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

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Good afternoon Chairman Reichert, Ranking Member Doggett, and Members of the Subcommittee. Thank you for the opportunity to testify on behalf of the Nurse-Family Partnership (NFP) program and Yakima Valley Memorial Hospital in support of evidence-based home visiting and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.

I am Crystal Towne and I have worked as a Nurse Home Visitor for the Nurse-Family Partnership program serving Yakima County, WA since 2003. I am here with one of my former clients, Sherene Sucilla, who graduated from the Nurse-Family Partnership 2 years ago and is a wonderful example of how this innovative program can empower young mothers to succeed. As a nurse home visitor, I serve a caseload of no more than 25 first-time, low income mothers and their families.

I am here in support of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program which is currently serving over 80,000 families nationwide and 1,320 families in Washington State. On behalf of the mothers, children and families served by Nurse-Family Partnership, I want to thank Chairman Reichert and the Members of this Subcommittee for their commitment to improving the health and well-being of children with dedicated funding for evidence-based home visiting programs. Your work is paving the way for a healthier, brighter future for at-risk children and families.

Every year, approximately 800,000 first time, low-income mothers become pregnant with their first child. Nationwide, the Nurse-Family Partnership (NFP) model has served over 190,000 families to date, and currently has over 28,000 first-time families enrolled in 43 states, including Washington State. National expansion of this program will dramatically improve the lives of at-risk families and yield returns to society in more stable and productive families. 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.

In Washington, the NFP model currently serves about 1,300 families throughout 14 counties and one tribal entity. NFP is one of several home visiting models offered as part of a continuum of services supported by the Washington Department of Early Learning and Thrive by Five Washington at the state level, which also include Parents as Teachers, Early Head Start Home-based option, and the Parent-Child Home Program among others. NFP services in Washington are implemented by several local health and community service agencies. Public investments such as the federal MIECHV grants and the state's Home Visiting Services account (HVSA) fund evidence-based home visiting but also support promising and research-based programs. The HVSA includes a private match on public dollars for evidence-based, research-based, and promising voluntary home visiting services; and infrastructure supports for home visiting programs, including training, quality improvement, and evaluation are delivered through Thrive by Five's Implementation Hub.

In Yakima, the Nurse-Family Partnership is operated by the Yakima Valley Memorial Hospital, in partnership with the Yakima Valley Farmworkers Clinic. The program is housed at Children's Village, and currently has the capacity to serve 150 families. The site uses innovative strategies to support funding the NFP program, including local support, federal MIECHV funding, and private support through the Thrive by Five Washington HVSA. Gang activity and high crime rates in the

area 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 low-income, first-time mothers by registered nurses beginning early in pregnancy and continuing through the child's second year of life. The program is free and voluntary to the women that enroll. 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. Nationally, 31 percent of families served by Nurse-Family Partnership are Hispanic; 27 percent are African-American; 42 percent are Caucasian; and 3 percent are Native American or Alaskan Native.

NFP nurses and their clients make a 2 ½ 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 with families is designed to help them 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.

Over the past 10 years, I have worked with hundreds of young parents, like Sherene, to help them feel empowered and supported while starting out with their first child. I am so proud to be their nurse, counselor, life coach, confidant, support system, and most importantly their friend through this journey. Every client's story is unique and since she is here with me today, I would like to share my experience as Sherene's nurse home visitor.

On May 6, 2010, I knocked on Sherene's front door for the first time. I did not know much about Sherene, only that she was 10 weeks pregnant and had spent her childhood living in several foster homes. She answered the door with a kind, warm smile and invited me inside. We spent the next 2 hours talking, connecting, and setting the foundation for what became a much longer relationship.

During that first encounter, there were several questions I wanted to ask, but did not. I wondered how a young pregnant woman could appear so happy and speak about her hopes and dreams for the future, but yet have several scars on her arms. I quickly recognized that Sherene's smile did not always appear easily, but she is a resilient woman who has hope, even in the face of past and current challenges.

Since meeting Sherene, several of those questions have been answered. Her father is deceased, and her mother has spent her life challenged with various addictions that ultimately led to her separation from Sherene. When she was 10, her grandfather died. She spent the next 8 years in foster care. Her grandfather's death had a huge impact. She describes him as an amazing man, who instilled the importance and love of education. He is the only person displayed on her living room wall.

I identified Sherene's family history with Type 2 diabetes – her sister, father, and grandmother all suffered from this disease. In addition, Sherene had a significant history of depression that was addressed numerous times during pregnancy although she elected for no intervention. However, this history did precipitate conversation related to post-partum depression and multiple Edinburgh Postnatal Depression Scales. Sherene was referred for essential primary care services such as her

Tdap and flu shots. I also helped her to find dental services when her own efforts to do so had failed.

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. Sherene was determined to continue with her education and despite attending seven different high schools, she graduated from high school on time. She now has a steady job in a wonderful career. Sherene's biggest priority is self-sufficiency and providing economic stability for her son, Andrew. It is also her dream to raise her son in a loving, supportive family. She and her husband were recently married and both share the dream of continuing to grow as a family. Sherene aspires to continue working towards her educational dreams, and she hopes to pursue a degree in social work. She feels it is her calling to connect with and support youth in our community. I know that she will be a great role model.

Stories like Sherene's are just a glimpse of the impact that Nurse-Family Partnership has on low-income, first time parents. NFP can help break the cycle of poverty by empowering young mothers to become knowledgeable parents who are able to 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 35 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's replication plan reflects a proactive, state-based growth strategy that maximizes fidelity to the

program model and ensures consistent program outcomes. NFP urges Congress to support a wide range of home visitation models that meet the highest level of evidentiary standards in order to ensure the largest possible economic return on investment. NFP applauds Congress for their bipartisan, bi-cameral support for the MIECHV program and in particular, this Subcommittee for your collective commitment to funding programs proven to work through rigorous, scientific evidence and research.

The bipartisan-supported 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.

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 report in April 2013 which found significant government savings from the NFP model in particular, Medicaid and health care cost savings. For example, in Washington, this formula translates into $19,023 in government savings per family by the child's 18th birthday, with 55% of these savings attributable to Medicaid. Recent analyses indicate that the costs of NFP compared to other home visitation programs fluctuate by region, and even though the NFP model is more intensive than other programs, it is not always more expensive.

The Nurse-Family Partnership thanks the Subcommittee for your continued interest in this important issue and in particular, the federal MIECHV program, which has significantly assisted states like Washington to implement and expand evidence-based home visiting servings to serve more needy families. States have embraced this accountable program to improve a host of conditions that hinder children and families from becoming healthy, thriving in school and achieving economic success. MIECHV saves scarce taxpayer resources and produces tangible results. I hope that the Subcommittee will continue to support the MIECHV program, which is serving thousands of vulnerable children and families nationwide. Thank you again, Chairman Reichert, Ranking Member Doggett, and Members of the Subcommittee, for the opportunity to testify today.