Statement of

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Chairman Pitts, Ranking Member Pallone, and Members of the Committee, thank you for the opportunity to testify today. I am Dr. Michael Lu, Associate Administrator of the Maternal & Child Health Bureau (MCHB) at the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS).

HRSA focuses on improving access to health care services for people who are uninsured, isolated or medically vulnerable. HRSA's mission is to improve health and achieve health equity through access to quality services and a skilled health care workforce. The Agency collaborates with government at the Federal, State, and local levels, and also with community-based organizations, to seek solutions to primary health care challenges.

We are pleased to have the opportunity to share with you today some of the activities underway in MHCB associated with the goal of enhancing access to care for women, children and families.

HRSA's Maternal & Child Health Bureau

As Associate Administrator of MCHB, I have the opportunity to direct programs with an overall mission of improving the health of America's mothers and children, including children with special healthcare needs, and their families. MCHB's vision for the Nation is one where all children and families are healthy and thriving.

We carry out our mission through targeted programs designed to improve maternal and child health in our nation. I am pleased to provide an overview and update on two of our programs: the Maternal, Infant, and Early Childhood Home Visiting and the Family-to-Family programs. Their activities are complementary but with different purposes and program design.

Home Visiting

The Maternal, Infant, and Early Childhood Home Visiting program, administered by HRSA in close collaboration with the Administration for Children and Families (ACF), aims to improve health and developmental outcomes for children and families who reside in at-risk communities through implementation of evidence-based voluntary home visiting programs. The Affordable Care Act provided initial funding of $1.5 billion in mandatory dollars for 2010 through 2014. The President's Fiscal Year (FY) 2014 Budget proposes to extend and expand this program in future years.

The Maternal, Infant, and Early Childhood Home Visiting program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to age five. Providers in the community work with parents who chose to participate in the program voluntarily to build the skills to help take care of their children and family. Priority populations include: low-income families; teen parents; families with a history of drug use or of

child abuse and neglect; families with children with developmental delays or disabilities; and military families.

The legislation requires that all grantees demonstrate improvement in six benchmark areas:

1. Improved maternal and newborn health;
2. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;
3. Improvement in school readiness and achievement;
4. Reduction in crime or domestic violence;
5. Improvements in family economic self-sufficiency; and
6. Improvements in the coordination and referrals for other community services and supports.

The strength of the overall Maternal, Infant, and Early Childhood Home Visiting program lies in its evidence-based approach. The program is built on decades of scientific research. This research shows that home visiting by a nurse, a social worker, or early educator during pregnancy and in the first years of life improves specific child and family outcomes, including prevention of child abuse and neglect, positive parenting, child development and school readiness. And that positive impact continues well into adolescence and early adulthood. For example, previous work in this area has shown that among 19-year old girls born to high-risk mothers, nurse home visiting during their mother's pregnancy and their first two years of life reduced their lifetime risk of arrest or conviction by more than 80 percent, teen pregnancy by 65 percent, and led to reduced enrollment in Medicaid by 60 percent.[1] There have been a number of return-on-investment studies. The most current one, funded by The Pew Charitable Trusts on Nurse Family Partnership, found that for every dollar invested in home visiting, you get $9.50 in return to society.[2]

In order to meet the legislative directive of prioritizing home visiting models that demonstrate evidence of effectiveness, HHS established rigorous criteria and conducted a systematic review of the research. This review determined that to date 14 models meet the evidence-based criteria. Since the models target different populations and support different interventions, 41 States have implemented more than one model. States are tailoring their programs to fit the needs of their different communities and population groups. The models most frequently selected by States are

[1] Eckenrode J, Campa M, Luckey DW, Henderson CR Jr, Cole R, Kitzman H, Anson E, Sidora-Arcoleo K, Powers J, Olds D. Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial. Arch Pediatr Adolesc Med. 2010 Jan;164(1):9-15.
[2] Miller, T., *"Nurse-Family Partnership Home Visitation: Costs, Outcomes, and Return on Investment: Executive Summary,"* (personal communication), 2012.

Nurse-Family Partnership, Healthy Family America, Parents as Teachers, and the Early Head Start-Home Based Model.

The Maternal, Infant, and Early Childhood Home Visiting program is being implemented on a national scale. There are three components to the program. All 50 States, the District of Columbia, and five territories received formula grants based on child poverty rates to provide home visiting services to at-risk families that chose to participate in the program. HHS also awarded competitive funding to 19 States for development grants focused on building the capacity of the workforce, data infrastructure, and care coordination and referral systems. Thirty-one States received expansion grants to build upon efforts already underway and expand services to more families and more communities. The home visiting program also includes a 3% set aside for grants to Tribes, Tribal and Urban Indian Organizations, which is administered by the Administration for Children & Families.

Most States started serving families through the home visiting program at the end of 2011. Our early data found that, within the first nine months of implementation in 2012, the program provided more than 175,000 home visits to over 35,000 parents and children in 544 communities across the country. Preliminary data from 2013 indicate that more than 80,000 parents and children are receiving home visiting services, and the program is now available in 656 counties across the country, which is 20 percent of all the counties in the United States, and includes three-fourths of urban areas that have populations over 500,000. As a result, we are expanding the reach of home visiting programs that have been proven critical in improving maternal and child health outcomes in the early years, leaving long-lasting, positive impacts on parenting skills; children's cognitive, language, and social-emotional development; and school readiness. This effort will help ensure that our most vulnerable Americans are on track from birth.

States and communities are the driving force in terms of carrying out this program. And while home visiting services may have existed in some States and communities before this program, they were often not evidence-based, quality was variable and services were often uncoordinated. With the support of this program, States and communities are building capacity in this area and have demonstrated improved quality, efficiency and accountability of their home visiting programs.

Several States are building upon the national Maternal, Infant, and Early Childhood Home Visiting framework and demonstrating strong leadership. For example:

> **California** is offering home visiting services to over 10,000 homes in the State where parents have chosen to participate. CA MIEHCV is a leader in providing home visiting workforce education and training to address the critical areas of domestic violence and mental health.

Georgia has tailored its focus to build on the capacity for the Georgia Home Visiting Information System, a centralized intake system that integrates state and local data systems to assure at-risk families are appropriately identified and receive home visiting services. At the state level, as Georgia utilizes multiple evidence-based home visiting models, families are matched to the appropriate models based on program expertise and availability. At the local level, central intake coordinators accept referrals, conduct standard screening, and connect families who chose to participate to local home visiting programs as appropriate.

Michigan is creating an evidence-based, data-driven, home visiting system utilizing three evidence-based models that will improve the well-being of families in eight high need communities with a special focus on improving birth outcomes and reducing health disparities. Michigan is also collaborating directly with Tribal communities and a MIECHV Tribal grantee to reduce infant mortality by the implementation of evidence-based home visiting with Tribal families.

Texas is implementing five evidence-based home visiting models and supports home visiting services through 24 sites distributed across seven communities in the State. With the support of the home visiting program, Texas continues to strengthen a data-driven, local early childhood system focused on improving school readiness. The Texas program is also working to enhance the abilities of home visiting program models to better engage fathers in home visiting services and their children's lives.

HRSA and ACF have taken a number of steps to ensure program effectiveness and accountability. HRSA and ACF provide ongoing technical assistance to grantees and encourage the dissemination of best practices, which accelerates collaborative learning across States. Additionally, HRSA and ACF closely monitor States' progress toward 37 outcome measures in six benchmark areas, such as improvements in breastfeeding and reductions in emergency room visits. These data are collected on an annual basis and, by October 2014, States are expected to demonstrate improvement in at least four of the six benchmark areas.

Furthermore, the law calls for a national evaluation to assess the impacts of Maternal, Infant, and Early Childhood Home Visiting using a random assignment study paired with a rich implementation and cost study. The goal of the national evaluation is to inform the field about specific program components that might lead to even greater positive outcomes for families. While each program model is based on research, this evaluation will not only identify which specific program features are associated with program outcomes across models but will also provide new learning to strengthen home visiting services in state and local communities.

<u>Family-to-Family Health Information Centers</u>

Additionally, HRSA administers a unique program that focuses specifically on providing support to families of children and youth with special health care needs. The Family-to-Family program helps families connect to and share information and resources, acquire the skills to partner with their children's health care providers, and better navigate the health care system.

History

From 2002 through 2007, 36 States received Real Choice Systems Change Grants for Community Living from the Centers for Medicare & Medicaid Services and MCHB to establish Family-to-Family Health Information and Education Centers for families of children with special health care needs to give information to and mentor other families. Funding for the Family-to-Family Health Information Centers was established by the Family Opportunity Act as a part of the Deficit Reduction Act of 2005 to provide information and support to parents of children with disabilities and special health care needs to partner with their health providers. The Affordable Care Act extended the program from 2010 through 2012. In FY 2013, the American Taxpayer Relief Act of 2012 (ATRA) extended the program for one year. The recently enacted Bipartisan Budget Act of 2013 extended funding for Family-to-Family Health Information Centers through April 1, 2014.

Family-to-Family Health Information Centers

A Family-to-Family Health Information Center is a statewide, family-staffed center that provides information, education, technical assistance and peer support to families of children with special health care needs about how to access health and related resources in their States and communities. Children with special health care needs are those children who have or are at risk for chronic physical, developmental, behavioral or emotional conditions, and who also require health and related services of a type or amount beyond that required by children generally. According to the 2010 National Survey of Children with Special Health Care Needs, approximately 11.2 million (or 15.1 percent) of children ages zero to 17 years in the United States have special health care needs. Nearly 60 percent of children with special health care needs experience more complex service needs beyond a need for prescription medications to manage their health conditions. Over one-third of parents of children with special health care needs reported difficulties in accessing needed community-based services and not feeling they, as parents, are treated as full partners in their children's care.

The Family-to-Family Health Information Centers are responsible for developing partnerships with those organizations serving children with special health care needs and their families, including State Maternal and Child Health Block Grants program, other parent/family-led organizations and patient navigator programs in their States. They are typically staffed by

parents of children with special health care needs. With their knowledge of and experience with state and community resources, they provide advice, offer resources, and access a network of other families and professionals for support and information.

In May 2012, $5 million in Affordable Care Act funding was allocated to support 51 HICs, one in each State and the District of Columbia. Each center received $95,700 to perform the activities outlined in statute. The ATRA in FY 2013 extended the $5 million funding for Family-to-Family Health Information Center to continue their activities outlined in the statute.

The centers assist States in developing and implementing a plan to achieve appropriate community-based systems of services for children with special health care needs and their families, including increasing families' confidence in relating to the health care system and their problem-solving capacity; culturally-appropriate communication between families and providers to reduce health disparity; and family participation—to improve transition, strengthen community-based systems, and decrease bottlenecks within specialty referral process. MCHB monitors program effectiveness by measuring six core outcomes that include: family/professional partnerships, medical home, early and continuous screening, adequate financing, community services and transition to adulthood. Family-to-Family Health Information Centers have made notable contributions to meeting these outcomes. A 2012 Family Voices report supported by HRSA on the activities and accomplishments of F2F HICs indicated approximately 200,000 families and 100,000 professionals received direct assistance and/or training from a center between June 2010 and May 2011.[3]

Conclusion

The work of these two programs are examples of full partnerships across Federal, State and local stakeholders focused on improving the health of America's mothers and children. They capitalize on a proven evidence based approach to services, the support and full engagement of families in addition to providers, and as a result, these programs are making a difference in growing human potential for some of the nation's most vulnerable children and families, including high-risk families and children with special health care needs.

I appreciate the opportunity to testify today, and I would be pleased to answer any questions you may have.

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[3] National Center for Family/Professional Partnerships. 2012 Activities & Accomplishments of Family-to-Family Health Information Centers. Albuquerque, NM: Family 2012. http://www.fv-ncfpp.org/files/5513/5066/2047/2012F2F-Booklet_10-19-2012-r.pdf.