Supporting First-Time Mothers: South Carolina Nurse-Family Partnership Project

The Government Performance Lab (GPL) provided pro bono technical assistance to help South Carolina’s Department of Health and Human Services launch the Nurse-Family Partnership Pay for Success (PFS) project. The project will provide 4,000 low-income mothers and their children with comprehensive nurse home visiting services.

The Challenge: Without proper prenatal and postpartum care, mothers and infants are at a higher risk of negative health outcomes such as preterm births or infant mortality. In many cases, these negative outcomes can be mitigated by nurse home visits from the start of pregnancy through the first few years of a child’s life. In particular, nurse home visiting programs have been shown to reduce child injuries, increase spacing between subsequent births, improve prenatal health for mothers, and improve child well-being overall. In South Carolina, some new mothers have been receiving home visits through the state’s Maternal Infant Early Child Home Visiting (MIECHV) program. However, this program only permitted two home visits per family, well below the threshold of evidence of a positive impact on health outcomes. In addition, due to limited MIECHV resources, many low-income first-time mothers weren’t receiving any home visiting services at all.

The Project: The South Carolina Department of Health and Human Services (SCDHHS) aimed to improve health outcomes for low-income mothers and infants by expanding nurse home visiting services. The GPL helped SCDHHS design a PFS project with Nurse-Family Partnership (NFP), a national model for home visiting already operating in the state. The project was able to:

1. **Expand comprehensive home visiting services to 4,000 mothers and their children.** Over six years, NFP aims to deliver preventive services through nurse home visits to 4,000 mothers and their children. Mothers will be eligible for up to 40 home visits from early in their pregnancy until their child’s second birthday. Registered nurses provide a range of health and development services to during the visits, including instruction on prenatal care, parenting coaching, and training in economic self-sufficiency. Nine implementing agencies, including hospitals and health clinics, will be responsible for service delivery.

2. **Design referral and enrollment systems that match low-income, first-time mothers to services.** The state aimed to provide services to low-income, first-time mothers who tend to be most at risk of negative outcomes. However, in practice it is often difficult to ensure high enrollment and service uptake levels among this population. As part of the project, SCDHHS designed the enrollment process to require that all program participants be first-time mothers who are eligible to receive Medicaid. To reach more low-income mothers, the state also set a target for the percentage of enrollees living in zip codes with poverty rates above 15 percent.
3. **Implement a rigorous evaluation that extends to testing the project’s long-term impact.** Although this project expands home visiting to 4,000 mothers across the state, there are still more mothers who are eligible to receive NFP’s services. The state decided to use this gap in service delivery to evaluate the program with a randomized controlled trial (RCT), the gold standard in evaluation design. In addition to the rigorous short-term RCT that will determine success payments, the project has built in a long-term evaluation of NFP’s impact on mothers and children to measure its effectiveness.

**The Innovations:** Although the nurse home visiting model functions in several states, this project employed several innovative components to expand and evaluate services in South Carolina. Innovations include:

1. **Testing program delivery with a pilot period to ensure smooth referral, enrollment, and data sharing processes.** Although NFP had already been operating in South Carolina, this project mandated changes in enrollment protocols and data collection. A three-month pilot period enabled implementing agencies to test these new procedures with a group of 100 women and to make adjustments accordingly. It also gave project partners additional time to refine data sharing agreements so that progress could be comprehensively tracked.

2. **Developing a payable outcome metric focused on enrollment to incentivize serving the highest-risk target population.** In order to incentivize implementing agencies to enroll low-income mothers who may have more risk factors, project partners made enrollment from low-income zip codes a payable outcome. This is the first PFS project to use zip codes in this way. Additional payable outcomes for the project include reductions in child injury rates, preterm births, and rapid repeat pregnancies.

3. **Partnering with the federal Centers for Medicare and Medicaid Services to pool resources and expand services.** SCDHHS received a federal 1915(b) waiver from the Centers for Medicare and Medicaid Services, which allow NFP to bill Medicaid directly and to increase the number of billable home visits from two to 40. This waiver reduced the financial burden on the state by allowing the federal government to pay for a portion of the project’s costs. This mix of fee-for-service (from the federal government) and pay for success (from the state government) has maximized state and investor dollars to improve service delivery for a much larger total amount of services.

4. **Utilizing philanthropic investment to rollover success payments back in to the project.** Philanthropic investors contributed $17 million to fund upfront operations of the project. These investors have pledged to roll over any success payments back into the project operating budget, allowing for ongoing NFP services in the state.