

CONTRACT AGREEMENT
By and Between
Kitsap Public Health District and Jefferson County Public Health

For provision of one (1) Public Health Nurse for Nurse Family Partnership (NFP) Supervisor Role

Section 1: PURPOSE:

THIS AGREEMENT for Professional Services is entered into between the Kitsap Public Health District (KPHD), hereinafter referred to as “District” and Jefferson County Public Health (JCPH), hereinafter referred to as “Contractor” to provide services as a Nurse Family Partnership (NFP) Supervisor.

Section 2: TERMS:

This Agreement shall commence on January 1, 2020 and continue through December 31, 2020, unless terminated as provided herein. The agreement may be extended beyond December 31, 2020, upon mutual written consent of the District and the Contractor.

Section 3: SCOPE OF AGREEMENT:

Contractor will provide Public Health Nurse services for NFP Supervisor Role and will meet obligations as contained in Exhibit A, Statement of Work.

Section 4: CONTRACT REPRESENTATIVES:

District and Contractor will each have a contract representative who will have responsibility to administer the contract for that party. A party may change its representative upon providing written notice to the other party. The parties' representatives are as follows:

Kitsap Public Health District Contract Representative

Yolanda Fong, Community Health Director
345 6th Street, Suite 300
Bremerton, WA 98337
(360) 728-2275

Contractor's Contract Representative

Vicki Kirkpatrick, Director
Jefferson County Public Health
615 Sheridan St.
Port Townsend, WA 98368
(360) 385-9400

Section 5: COMPENSATION:

- A. Calculation for the cost of supervisor is total salaries and benefits, based 28 hours per week, and overhead. Total cost of \$118,878.41 will be shared between the Contractor and District, allocated based on the number of Public Health Nurses in the NFP program.

- B. District will pay Contractor an annual fee for regular nurse supervision for 3 of five (5) NFP nurse home visitors at \$5,943.92 monthly, or quarterly at the rate of \$17,831.76, so long as the total actual expenses meet or exceed the monthly or quarterly rate, whichever is agreed upon by the District and the Contractor.
- C. At such time as JCPH hires an additional NFP nurse home visitor to provide expanded services into Clallam County, as part of our regional expansion team, charges for nurse supervision will be shared among six (6) nurses instead of five (5). The new supervisory fee for regular nurse supervision for 3 of 6 NFP nurse home visitors will be \$4,953.27 monthly, or \$14,859.80 quarterly, whichever is agreed upon by District and Contractor.
- D. Contractor will notify District if actual expenses fall below the monthly or quarterly rate. Contractor shall submit invoices to the District, 345 6th St. Suite 300, Bremerton, WA 98337, Attn: Yolanda Fong, for payment of work actually completed to date.
- E. Until JCPH is able to hire a registered nurse for NFP in Clallam County, then rates in Section B will apply. Once hired, rates would be adjusted as reflected in Section C.
- F. Any additional fees required by NFP for the supervisor's training will be split between the District and the Contractor. District will be given adequate notice of needed trainings.
- G. Additional fees for Annual Program Support and Annual Nurse Consultation Fees will be split between the District and the Contractor. District's portion of fees will be based on the number of agencies participating under the JCPH NFP Program.
- H. In the event that approved program supplies required by NFP are unavailable for direct purchase, Contractor will purchase supplies and bill District for incurred cost. Total purchases of supplies or equipment will not exceed \$2,000 without prior approval of the District.
- I. District may request additional nursing supervisory hours at an hourly rate commensurate to Contractor's employee's hourly rate. In the case of emergency nursing supervisory needs, District will be charged an hourly rate.
- J. Contractor records and accounts pertaining to this agreement are to be kept available for inspection by representatives of the Health District and state for a period of six (6) years after final payments. Copies shall be made available upon request.

Section 6: INDEMNIFICATION:

The Contractor shall indemnify, defend, and hold the District, its officers, agents, and employees and volunteers harmless from any and all claims, injuries, damages, losses or suits including attorney fees, arising out of or resulting from the acts, errors or omissions of Contractor in performance of this Agreement, except for injuries and damages caused by the sole negligence of the District. Solely for the purposes of this provision, Contractor waives its immunity under Title 51 (Industrial Insurance) of the Revised Code of Washington and acknowledges that this waiver

was mutually negotiated by the Parties. This provision will survive the expiration or termination of this Agreement.

Section 7: INSURANCE:

Each party shall obtain and keep in force during the terms of this Agreement, or as otherwise required.

- A. Commercial Automobile Liability Insurance providing bodily injury and property damage liability coverage for all owned and non-owned vehicles assigned to or used in the performance of the work for a combined single limit of not less than \$1,000,000 each occurrence.
- B. Professional Liability Insurance providing \$2,000,000 per incident; \$4,000,000 aggregate.
- C. Each party shall participate in the Worker's Compensation and Employer's Liability Insurance Program as may be required by the State of Washington.
- D. Contractor will maintain its membership in the Washington Counties Risk Pool.

Section 8: CONFIDENTIALITY:

All parties to this Agreement and their employees or representatives and their subcontractors and their employees will maintain the confidentiality of all information provided by Contractor or District or acquired in performance of this Agreement as required by the HIPAA and other privacy laws. This Contract, once executed by the parties, is and remains a Public Record subject to the provision of Ch. 42.56 RCW, the Public Records Act.

Section 9: OWNERSHIP AND USE OF DOCUMENTS

Contractor acknowledges and agrees that any and all work product directly connected to and/or associated with the services rendered hereunder, including but not limited to all documents, drawings, reports, and the like which the Contractor in the performance of the service hereunder, either solely and/or jointly with the District shall be the sole and exclusive property of the District. Other materials produced by the Contractor in connection with the services rendered under this agreement shall be the property of the District whether the projects for which they are made are executed or not. Each party may, with no further permission required from the other party, publish to the web, disclose, distribute, reproduce, or otherwise copy or use, in whole or in part, such items produced during the course of the project to the extent disclosure is allowed by HIPAA rules.

Section 10: INDEPENDENCE

Nothing in this agreement shall be considered to create the relationship of employer and employee between the Parties hereto. The Contractor shall not be entitled to any benefits afforded District employees by virtue of the services provided under this agreement. District shall not be responsible for withholding or otherwise deducting federal income tax or social security or for contributing to the state industrial insurance program, otherwise assuming the duties of an employer with respect to employee.

Section 11: REPORTING

Contractor will provide a report to the District, whichever is agreed upon by the District and the Contractor, for payment for services rendered. The report shall contain a brief summary of the work performed, relationship to the tasks identified in **Exhibit A**, and the total lines generated.

Section 12: DISPUTE RESOLUTION

The Parties agree to work cooperatively to accomplish all of the terms of this Agreement, however, acknowledge that there may be instances in which either the District or the Contractor has not complied with the conditions of this Agreement or that clarification is necessary to interpret provisions of this Agreement. In such an instance, the Parties shall attempt to resolve the matter through good faith efforts. If unsuccessful, the Parties shall refer the matter to non-binding mediation.

If the mediator cannot resolve the dispute, the issue shall be referred to a Dispute Panel. The Dispute Panel shall review all issues, concerns, and conflicts to determine a solution acceptable to both Parties. The decisions of the Dispute Panel shall be final and binding on both Parties.

DISPUTE PANEL: The Parties may voluntarily submit any contractual dispute to a dispute panel as follows: each party will appoint one member to the panel and those two members in turn will appoint a third member. The dispute panel will review the facts, contract provisions, and applicable law, and then decide the matter. The decision of the dispute panel shall be binding on the Parties and final.

Section 13: TERMINATION

District and the Contractor reserve the right to terminate this contract in whole or in part with 30 days-notice. In the event of termination under this clause, District shall be liable only for payment for services rendered prior to the effective date of termination.

Section 14: INTEGRATED AGREEMENT

This Agreement together with attachments or addenda represents the entire and integrated agreement between the District and the Contractor and supersedes all prior negotiations, representations, or agreements written or oral between the Parties. This agreement may be amended or modified only by a written instrument signed of both District and Contractor.

Section 15: PROGRAM MODEL ELEMENTS

District and the Contractor understand and agree that Program implementation by District and Contractor must be based on key parameters-Model Elements identified through research and refined based upon the Program’s experience since 1997 and included in this Agreement as Nurse-Family Partnership Model Elements, hereto attached and herein referenced as **Exhibit B**.


Section 16: PROPRIETARY PROPERTY

District and the Contractor understand and agree that NFP grants to the District and Contractor a non-exclusive limited right and license to use the Proprietary Property for the purpose of carrying out the obligations of this Agreement. Further, the NFP reserves the right to modify the Proprietary Property from time to time in accordance with the data, research, and current

modalities of deliveries program. NFP shall retain ownership and all the rights to any Proprietary Property, whether modified or not by the District and/or Contractor. In any event, all software, Nurse-Family Partnership Community and Efforts to Outcomes Website content, excluding the District's and Contractor's data, shall remain the sole property of Nurse-Family Partnership.


Approved this 8th day of June, 2020.

BOARD OF COUNTY COMMISSIONERS
JEFFERSON COUNTY, WASHINGTON



Greg Brotherton, Chair
6/8/2020
Date

KITSAP PUBLIC HEALTH DISTRICT



Keith Grellner, RS
Administrator
5/7/2020
Date

ATTEST:



Carolyn Gallaway
Clerk of the Board, Deputy

APPROVED AS TO FORM:



Philip C. Hunsucker, Chief Civil Deputy
Attorney
5/20/2020

Exhibit A
Statement of Work

	JCPH	KPHD
Nurse Home visitors #	3*	3

Model Elements implemented through facilitation by Nurse Supervisor—applies to all sites:

Model element and description	JCPH	KPHD
#10, Work with NHVs to increase knowledge, practice, and individualization of NFP visit to visit guidelines with families across all domains.	X	X
#11, Work with NHVs to review and reflect on theoretical bases of NFP as related to clinical practice.	X	X
#12, Work with NHVs and team to maintain required number of clients. Includes caseload management, outreach, referrals and maintaining community relationships.	X	X
#13, Nurse supervisor provides supervision to 6 NHVs at this time, appropriate for .70 FTE Nurse supervisor	X	X
#14, Nurse supervisor provides: 1. Weekly 1:1 clinical supervision 2. Case conferences 3. Team meetings 4. Field Supervision	X In person weekly X at least 2 x month X at least 2 x month X at least 3x year	X In person at least 2x month X at least 2 x month X at least 2 x month X at least 3x year
#15 Data is collected and used to guide practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity.	X	X
#17, Regional CAB convened and will meet at least 3x year	X	X
#18, Nurse supervisor will help support and facilitate regional communication to assure accurate data entry and implementation of program	X	X

Other related program implementation areas:

Other areas related to program implementation	JCPH	KPHD
NFP Tribal Community of Practice	0	0
Washington State NFP Consortium: 1. Monthly calls with WA State Nurse consultant 2. Monthly calls with WA State Nurse supervisors 3. Quarterly meetings with WA State nurse supervisors 4. On-site visits with WA state nurse consultant at least once/year.	X	X
Coordination of team meetings, case conferences, and reflective supervision times based on regional composition, including associated travel.	X	X
DCYF Funding: application, Monthly and quarterly reports.	X	X
NFP required Education and training, such as DANCE education and annual NFP National Symposium	X	X

* If JCPH is unable to hire a registered nurse for NFP in Clallam County, then 2 NFP nurses will be providing services.

Exhibit B



Nurse-Family Partnership

Model Elements

CLIENTS

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

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

Element 2 Client is a first-time mother.

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

Element 3 Client meets low-income criteria at intake.

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

Element 4 Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of the 28th week of pregnancy.

A client is considered to be enrolled when she receives her first visit and all necessary forms have been signed. If the client is not enrolled during the initial home visit, the recruitment contact should be recorded in the client file according to agency policy. It is recommended that only one pre-enrollment visit be provided. Early enrollment allows time for the client and nurse home visitor to establish a relationship before the birth of the child, and allows time to address prenatal health behaviors which affect birth outcomes and the child's neurodevelopment. Additionally, program dissemination data show that earlier entry into the program is related to longer stays during the infancy phase, increasing a client's exposure to the program and offering more opportunity for behavior changes.

INTERVENTION CONTEXT

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

Clients are visited one nurse home visitor to one first-time mother. The mother may choose to have other supporting family members/significant other(s) in attendance during scheduled visits. In particular, fathers are encouraged to be part of visits when possible and appropriate. The nurse home visitor engages in a therapeutic nurse-client relationship focused on promoting the client's abilities and behavior change to protect and promote her own health and the well-being of her child. It is important for nurse home visitors to maintain professional boundaries within the nurse-client relationship. Some agencies have found it useful to have other nurses on their team at times to accompany the primary nurse home visitor for peer consultation. This helps the client to understand that there is a team of nurse home visitors available and that this second nurse home visitor could fill in if needed. This may reduce client attrition if the first nurse is on leave or leaves the program. Other team members, such as a social worker or mental health specialist, may also accompany nurses on visits as part of the plan of care. The addition of group activities to enhance the program is allowed, but can not take the place of the individual visits and can not be counted as visits. It is expected that clients will have their own individual visits with their nurse, and not joint visits with other clients.

Element 6 Client is visited in her home.

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

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

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

EXPECTATIONS OF THE NURSES AND SUPERVISORS

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

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

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

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

APPLICATION OF THE INTERVENTION

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

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

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

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

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

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

Full time is considered a 40-hour work week. Agencies may have a different definition for full time, and should pro-rate the nurse's caseload accordingly. At least half-time employment (20-hour work week) is necessary in order for nurse home visitors to become proficient in the delivery of the program model. Existing teams that already are in place but do not meet these expectations should consult with their nurse consultant. Active clients are those who are receiving visits in accordance with the NFP Visit-to-Visit Guidelines and the plan established by the client and the nurse. In practice, clients are considered participating if they are having regular visits. Agencies can establish their own policies regarding a timeframe for discharging missing clients. It is expected that supervisors will work with their nurse home visitors to monitor caseloads and utilize the program to serve the number of families they are funded to serve. The contract between the NFP National Service Office and the Implementing Agency states that the Agency will:

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

REFLECTION AND CLINICAL SUPERVISION

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

Full time is considered a 40-hour work week. It is expected that a full-time nurse supervisor can supervise up to eight individual nurse home visitors, given the expectation for one-to-one supervision, program development, referral management and other administrative tasks. It also is assumed that other administrative tasks may be included in time dedicated to NFP, including the supervision of some additional

administrative, clerical and interpreter staff. Refer to the sample supervisor job description found in the *Implementing Agency Orientation Packet*. The minimum time for a nurse supervisor is 20 hours a week with a team of no more than four individual nurse home visitors. Though NFP discourages smaller teams, even teams with less than four nurse home visitors still require at least a half-time supervisor. Existing teams that are already in place but do not meet these expectations should consult with their nurse consultant.

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

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

- 1) One-to-one clinical supervision: A meeting between a nurse and supervisor in one-to-one weekly, one-hour sessions for the purpose of reflecting on a nurse's work including management of her caseload and quality assurance. Supervisors use the principles of reflection as outlined in NFP supervisor training. Supervisors who carry a caseload will make arrangements for clinical supervision with reflection from a qualified person other than the nurse home visitors he/she supervises.
- 2) Case conferences: Meetings with the team dedicated to joint review of cases, Efforts to Outcomes (ETO™) data reports and charts using reflection for the purposes of solution finding, problem solving and professional growth. Experts from other disciplines are invited to participate when such input would be helpful. Case conferences reinforce the reflective process. Case conferences are to be held twice a month for 1 ½ to 2 hours per case conference.
- 3) Team meetings: Meetings held for administrative purposes, to discuss program implementation issues, and team building twice a month for at least an hour or as needed for team meetings. Team meetings and case conferences alternate weekly so there is one meeting of the team every week.
- 4) Field supervision: Joint home visits with supervisor and nurse. Every four months the supervisor makes a visit with each nurse to at least one client and additional visits on an as needed basis at the nurse's request or if the supervisor has concerns. At a minimum, time spent should be 2 – 3 hours per nurse every four months. Some supervisors prefer to spend a full day with nurses, enabling them to observe comprehensively the nurse's typical day as well as her home visit, time and case management skills and charting. After joint home visits with a supervisor and nurse, a Visit Implementation Scale is completed and discussed.

PROGRAM MONITORING AND USE OF DATA

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

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

AGENCY

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

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

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

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

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

Support includes the necessary infrastructure to support and implement the program. This includes the necessary physical space, desks, computers, cell phones, filing cabinets and other infrastructure to carry out the program. Further, this includes employing a person primarily responsible for key administrative support tasks for

NFP staff, as well as entering data and maintaining accuracy of ETO reports. This resource is critical to ensuring administrative support and accuracy of data entry, allowing nurse home visitors time to focus on their primary role of providing services to clients. NFP Implementing Agencies shall employ at least one 0.5 FTE general administrative staff member per 100 clients to support the nurse home visitors and nurse supervisors and to accurately enter data into the Nurse-Family Partnership National Service Office ETO database on a timely basis.

References

Korfmacher, J., Kitzman, H., & Olds, D. (1998) Intervention processes as predictors of outcomes in a preventive home-visitation program. *Journal of Community Psychology, 26*, 49-64.

Olds, D. (2006) The nurse-family partnership: An evidence-based preventive intervention. *Infant Mental Health Journal, 27*, 5-25.

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

Olds, D., Racine, D., Glazner, J., & Kitzman, H. (1998) Increasing the policy and program relevance of results from randomized trials of home visitation. *Journal of Community Psychology, 26*, 85-100.

Exhibit C

**Nurse-Family Partnership
Network Partner Rate Schedule
2019—2020**

The Nurse-Family Partnership National Service Office (NSO) is an independent nonprofit organization that exists to license and promote the NFP program. NSO also provides research, education, support implementation and improvements to ensure the model continues to produce positive results for moms, babies, families and communities. As an independent nonprofit, the NSO receives no government funding and although it helps obtain and sustain funding network partners receive to implement the program, such as MIECHV, it does not directly receive any of those funds. Fees represent a way for network partners to contribute to the overall shared costs of the NFP model they implement. Historically, fees have been set well below actual costs and generous private philanthropy has enabled the NSO to continue to operate. For the year ending September 30, 2019, total fees received represented 33% of actual operating and capital expenditures.

	<u>Effective</u> <u>1/1/2019</u>	<u>Effective</u> <u>1/1/2020</u>
<u>NFP Program Participation</u> (annual, per supervisor)		
Program Support	\$ 8,328	\$ 8,580
Nurse Consultation, first supervisor at location	\$ 9,984	\$ 10,284
Nurse Consultation, co-located supervisor	\$ 6,402	\$ 6,594
<u>Education</u>		
Nurse Home Visitor, Initial Education	\$ 4,808	\$ 4,952
Nurse Supervisor Education	\$ 868	\$ 895
Nursing online and initial educational materials	\$ 611	\$ 629
Administrator Education	\$ 568	\$ 585
<u>Other</u>		
Supervisor expansion/replacement, per occurrence	\$ 3,269	\$ 3,360
Specialized, custom information systems or other services:	<i>Please contact us</i>	

Please note that these prices go into effect on your contract anniversary date within the calendar year noted above. Thus if your contract anniversary date is June 1, you would have 2019 prices from 6/1/19 – 5/31/20.

Please remember that we all operate in a dynamic and evolving environment that may necessitate changes. For questions or additional information, please contact Sally Isaacson at 303.327.4279 or at Sally.Isaacson@nursefamilypartnership.org