Nurse-Family Partnership National Statistics

Data Through 07/31/2010

This report is based on the intervention model developed and tested by Dr. David Olds and colleagues. Thirty one states implement the Nurse-Family Partnership program throughout the United States. This report presents analysis of data available from program initiation in 1996 through July 31, 2010, and covers the pregnancy, infancy and toddler phases of the program.

Throughout the report, indicators of program implementation, maternal and child health and functioning are listed for the national sample of Nurse-Family Partnership clients.

Pregnancy Health and Outcomes

An important part of the Nurse-Family Partnership program is improving the health and wellbeing of the clients and children enrolled in the program and monitoring any changes that occur. Table 1 provides information on pregnancy health and outcomes. "Weight gain during pregnancy is very important to the health of the baby and the health of the mother. Gaining too much weight can increase the mother's chances of developing diabetes or high blood pressure. Gaining too little weight increases the chance of the having a low birth weight baby."[1]

Preterm Births

Reduction of preterm births is considered the best way to reduce infant illness, disability, and death. Table 1 illustrates the rates of preterm births for the NFP clients nationwide and provides the NFP Objectives.

The NFP Objective for preterm births is consistent with the target goal set in Healthy People 2010 Objectives for the percentage of preterm births among all women of childbearing age. Whereas it is a national goal to eliminate disparities in health outcomes among populations, health statistics for women from minority and low income populations served by the NFP substantiate the existence of disparities in rates of preterm and low birth weight infants by race and ethnicity. Thus, the progress that NFP Implementing Agencies can realistically achieve toward the goals may vary based on the racial and ethnic composition of the population served.

Table 1: Pregnancy Outcomes

	%	NFP Objective
Percent 1st prenatal visit in First Trimester	83%	
Percent with adequate weight gain	79.3%	
Preterm birth incidence overall	9.7%	7.6%
Low birth weight incidence overall	9.4%	5.0%

[1] Weight Gain During Pregnancy. March of Dimes, September 2009 <http://www.marchofdimes.com/pnhec/159_153.asp>.

Prenatal use of tobacco, alcohol, and other drugs has been associated with various adverse birth outcomes such as low birth weight, preterm delivery and birth defects. Assessments of personal health habits, including smoking and the use of alcohol, are conducted periodically throughout the program: shortly after enrollment, at 36 weeks of pregnancy and at 12 months of infancy.

Table 2 provides information about the maternal health habits of NFP clients nationwide between intake and 36 weeks of pregnancy with information being compared for those with data at *both* time points. The NFP Objective for reducing smoking during pregnancy is 20% or greater reduction in the percentage of women smoking from intake to 36 weeks pregnancy**.**

Table 2: Change In Maternal Substance Use During Pregnancy

	% of Clients at Intake	% of Clients at 36 Weeks	% Change	NFP Objective
Drug Usage	1.4%	.5%	-54.8	
Alcohol Usage	1.3%	.9%	-29%	
Cigarette Smoker	14.4%	12.1%	-15.8%	-20%

Change in Experience of Violence

Violence data are based on self-reported information which may not be divulged until the nurse/client relationship has developed and is more trusting. The potential under-reporting of this information should be considered when looking at changes in violence rates over time.

Table 3: Change In Experience Of Violence

	% of Clients at Intake	% of Clients at 36 Weeks	% Change
Experience Of Physical Abuse	6.1%	3.6%	-42.1%
Fear of Partner	6.1%	3.1%	-50%

Maternal Outcomes

Subsequent Pregnancies

NFP focuses on helping clients achieve life course development goals through the planning of future pregnancies, completion of their education, procurement of employment and development of stable partner relationships. The timing and number of subsequent pregnancies has important implications for a client's ability to stay in school, find work, and/or find appropriate child care. Table 4 indicates rates of subsequent pregnancies for NFP clients nationwide after the birth of the first child. The NFP objective is to have no more than 25% of clients experience a subsequent pregnancy by 24 months after the birth of the first child.

Table 4: Subsequent Pregnancies

	%	NFP Objective
Subsequent pregnancy within 1 year postpartum	10.6%	
Subsequent pregnancy within 2 years postpartum	30.4%	25%

Education

Education status and enrollment in school are also factors to consider when looking at clients' life course development. Nurse home visitors work with clients to set educational and career goals, including completion of a high school diploma or GED. Table 5 presents information on education status of NFP clients at intake. Table 6 presents information on client enrollment in school and completion of a high school diploma/GED for those clients who entered the program *without* a high school diploma or GED.

Table 5: Educational Status

	% of clients at Intake
With a High School Diploma or GED	49.2%

Table 6: School Enrollment For Clients With No High School Diploma Or GED At Intake

	% of clients at Intake	% of clients at 12 Months Postpartum	% of clients at 24 Months Postpartum
Clients 17 Years and Younger Enrolled in School	75.6%	56.2%	45.3%
Clients 17 Years and Younger Who Earned Their Diploma or GED	--	23.6%	40.8%
Clients 18 Years and Older Enrolled In School	31.6%	20.2%	19.3%
Clients 18 Years and Older Who Earned Their Diploma or GED	--	30.1%	35.9%

Workforce Participation

Participation in the workforce is another area that is tracked as an indicator of the client's life course development. The tables below look at workforce participation for all clients during the different time points. The percentages listed in Tables 7 and 8 only include those clients who have ever worked a paid job during their life.

Table 7: Percentage Working During The Program Of Those 17 Years Or Younger At Intake

	Intake	6 Months	12 Months	18 Months	24 Months
Working Full Time	2.6%	6.8%	10.1%	13.7%	17.3%
Working Part Time	12.9%	16.7%	21.0%	23.5%	23.8%

Table 8: Percentage Working During The Program Of Those 18 Years Or Older At Intake

	Intake	6 Months	12 Months	18 Months	24 Months
Working Full Time	20.4%	21%	25.3%	28%	31.7%
Working Part Time	21.5%	21.9%	23.8%	24.0%	23.2%

Table 9: Number Of Months Worked Postpartum

	Avg. # Months
0-12 months postpartum	6.4
13-24 months postpartum	11.9

Marital Status

Marital status of clients is assessed at program intake and every six months after the birth of the client's baby. Marriage is an important indicator of stable partner relationships which have important benefits for the family's economic and psychological health. Table 10 demonstrates the percentage of clients who were married from intake to 24 months of infant age.

Table 10: Percentage Married Over Time

	%
Intake	21%
6 months	28%
12 months	30%
18 months	29%
24 months	32%

Child Outcomes

Breastfeeding

The table below illustrates breastfeeding rates reported at initiation and 6 months of infant age for NFP clients nationwide. Breast milk is considered the ideal form of infant nutrition, with the practice of breastfeeding demonstrating wide-ranging benefits for infants' general health, immune systems, and development. The American Academy of Pediatrics recommends breastfeeding for the first 6 months of life, noting that "exclusive breastfeeding has been shown to provide improved protection against many diseases…".[2]

Table 11: Occurrence Of Breastfeeding

Child Outcomes	%	Healthy People 2010 Target
Initiated Breastfeeding	77.6%	75%
6 months	27.3%	50%

Table 12: Percent Of Children Assessed By Nurses As Being Current With Immunizations

Child Outcomes	%	NFP Objective
12 months	84.4%	
24 months	90.1%	90%

Table 13: Report Of Lead Screening By Parents By Child Age

Child Outcomes	%
By 24 months	59.5%

[2] American Academy of Pediatrics. (2005). Breastfeeding and the Use of Human Milk [Electronic version]. Pediatrics, 115 (2), 496-506.

Language Development

Development of language skills during the preschool years is an important indicator of school readiness. The Language Assessment Form (derived from the MacArthur CDI Short Form) is administered when toddlers are approximately 21 months of age. The client is asked to identify which words her child says from a list of 100 words, and the number of words that the infant says is summed and compared to age and gender adjusted norms. The NFP Objective for this measure is 25% or fewer toddlers scoring below the 10th percentile. This objective takes into account the lower socioeconomic population that NFP serves. Scoring below the 10th percentile may indicate a delay in language skills and a need for referral for further language assessment. However, scoring above the 10th percentile on this assessment does not necessarily rule out the possibility of a language delay, as multiple factors may influence test scores. Nurse home visitors consider all relevant sources of information (e.g. other assessments, observation, and parental concern) when making an assessment regarding any type of developmental delay, including language delay, and work with local service providers in determining criteria for referral to their agencies for further evaluation. (Note: prior to 10/1/2006, all toddlers were assessed with the English version of the Language Assessment Form).

Table 14: Language Production Scores

Child Outcomes	%
Language production scores < 10%**	10.3%

** Scoring below the 10th percentile may indicate a delay in language skills and a need for referral for further language assessment.

Screening For Determine Need for Developmental Assessment

The Ages and Stages Questionnaires (ASQ) and the Ages and Stages Questionnaires: Social-Emotional (ASQ-SE) are administered at several time points during the child's first two years. Scores from these screening tools will provide the nurse home visitor with a framework for monitoring or referring the child for further assessment. Collection of this data began in October 2006.

Table 15: Ages And Stages (ASQ)*

4 Months		10 Months		14 Months		20 Months	
Assessed	May need further evaluation +	Assessed	May need further evaluation +	Assessed	May need further evaluation +	Assessed	May need further evaluation +
69.1 %	10.4 %	67.9%	7.1 %	71.6%	9.7%	75.6%	16%

*Data through 6/30/2010

Table 16: Ages And Stages - Social And Emotional (ASQ - SE)*

6 Months		12 Months		18 Months		24 Months	
Assessed	May need further evaluation	Assessed	May need further evaluation	Assessed	May need further evaluation	Assessed	May need further evaluation
56.6%	4.2%	56.5%	3.6%	58.2%	3.9%	62.7%	4.2%

*Data through 6/30/2010