led initiatives that have been demonstrated to bring forth children’s lifelong potential by intervening during their most formative years. Because nurses work where families live, learn, work, play, and worship, they are in an ideal position to help babies, young children, and their families thrive.

Figure 1. Infants and Toddlers by Family Income, 2015



Key

- 23%** Poor
- 23%** Low income
- 55%** Above low income

Percentages do not total 100 due to rounding.

Nearly one in four infants and toddlers live in families whose incomes fall below the federal poverty threshold (\$24,036 for a family of four). Children living in poverty are exposed to ongoing stress associated with lacking life’s basic necessities and are more likely to suffer from chronic diseases and exposure to environmental pollutants. An equal number of children are considered low income, with their families living at less than twice the federal poverty threshold.

Data Source: National Center on Child Poverty

Before Birth to Age 3: The Time to Intervene

Childhood in the United States has changed a great deal in the past 50 years. Highly effective interventions, such as vaccines, antibiotics, and neonatal intensive care, have reduced death and disability from acute infectious diseases and congenital conditions.

Today's children face **different threats**. From 1960 to 2010, the portion of children with a chronic health condition severe enough to interfere with daily activities grew from 1.8 to 8 percent, a more than four-fold increase, with the rise coming mainly from asthma, obesity, mental health conditions, and neurodevelopmental disorders such as ADHD, autism, and learning disabilities. Scientists believe the increased prevalence of these health conditions has come from changes in the gene pool of reproductive-age adolescents and adults, the survival of children who would have died in an earlier era, and changes in children's social environments during the early years of life. As well, the growing numbers reflect advances in screening and greater public awareness.

In the same 50-year time span, scientists have learned a tremendous amount about brain development. The old idea that genes are "set in stone" or that they alone determine health outcomes has been disproven; instead, genes appear to turn on or off in response to positive or negative

experiences. Armed with this knowledge, scientists now assert what nursing pioneers have long suspected: that what happens in the home and the community before birth and during the first few years of life has a profound and enduring impact on an individual's immediate and long-term health.

- Prenatal exposure to **cigarette smoke**, **environmental chemicals**, or **alcohol** impairs fetal brain circuitry.
- **Prematurity**—which can be the result of health problems, a lack of preventive care, or elective early-term births—can result in higher medical costs and complications for mother and baby.
- Sustained exposure to **adverse childhood experiences (ACEs)**—such as physical, emotional, and sexual abuse; or living in a household challenged by mental illness, violence, substance abuse, divorce, or incarceration—can put young children's health at risk. ACEs activate a stress response that is linked to childhood obesity and learning and behavioral problems. Adults exposed to ACEs as children are more likely to suffer from chronic health problems and to engage in risky health behaviors such as violence, smoking, substance abuse, and sexual risk-taking.

University of Rochester Nursing and Pediatrics Professor Harriet Kitzman, RN, PhD, FAAN, saw first hand the impact of poverty, unsafe and crowded housing, and stress. As an obstetric and pediatric nurse, she visited low-income pregnant women and new mothers in their homes in Rochester, New York, to look for ways to address the social determinants of health.

"There is a lot we can't control and don't know, but we have found ways to intervene at the earliest possible moment for children born into adversity," says Kitzman, a major contributor to the development of the Nurse-Family Partnership, the nation's most robust nurse home visiting program for mothers and babies (see p. 7). "Nurses bring an in-depth, integrated, comprehensive approach to helping women and their babies, increasing the potential for both to live healthier lives."



Photo: Barry Gutierrez Photography

Nurse-designed prenatal interventions such as CenteringPregnancy, above, effectively reduce the risk of prematurity, leading to healthier newborns.

The Value of Nursing Interventions

In the following pages, we showcase nurse-led and nurse-designed programs that influence health and well-being at the start of life, with an emphasis on boundary-breaking efforts outside traditional settings. Rooted in nurses' long history of looking at families' lives within their social contexts, these initiatives:

- give mothers access to the latest scientific evidence about pregnancy,
- facilitate peer support,
- model successful parenting,
- facilitate health in early childhood, and
- strengthen the bonds between parents and children.

In some cases, these programs cost the same as conventional care. In others, they call for additional funds. Either way, they demonstrate better outcomes and significant savings over the long term—by offsetting health, educational, or juvenile justice costs incurred in later years. States, private foundations, Affordable Care Act set-asides, and federal pilot programs have helped expand these programs and could extend their impact.



Photo: Barry Gutierrez Photography

Nurse home visiting gives first-time, low-income mothers emotional support and the latest evidence-based information on pregnancy and parenting.

Improving Birth Outcomes

One in 10 babies is born prematurely in the United States—and the rate is far higher for mothers who are black, teens, or more than 35 years old—with grave health and financial consequences to society. The earlier a baby is born before 39 weeks, the greater the risk of death or long-term health issues such as cerebral palsy, developmental delays, and vision and hearing problems. Additionally, premature infants incur 10 times the medical expenses of healthy full-term infants in their first year of life, according to a March of Dimes estimate.

Not all prematurity can be prevented, and its causes are complex. Prenatal care, delivered through a series of scheduled visits to a provider's office, is widely used to reduce prematurity. Although approximately two-

thirds of minority women access prenatal care, their rate of preterm birth is persistently higher than that of their white peers. Because typical prenatal care cannot include in-depth counseling about nutrition, quitting smoking,

exercise, breastfeeding, and reducing stress, some experts have wondered whether augmenting traditional prenatal care with health promotion and peer support could more effectively reduce prematurity.

Nurse-Midwife Pioneers New Model of Prenatal Care



Photo: Barry Gutierrez Photography

In CenteringPregnancy, mothers-to-be and their partners meet with their health care provider in a group setting for 10 two-hour sessions. Individual health assessments are conducted in a private area in the group space.

The idea for CenteringPregnancy was born in a waiting room 50 years ago. While chatting with expectant women, certified nurse-midwife Sharon Schindler Rising, MSN, FACNM, noted that the women opened up and supported each other outside the formal exam room.

For the next two decades while practicing midwifery, Rising questioned what she called the “drudgery and delays” of the individual patient visit. Clinicians answered the same questions day after day, with patient-clinician interaction lasting a scant 15 minutes.

In 1994, Rising made the decision to meld waiting room wisdom with clinical visits, developing what is now a highly respected model of group prenatal care. In the groups, participants discuss pregnancy-related topics such as nutrition, sleep, discomfort, and oral health. Two co-facilitators, at least one of whom is a clinician, avoid providing definitive “answers” so as to let each participant share her point of view.

“Much of what happens in pregnancy remains mysterious, so it becomes a dynamic discussion,” Rising says. “The women are testing out their own wisdom and sharing in the wisdom of others.”

Research shows that CenteringPregnancy reduces the risk of preterm birth by between 33 and 47 percent, reduces gestational diabetes, and increases birth weights and the use of breastfeeding. Rising cannot say for sure why CenteringPregnancy lessens prematurity, but believes participation keeps women focused on their pregnancies, supports behavior change, and eases stress. “Women call each other on their behaviors,” Rising says. “They think of each of these babies as their babies, and want each of their babies to be healthy.”

CenteringPregnancy is being used across the United States in more than 470 clinical sites, 85 percent of which serve low-income women. The model is being tested through the U.S. Department of Health and Human Services Strong Start for

Mothers and Newborns Initiative. The hope is that CenteringPregnancy will continue to demonstrate better health outcomes and a reduction in costs for Medicaid and Children's Health Insurance Program beneficiaries through the child's first birthday, encouraging its use in a greater number of sites.

From 2013 through 2015, the South Carolina Department of Health and Human Services invested \$1.9 million to implement CenteringPregnancy for 1,800 Medicaid recipients in 10 physician practices across the state. As part of the South Carolina Birth Outcomes Initiative (see p. 4), CenteringPregnancy group prenatal visits were billed the same as traditional prenatal visits, but providers also received an additional payment per visit. The state estimates that it averted millions of dollars in expenses for the targeted mothers by reducing the likelihood of preterm birth by 36 percent and the risk of a stay in the neonatal intensive care unit (NICU) by 28 percent.

Fast Facts: Prematurity

9.6%	Babies born prematurely
13.4%	Black babies born prematurely
\$49,000	Average medical costs in the first year of life of a premature baby (2007 dollars)
10X	The cost of medical care for premature versus healthy full-term babies
Nearly 1/2	Share of U.S. births paid for by Medicaid
Up to 47%	The amount CenteringPregnancy reduces the risk of prematurity

Changing the Trend of Late Prematurity

Whether done for scheduling convenience or to alleviate a pregnant woman's discomfort, until recently, births were induced early (between 37 weeks and 38 weeks and six days of gestation) upon request. No more.

Early-term babies run a greater risk of having respiratory problems and needing a stay in the NICU and incur, on average, an estimated **17.4 percent more** in medical costs than babies born at full term. In infancy, babies born between 37 and 39 weeks have an **elevated risk** for respiratory distress, sepsis, feeding problems, and death.

The U.S. rate of early elective deliveries (EEDs) has fallen from 17 percent of live births in 2010 to 1.9 percent in 2016. Credit for the decline goes to state and federal public awareness campaigns, hospital quality-improvement efforts, public reporting, and—in some states—a refusal by Medicaid and private insurers to pay for such deliveries altogether.

Until recently, 37 weeks marked the earliest point at which births were defined as full-term, but that definition was **changed** in 2013 to denote births that occur between 39 weeks and 40 weeks and six days.

South Carolina Nurse-Leader Convenes Birth Outcomes Initiative

A South Carolina initiative suggests how working with clinicians and hospitals can dramatically reduce the incidence of EEDs. The **South Carolina Birth Outcomes Initiative** (SCBOI) began in 2011 to make South Carolina a leading state in maternal/infant

health. “We wanted to have an impact not just on cost savings but also on improving health outcomes,” says SCBOI Director Melanie “BZ” Geise, BSN, RN.

Everyone knew the evidence about EEDs. But Geise, a former ICU nurse, pharmaceutical sales representative, and deputy director of health services at the South Carolina Department of Health and Human Services, believed that on-the-ground behavior change would happen only if trusted and influential voices spoke for it. She recruited the American College of Obstetrics and Gynecology, the March of Dimes, BlueCross BlueShield of South Carolina, the South Carolina Hospital Association, and the state's public health department to help her steer the initiative. “You have to have the right people involved from the get-go,” she says. “Otherwise, people will find every reason in the world not to cooperate and collaborate.”

In 2011, South Carolina's EED rate was 9.6 percent. Thanks to SCBOI's outreach and education campaign aimed at physicians and hospitals, the state's EED rate has fallen to 2.2 percent with 75 percent of their 44 birthing hospitals performing no unnecessary EEDs.

In 2013, South Carolina became the **first state in the nation** in which Medicaid and the

Fast Facts: Prematurity Trends

17.4% more The difference in medical costs for early-term babies versus full-term babies

From 17% to 1.9% The decline in the national rate of early elective deliveries between 2010 and 2016

state's largest insurer—together providing 85 percent of all payments for births—ceased paying for EEDs. “There was no pushback at all because everyone involved had been working with us on this for 18 months,” Geise says.

As a result of fewer unnecessary early deliveries and averted C-sections, birth inductions, and NICU stays, South Carolina expects to save \$11.25 million over five years.

In late 2016, the SCBOI celebrated five consecutive years of monthly planning meetings, with more than 100 people in attendance. The initiative's focus extends beyond EEDs. SCBOI is also implementing evidence-based programs and policies that aim to reduce prematurity; support breastfeeding, vaginal birth, and optimal birth spacing; treat newborns exposed to opiates while in the womb; and help substance-addicted pregnant mothers get treatment.

Supporting Breastfeeding, Changing Lives

Human milk is considered by many to be one of the most powerful preventive treatments in existence, and is believed to protect against risks that include respiratory illness, ear infections, diabetes, and sudden infant death syndrome. Yet fewer than **one in five U.S. mothers** breastfeeds exclusively for six months.

If 90 percent of mothers met the American Academy of Pediatrics' recommendation that infants be exclusively breastfed until six months old, economists estimate that the resulting health, lack of hospitalization, and averted deaths would save **billions of dollars**.

Breastfeeding rates, although high during the initial days after birth, trend down quickly. Pain, inconvenience, family dynamics, workplace demands, embarrassment about breastfeeding in public, and a host of other

factors make it challenging for mothers to continue after leaving the hospital.

While breastfeeding is believed to be good for all infants, for the one in 66 babies born at fewer than 3.3 pounds, being fed their mother's own milk is a matter of life or death.

Within the first year of life, one in four very premature infants dies. By simply ingesting their mother's milk—even before they are able to latch and suckle—these babies are more likely to survive.



“Nurses need to give moms appropriate resource-based interventions and support, so that if they run into a challenge, they know how to get past that challenge. We are not at a place in the U.S. where breastfeeding is the cultural norm.”

—Diane L. Spatz, PhD, RN-BC, FAAN, Professor of Perinatal Nursing, University of Pennsylvania School of Nursing; Director, the Lactation Program, The Children's Hospital of Philadelphia

Supporting Breastfeeding, Changing Lives *continued*

Florida Nurses Promote Breastfeeding for Vulnerable Newborns

In 2011, nurses at Tampa General Hospital (TGH), with an 82-bed NICU, set out to improve breastfeeding rates for very-low-birth-weight (VLBW) newborns in their care using [Ten Steps for Promoting and Protecting Breastfeeding for Vulnerable Infants](#), a program developed by Diane Spatz (see p. 4). Initially, 40 percent of white and 13 percent of black VLBW infants, infants born weighing less than 3.3 lbs., were receiving their mother's milk at the time of discharge.

Under the leadership of University of South Florida College of Nursing Assistant Professor Ivonne Hernandez, PhD, RN, IBCLC, and TGH Quality Specialist Karen Fugate, MSN, RNC-NIC, CPHQ, the hospital changed its workflow so that all mothers of VLBW newborns would be counseled on the benefits of lactation. With a goal of starting mothers pumping as soon as they returned to their rooms after birth, nurses delivered one-on-one lactation coaching on how to use an electric breast pump and log and store milk.

"Within a couple of hours of birth, a mother needs help to initiate pumping to bring in a full supply of milk. Then, she needs encouragement to keep going, because that light at the end of the tunnel, where she can put her baby to her breast, might not come for two or three months," says Hernandez.

"Mothers need education, timely support, and pumps."

When TGH's mothers left the hospital, they faced yet another challenge. Eighty percent were insured by Medicaid, and in Florida the state did not pay for hospital-grade double breast pumps, which are superior to single or retail pumps for establishing milk supply. Using grant funds, the hospital built a loaner pump program that filled gaps until the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) could make pumps available. As mothers visited their newborns daily, NICU nurses inquired about their milk supply, advised on pumping, and gave them access to on-site refrigeration for their milk.

Five years later, 43 percent of TGH's mothers of very tiny infants had begun pumping within six hours of giving birth—a best practice—and between 55 and 60 percent of TGH's VLBW newborns were receiving their mother's own milk upon discharge. The percentage of black mothers providing their own milk to their VLBW newborns had tripled.

In June 2016, at the urging of the Florida Breastfeeding Coalition, Florida's Medicaid program changed its policy. It now pays for hospital-grade double breast pumps for mothers of vulnerable infants.



Photo: © 2010 Ed Kashi

A nurse helps a new mother with breastfeeding. Evidence shows that lactation consultants, peer counselors, group prenatal care, nurse home visiting programs, and the availability of breast pumps—a necessity for mothers who work outside the home—can increase breastfeeding success, especially among low-income mothers.

Fast Facts: Breastfeeding

- 6 months** The length of time the American Academy of Pediatrics recommends mothers exclusively breastfeed
- Fewer than 1 in 5** Mothers who meet the recommendation
- Less than half** Very-low-birth weight (VLBW) babies who breastfeed upon leaving the hospital
- 3X** How much a nurse-designed clinical care initiative raised the rate of breastfeeding at discharge for black VLBW infants

WIC Delivers Mixed Message on Breastfeeding

The WIC program feeds more than [half of all infants](#) born in the United States. WIC sometimes makes breast pumps available to very-low-income mothers, but the coverage is not consistent. Some WIC programs offer peer counseling to support breastfeeding, but that varies by county and state. Meanwhile, infant formula is readily available through WIC, sending a mixed message. WIC spends 25 times more on infant formula than on breastfeeding support.

In 2013, the American Academy of Nursing Expert Panel on Breastfeeding [called for](#) reallocating how WIC dollars are spent. "The inconsistency between WIC's policies that encourage breastfeeding versus practices that favor formula begs further examination," wrote Diane Spatz, who led the panel. "Research shows consistent success with peer counseling programs among WIC participants; however, little money is budgeted for these programs."

For More Information

Spatz D. [Ten Steps for Promoting and Protecting Breastfeeding for Vulnerable Infants](#). *Journal of Perinatal and Neonatal Nursing*. 2004; 18(4): 385-396.
Florida Perinatal Quality Collaborative. [Mother's Own Milk \(MOM\) Toolkit](#). 2016.
American Academy of Nursing. [Raise the Voice Edge Runner](#). Description of Ten Steps for Promoting and Protecting Breastfeeding for Vulnerable Infants.

Keeping Young Children Healthy and Safe

Chicago Parent Program Helps Families Engage in Positive Parenting

When psychiatric nurse Deborah Gross, DNSc, RN, FAAN, began working in poor neighborhoods around Chicago's South Side in the late 1990s, she saw parents struggling to find work, good food, and adequate housing while raising children in violent, under-resourced neighborhoods. Sometimes in these stressed homes, praise for children was scarce, and expectations were out of sync with children's developmental stages.

Positive and skilled parenting is a predictor of healthy child outcomes, but as Gross points out, "It is very difficult to be an attentive parent when you are worried about housing and food. These parents are raising their children in a world where it is not three strikes, you're out; it is one strike and you're out." As a result, children begin to behave in ways that hurt their performance in school and their own well-being.

Parent training is widely used to promote positive parenting and improve child mental health. Yet Gross knew that traditional parenting programs were ill-suited to her families' cultures and experiences. So she convened an advisory board of black and Latino parents, and together they co-created

what became the **Chicago Parent Program** (CPP), a 12-week parenting course designed for low-income parents.

Through facilitated discussions and viewing videos that portray real-life situations, parents learn to expand their responses to tough situations. More fundamentally, CPP asks parents to dream of the types of people they want their children to become in 15 years. Parents usually say "smart, successful, happy, and confident," and facilitators challenge them to build and reinforce those qualities in their children right away.

Now in its 17th year, CPP has been implemented in Head Start programs and in public schools in 19 states, Washington, D.C., and two Canadian sites. Two randomized controlled trials **showed** that one year after parents complete the program, they spank their children less, feel more confident, are more consistent with discipline, and show more positive parenting behaviors.

Gross is currently implementing CPP in the Baltimore City Public School System. Preschool behavior problems often lead to future problems in school that

result in suspension or expulsion. These early problems are linked to later mental health challenges and involvement with the juvenile justice system.

Early results of the Baltimore effort show that CPP has cut the number of clinically significant child behavior problems by 48 percent, which Gross expects will lead to better academic and health outcomes.

Yet group-parenting programs face a barrier to widespread implementation: Low-income parents often lack the time and transportation required to attend. In response, Gross' colleague Susan Breitenstein, RN, PhD, a Robert Wood Johnson Foundation Nurse Faculty Scholar, is using funding from the Agency for Healthcare Research and Quality **to test** whether CPP can be effectively self-administered as a **tablet-based program**. She expects to know more in 2018.

For More Information

[Chicago Parent Program video](#)

CPP is listed in the Substance Abuse and Mental Health Services Administration's [National Registry of Evidence-Based Programs and Practices](#), the [California Evidence-Based Clearinghouse for Child Welfare](#), and the [Clearinghouse for Military Family Readiness](#).

Nurse Health Consultants Support Child Care Centers



Photo: Barry Gutierrez Photography

Pediatric nurse practitioner Debbie Bradley conducts a hearing screening at a preschool. As a child care health consultant, Bradley identifies potential health concerns so families can address them early.

Every day, thousands of nurses help ensure that millions of children are kept healthy and safe. And they do it in a community-based setting that is far from clinical: child care. With **61 percent** of children under age 5 in child care on a regular basis, these settings provide

a ready-made entry point for parent education, health promotion, and disease prevention—three building blocks for a lifetime of health.

Child care health consultants (CCHCs)—most of whom are nurses—deliver health education and monitoring services to early child care centers. They coach staff on proper diapering and hand sanitation, teach proper medication administration, and inspect play rooms for hazards such as dangling cords and loose plastic bags. They screen children for developmental delays, provide

referrals to community resources, and give input on licensing rules to keep children safe.

When child care centers use health consultants, they are more likely to have

policies in line with national standards and follow evidence-based health practices. The frequency of CCHC visits and ratio of CCHCs to child care programs, however, varies widely across the country.

For More Information

[Head Start: Early Childhood Health and Wellness](#)
[National Resource Center For Health and Safety in Child Care and Early Education](#)

Fast Facts: CCHCs

- 50 years ago** When the child care health consultant (CCHC) role was created
- 25 years ago** When the federal government recognized CCHCs
- 17** Number of states that require licensed early child care centers to use CCHCs

Expanding Nurse Home Visiting

The evidence showing the value of nurse home visiting is strong and consistent. Just look at the more-than-40-year-old **Nurse-Family Partnership (NFP)**. When nurses visit low-income first-time mothers in their homes and build long-term supportive and educational relationships, lives are changed. Participation in NFP improves children's well-being and safety, and curbs accidents and preventable deaths. It also boosts the health of the mother, reduces her dependence on public aid programs, and improves the spacing between her subsequent births.

Yet NFP is still out of reach for many families who would benefit. "Cost is often an objection to the program from the policymaker point of view," explains Tamar Bauer, chief policy and government affairs officer at NFP. At an average cost of \$6,333 per participating family per year, the program is considered expensive, especially at a time of economic constraint. When budgets are tight, Bauer explains, "state governments have trouble focusing on the long-term return on investment. They think they have to choose between delivering optimal outcomes to a smaller group of women versus less-than-optimal results to a larger group."

The Case for Investing in Nurse Home Visiting

To reduce costs, other home visiting programs use less skilled, non-clinical, lower-paid workers, such as peer counselors. Aware of the cost barrier to adopting nurse home visiting, NFP tested its model in 1994 using paraprofessionals to see if the intervention could achieve the same results without RNs. The answer, quite simply, was no.

"The nurse brings a unique set of skills," says Harriet Kitzman, RN, PhD, FAAN, nursing and pediatrics professor at the University of Rochester, who researched the effects of nurse home visiting. "While others can provide elements of the intervention, only nurses take an in-depth, integrated, and comprehensive approach, understanding all the roles a new mother must play."

Another lesser-known fact: When the impact of NFP is measured through a child's 18th birthday, nurse home visiting more than pays for itself. One independent study found that state and federal governments save more than three times as much as they invest in NFP through reductions in food stamp use, Medicaid expenditures, emergency department use, and crimes and arrests.

Diverse Funding Enables Spread

In 2010, the Affordable Care Act established the **Maternal, Infant, and Early Childhood**



Photo: Barry Gutierrez Photography

Nurse-Family Partnership nurse Julia Blair, RN, BSN, with Colorado's Tri-County Health Department, gets down on the floor to listen to the heart and lungs of Tra'von, 10 months, while his mother Reanna engages him with a measuring tape.

Home Visiting (MIECHV) Program and set aside \$1.5 billion to fund it. NFP was one of 10 evidence-based models authorized under the program, and NFP has delivered about one-quarter of MIECHV-funded services. From 2010 through 2014, 39 states, six tribal organizations, and one territory used MIECHV funding to deliver NFP services, enrolling an additional 19,540 clients and their children.

Congress has extended funding for MIECHV twice at \$400 million a year through September 30, 2017, but future federal funding for NFP is uncertain. Medicaid dollars that subsidize nurse home visiting could also be affected by federal health policy changes.

South Carolina Pilots "Pay for Success" Project

Should federal support for nurse home visiting wane, states and municipalities that aim to implement NFP may want to look to South Carolina for a creative financing model. In 2016, the state launched the first **Pay for Success NFP project** in the nation. Using a federal 1915(b) waiver, the state's Medicaid department joined with private foundations and one corporation to provide up-front funding of \$30 million to bring NFP to 3,200 additional first-time mothers.

The South Carolina government has agreed to repay \$7.5 million of the \$17 million

invested by private funders if the program reduces preterm births, decreases child hospitalizations and emergency department use due to injury, and improves birth spacing—all short-term, easily measurable goals. Should this occur, the private funders have agreed to reinvest the \$7.5 million to bring NFP to even more first-time mothers.

As part of the program, NFP is conducting a randomized controlled trial to see if reducing the cost of delivering its services by 25 percent will affect program outcomes.

Fast Facts: NFP

\$6,333	Average cost of Nurse-Family Partnership (NFP), per family, per year
9%	Reduction in Medicaid costs for NFP families
11%	Reduction in food stamp costs for NFP families
59%	Reduction in child arrests by age 15 for NFP children
72%	Reduction in convictions for NFP mothers
\$1.26 to \$5.70	Estimated government savings for every dollar invested in NFP

Bringing Proven Programs to Scale

Nurse-led innovations have helped tens of thousands of mothers and infants, and have achieved a foothold across the world. But despite these advances, the programs are far from universal. How can more people receive these interventions, and society as a whole benefit from the healthiest possible pregnancies, births, and young childhoods? The solution lies in pushing for policy changes to allow programs to scale (that is, to increase their reach). Strategies to help nurses make the case for such changes—or to more rapidly expand proven programs—include:

• Demonstrate Program Value

Proven health outcomes are the first step. Since 1977, the Nurse-Family Partnership (see p. 7) has conducted randomized controlled trials. The mountain of evidence generated from them now makes the program attractive to policymakers who care not just about health outcomes but also about mothers gaining economic self-sufficiency and about stemming juvenile justice costs. “Innovators must be diligent about collecting and reporting data,” says Jill Alliman, DNP, CNM, project director, American Association of Birth Centers. “It is a required part of scaling.”

• Show a Return on Investment (ROI)

Quantifying benefits and savings can provide a powerful motivation for investing in innovative programs, but some programs take years to demonstrate their ROI. To garner support, a program must also pay off in the short term—within the first two years, says Jennie Chin Hansen, RN, MS, FAAN. She was instrumental in achieving Medicare and Medicaid recognition for the Program of All-Inclusive Care for the Elderly (PACE), which became an official benefit in 1997, 25 years after the program’s founding. “The economic argument is the only thing that convinces policymakers; they have to be able to show an ROI to their constituents for the money invested.”

• Pilot in Fertile Ground

Programs have a higher likelihood of success when “planted” in cities and states with child-friendly and flexible Medicaid programs and a commitment to innovation. For interventions that must overcome multiple barriers to implementation, such as Diane Spatz’ Ten Steps for Promoting and Protecting Breastfeeding in Vulnerable Infants (see p. 5), it may help to have a champion within state government or a quality improvement initiative.

• Make It Easy to Implement

As much public health experience shows, interventions are more readily adopted when they are accessible, cost little, and are easy to implement and replicate. “It also helps if the intervention benefits a lot of people,” says Hansen.

• Use Carrots and Sticks

New programs can spread more quickly when policymakers put financial incentives in place. South Carolina’s Medicaid program, for instance, gives clinics that adopt CenteringPregnancy a \$250 incentive per patient to cover administrative costs. Another example: When insurers refuse to pay for early elective deliveries or pay a uniform rate for both vaginal and C-section deliveries, behavior changes.



“Ultimately, the knowledge of what needs changing and the best practices for achieving results are well known. What’s been missing is one magic ingredient:

determination to change. Today, we see far more determination than ever before, as leaders forge ahead and show results. This will help women and families get out of jeopardy.”

—Leah Binder, President & CEO, The Leapfrog Group

• Leverage Star Reputation

Nursing innovations may sprout in underserved or rural areas, away from the spotlight. But having nationally acclaimed institutions adopt the intervention can hasten dissemination. “When a few heavy hitters—name brands in health care—get on board, you become more visible and your likelihood of success increases,” says Hansen.

• Take Advantage of Trends

The transition away from fee-for-service medicine toward paying for value may be the enduring legacy of the Affordable Care Act. Nursing innovators can make the case that their programs provide better value and advocate for their inclusion in alternative payment models.

Credits

EXECUTIVE EDITOR: Maryjoan D. Ladden, PhD, RN, FAAN, senior program officer, Robert Wood Johnson Foundation

CONTRIBUTING EDITOR: Susan B. Hassmiller, RN, PhD, FAAN, senior adviser for nursing, Robert Wood Johnson Foundation, and director, The Future of Nursing: Campaign for Action

Propensity Project Team

PROJECT DIRECTOR/SENIOR EDITOR:

Nicole Fauteux, Propensity LLC

SERIES ADVISOR: Joanne Disch, PhD, RN, FAAN

SENIOR WRITER: Rachel Brand, Brand Communications

EDITORIAL ASSISTANT: Leah Kloeck

DESIGN: Propensity LLC

ACKNOWLEDGMENTS: Thanks to Melissa Avery, Fran Benton, Debbie Bradley, Marena Burnett, Janet Dietrick, Linda Lindeke, and Joan Lombardi

To see other briefs in this series, visit www.rwjf.org/ChartingNursingFuture

Follow us on Twitter @NursingFuture

