STATEMENT OF
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BEFORE THE
HOUSE COMMITTEE ON WAYS & MEANS
SUBCOMMITTEE ON HUMAN RESOURCES

MARCH 15, 2017

Good morning Chairman Smith, Ranking Member Davis, and members of the subcommittee. Thank you for the opportunity to testify on behalf of Nurse-Family Partnership (NFP) and Lancaster General Health/Penn Medicine in support of evidence-based home visiting and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to strengthen families living in poverty.

I am Beth Russell and I have worked as an NFP Nurse Home Visitor for nearly five years. I have the privilege of helping new mothers become the best moms they can be for their babies. As a nurse home visitor, I serve a regular caseload of 25 first time, low-income mothers and their families, including my client who is with me today, Rosa Valentin.

Every year, 380,000 children are born to first time mothers living below the federal poverty level in the United States. Nationwide, the NFP model has served over 253,000 families since replication began in 1996, and currently has over 32,000 first-time mothers enrolled in 42 states, 6 tribes, and 1 territory (USVI). We believe that the national replication of our program is dramatically improving lives of vulnerable families and yielding significant returns to society by more stable and productive families. We start at the beginning – where there is the most opportunity – during pregnancy –to have the most impact on that baby's life. By starting early, Nurse-Family Partnership builds confident parents, strengthens families, prevents tragedies, improves outcomes for communities, and saves government money. For every 100,000 families served by NFP, research demonstrates that 14,000 fewer children will be hospitalized for injuries in their first two years of life; 300 fewer infants will die in their first year of life; 11,000 fewer children will develop language delays by age two; 23,000 fewer children will suffer child abuse and neglect in their first 15 years of life; and 22,000 fewer children will be arrested and enter the criminal justice system through their first 15 years of life, among other outcomes.

NFP currently serves 45 of Pennsylvania's 67 counties. The first three sites were started in 1999 through the Pennsylvania Commission on Crime and Delinquency. In 2001, then- Governor Tom Ridge and the Pennsylvania Department of Human Services utilized unspent Temporary Assistance for Needy Families (TANF) funds to help expand Nurse-Family Partnership to 20 additional locations throughout the Commonwealth. In 2012, a significant expansion of Nurse-Family Partnership services was made possible through MIECHV, and today, NFP has the capacity to serve over 4,000 moms across the state. My implementing agency, Lancaster General Health/Penn Medicine, strongly supports implementation of the NFP model, which serves 225 moms throughout the county. The mission of Lancaster General Health/Penn Medicine is to "advance the health and well-being of the communities we serve." The young mothers and children that the NFP program serves is an integral part of its long-standing commitment to these families and their future. Our clinical, community wellness and community benefit commitments also wrap themselves around these families. A multitude of unfortunate factors in the community make Nurse-Family Partnership a critical element of the county's continuum of services for prevention and families in need.

NFP is a voluntary program that provides regular home visits to first time, low-income mothers by registered nurses beginning early in pregnancy and continuing through the child's second year of life. Each woman is partnered with her own free, personal nurse – a nurse that can be there for her, getting to know her during pregnancy, and building trust with her family to offer critical support when it is most needed.

The children and families NFP serves are young, living in poverty, and at the highest risk of experiencing significant health, educational and employment disparities that have a lasting impact on their lives, their families, and communities. The average age of our clients is usually around 18-19 years old, which puts both the mom and the child at risk for a number of challenges. For example, studies have shown that only 38% of young women who have a child before age 18 complete high school, and their children score significantly worse on measures of school readiness [i]. NFP nurses help them stay focused on their goals and what they want for their baby's future. Nationally, 28 percent of families served by Nurse-Family Partnership are Hispanic; 29 percent are African-American; 24 percent are Caucasian; 5 percent are Native American or Alaskan Native; and 2 percent are Asian/Pacific Islander (the remainder declined to identify).

NFP nurses and their clients make a 2.5-year commitment to one another, and develop a strong relationship over the course of 64 planned visits that focus on the strengths of the young mother and on her personal health, quality of care giving, and life course development. Their partnership is designed to help families achieve three major goals: 1) improve pregnancy outcomes; 2) improve child health and development; and 3) improve parents' economic self-sufficiency. By achieving these program objectives, many of the major risks for poor health and social outcomes can be significantly reduced.

In addition to our clinical training as registered nurses, NFP nurses are trained in a variety of developmental concepts and assessments. Nurses are able to work one-on-one with each mom to improve her child's development and teach her what is valuable at each stage of the baby's life. They are also able to answer questions when a new mom thinks something may not be right with her child and needs a nurse's expert clinical advice. NFP nurses use Partners in Parenting Education (PIPE) lessons to teach clients a variety of concepts such as attachment, bonding, early language and the importance of reading and literacy. We also perform continual assessments of the child's growth and development and use tools such as the Ages and Stages Questionnaire (ASQ) at prescribed times help influence visit content and activities. By addressing deficits discovered through regular contact and use of the evaluative tools, nurses are able to instruct clients in a variety of ways such as floor play, demos with a doll, videos, handouts, and then finally, if necessary, a referral to early intervention. Lastly, using the NFP Strengths and Risks (STAR) framework we regularly access a variety of client risk factors and changes in areas such as personal health, home safety, unsafe family/friend network, and economic adversity. It helps us serve clients better, maintaining engagement with NFP and the visit schedule.

As a nurse home visitor, I serve many different kinds of clients. Truly, you never know what you will encounter until you meet with that mom for the first time. However, in every instance, I meet the client where she is and hopefully, I can be a positive force for good in her life amidst often stressful situations.

When I first met Rosa in early 2015, I met a scared, quiet, 14-year old with little direction other than that she was four months into an unplanned pregnancy and wanted to do the right thing for her baby. She was anxious and unsure if she could be good mom, and did not want to give up on her goals to finish high school and further her education. Rosa had her whole life ahead of her and was still figuring out who she wanted to be. Unlike many of my clients, Rosa had supportive

parents who wanted to help her, but Rosa sought guidance, health advice, and one on one support as she attempted to navigate becoming a parent at such a young age.

I quickly realized during that first encounter that it would take some work to open Rosa up to me, so I took my time to make her comfortable. Combine the uncertainty of being pregnant for the first time with being a teenager, and Rosa had a lot of anxieties she needed to share. "I need to vent," Rosa would say. I was there to listen at each visit and became the person Rosa could open up to.

I had Rosa make a list of her needs and goals, and at that first visit made several referrals to get her the right services that she needed to complement our visits. I referred her to A Woman's Concern, which is a local pregnancy support organization in Lancaster that provides education support for parents, and Teen Elect, which helps pregnant and parenting students complete their education goals. Rosa was already attending Cyber School, a program that allows you to complete your high school diploma primarily online. While she had a strong desire to finish, she needed confidence to continue given her pregnancy and impending motherhood.

Rosa had a generally healthy pregnancy, but she struggled with the fact that the child's father was not around as much as she would have liked, and disappointment about not having the type of family she would have liked to bring a child into. Additionally, routine screening for depression did show that Rosa had elevated scores which prompted conversations about counseling. NFP's client centered approach allowed Rosa to make this decision, and while initially she did not want to see a counselor, she eventually agreed and now sees how it helped her. Through lots of individual conversation, reflection and, to be honest – venting -- she was able to get past the things that were holding her back and focus on the parent that *she* wanted to be for her child. I also know that our conversations about health and wellness—prenatally, post-natal, and for her child—were important to her and helped reassure her when she was concerned.

Now, two years after our first meeting, Rosa is the proud, confident parent of 20-month old Angelica, who is here with us today. She is a junior in high school, and on track to graduate next year. She has also been accepted into a local vocational-technical program where she plans to enroll next year. Initially, she was interested in cosmetology, but has a growing interest in the field of healthcare. Learning lots of new medical terminology over the course of her pregnancy and being a mom might have had something to do with that! In addition, Angelica continues to be a very healthy child, up-to-date on all well child visits and immunizations, and has excellent developmental scores that reinforce Rosa's positive and responsive caregiving.

In my role as a nurse home visitor, I work with each client to help her to establish and pursue her education, employment, and life course development goals. While Rosa was initially very unsure about where this road would take her, she had the sheer will to try to make the best of it and it is that determination – those glimmers of achievement along the way—that keep me doing the work that I do has a nurse home visitor. I am so proud of her progress, and her willingness to share her story with you today.

Rosa's story is just a glimpse of the impact that Nurse-Family Partnership has on low-income, first-time parents. Rosa is one of over 250,000 that have been partnered with a registered nurse through Nurse-Family Partnership. This program is backed by over 40 years of evidence, and

each visit to a new mom's home is tracked to measure the impact we are making in a young family's life. NFP can help break the cycle of poverty by empowering young mothers to become knowledgeable parents who are able to confidently care for their children and guide them along a healthy life course. NFP nurses use a client-centered approach, which means the nurse is constantly adapting to the needs of the family, ensuring that each visit is relevant and valued by the parent(s). These client-centered principles drive our practice with families to create positive, lasting change for the family that sustains long after our time as their nurse home visitor has ended. These principles include:

- The client is the expert on her own life. When the client is the expert, you build solutions based on information provided by the client on what's relevant and valued to her.
- Follow the client's heart's desire. The client leads the way and the central focus is on what the client wants. Find out what they want to do and help them do it.
- Focus on strengths. By focusing on capabilities, opportunities and successes, while being aware of risk factors, you can support the client through tough situations and encourage them to move forward, in turn, helping them to develop this strength within themselves that can sustain long after my visits are completed.
- Focus on solutions.
- Only a small change is necessary. The experience of one small success builds self-efficacy and causes a ripple effect in other areas of functioning and creates a context for bigger changes.

NFP nurses also continue to monitor the model's progress in the field through data collection, which nurses submit to the national database, and receive quarterly and annual reports evaluating the local program's ability to achieve sizeable, sustained outcomes. Each NFP implementing agency's goal is not only to improve the lives of first-time families, but also replicate the nurse home visitation model that was proven to work through rigorous research.

NFP is an evidence-based program with multi-generational outcomes that have been demonstrated in three randomized, controlled trials that were conducted in urban and rural locations with Caucasian, African-American and Hispanic families. A randomized, controlled trial is the most rigorous research method for measuring the effectiveness of an intervention because it uses a "control group" of individuals with whom to compare outcomes to the group who received a specified intervention. The NFP model has been tested for over 40 years through ongoing research, development, and evaluation activities conducted by Dr. David L. Olds, founder of the NFP model and Director of the Prevention Research Center for Family and Child Health (PRC) at the University of Colorado in Denver.

Dr. Olds and his research team have conducted three randomized, controlled trials with diverse populations in Elmira, NY (1977), Memphis, TN (1987), and Denver, CO (1994). Evidence from one or more of these trials demonstrates powerful outcomes including the following (in connection to each of NFP's program goals):

Improved pregnancy outcomes

- Reductions in high-risk pregnancies as a result of greater intervals between first and subsequent births, including a 28-month greater interval between the birth of first and second child.
    - 31% fewer closely spaced (<6 months) subsequent pregnancies,
    - 23% reduction in subsequent pregnancies by child age two, and
    - 32% reduction in subsequent pregnancies for the mother at child age 15 (among low-income, unmarried group)
- 79% reduction in preterm delivery among women who smoked
- 35% fewer hypertensive disorders during pregnancy

Improved child health and development

- 39% fewer injuries among children (among low-resource group)
- 56% reduction in emergency room visits for accidents and poisonings
- 48% reduction in child abuse and neglect
- 50% reduction in language delays of child age 21 months
- 67% reduction in behavioral and intellectual problems at child age 6
- 26% improvement in math and reading achievement test scores for grades 1-3
- 59% reduction in arrests at child age 15
- 90% reduction in adjudication as PINS (person in need of supervision) for incorrigible behavior

Increased family self-sufficiency

- 61% fewer arrests of mothers at child age 15
- 72% fewer convictions of mothers at child age 15
- 20% reduction in welfare use
- 46% increase in father presence in household
- 83% increase in labor force participation of mothers at child age 4

As the NFP model has moved from science to practice, great emphasis has been placed on building the necessary infrastructure to ensure quality and fidelity to the research model during the replication process nationwide. In addition to intensive education and planned activities for nurses to conduct in the home, NFP has a unique data collection system called Efforts-to-Outcomes (ETO) that helps NFP monitor program implementation and outcomes achieved. It also provides continuous quality improvement data that can help guide local practices and monitor staff performance. NFP's ETO system was designed specifically to record family characteristics, needs, services provided, and progress towards accomplishing NFP program goals.

NFP applauds Congress for their bipartisan, bi-cameral support for the MIECHV program, and in particular, this committee for your collective commitment to funding programs proven to work through rigorous, scientific evidence and research. The MIECHV program provides critical funding to states, territories, tribes and tribal organizations to implement and expand evidence-based home visiting services that have been proven to produce significant health, educational and economic outcomes for low-income children and families. MIECHV grantees have established benchmark requirements that will measure effectiveness of these programs on reducing poor

birth outcomes, child abuse, neglect and injuries, cognitive and learning disabilities, dependence on public assistance, and juvenile delinquency and crime, among other outcomes. These outcomes are saving state and federal government significant resources in reduced health, child welfare, foster care, remedial education and criminal justice expenditures. State governments have invested in Nurse-Family Partnership and other evidence-based home visiting programs for decades because of the impressive outcomes and cost-savings resulting from improved child and family outcomes. The MIECHV program is strong and cost-effective federal policy that is joining states and local agencies to support these valuable services to at-risk families.

Without congressional action, this program, which funds my work and is helping young moms like Rosa and young children like Angelica, will expire this September. I hope that Congress takes swift action to reauthorize the MIECHV program for at least five years with the increased funding that it needs to reach more families.

Independent evaluations have found that investments in NFP lead to significant returns to society and government (Washington State Institute for Public Policy, 2004 & 2008; 3 RAND Corporation studies 1998, 2005, 2008; Blueprints for Violence Prevention, Office of Juvenile Justice and Delinquency Prevention; and Pacific Institute for Research & Evaluation). Blueprints identified NFP as 1 of 11 prevention and intervention programs out of 650 evaluated nationwide that met the highest standard of program effectiveness in reducing adolescent violent crime, aggression, delinquency, and substance abuse. The RAND and Washington State reports weighed the costs and benefits of NFP and concluded that the program produces significant benefits for children and their parents, and demonstrated a savings to government in lower costs for health care, child protection, education, criminal justice, mental health, government assistance and higher taxes paid by employed parents. Most recently, the Pacific Institute for Research & Evaluation released a study in August 2015, which found significant government savings from the NFP model in particular, Medicaid and health care cost savings. This study projects that NFP will reduce Medicaid spending per child by 8.5% from birth to age 18, leading to $2.2 billion in total savings for the 177,517 children served by operational programs from 1996-2013. The study also projects that NFP will reduce estimated spending on Temporary Assistance by Needy Families (TANF) by $250 million and on food stamps by $540 million (present value in 2010 dollars), resulting in $3.0 billion in total governmental savings. By comparison, NFP costs $1.6 billion to serve those children and their families.

Nurse-Family Partnership thanks the subcommittee for your continued interest in harnessing the ability of evidence-based programs to improve the daily lives of people who need it most, and for your support of the MIECHV program, which has allowed states to implement and expand evidence-based home visiting services to reach more families in need. I hope that the Subcommittee will strongly support reauthorization of the MIECHV program. Thank you again, Chairman Smith, Ranking Member Davis, and Members of the Subcommittee, for the opportunity to testify today.

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[i] Ng, A. S., & Kaye, K. (2012). *Why It Matters: Teen Childbearing, Education, and Economic Wellbeing.* Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.