THE REAUTHORIZATION OF THE MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING (MIECHV) PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

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MARCH 15, 2017

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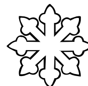

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THE REAUTHORIZATION OF THE MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING (MIECHV) PROGRAM

WEDNESDAY, MARCH 15, 2017

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 1100, Longworth House Office Building, Hon. Adrian Smith [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
Wednesday, March 15, 2017
HR–02

CONTACT: (202) 225–1721

Chairman Smith Announces Human Resources Subcommittee Hearing on the Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

House Ways and Means Human Resources Subcommittee Chairman Adrian Smith (R–NE), announced today that the Subcommittee will hold a hearing entitled "Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program" on **Wednesday, March 15, at 10:00 a.m. in room 1100 of the Longworth House Office Building**. This hearing will examine a range of home visiting models, review how States operate and fund programs, and highlight how an evidence-based home visiting program can produce positive outcomes for children and families.

In view of the limited time to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*Hearings*." Select the hearing for which you would like to make a submission, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, March 29, 2017**. For questions, or if you encounter technical problems, please call (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at *http://www.waysandmeans.house.gov/*

Chairman SMITH OF NEBRASKA. The Subcommittee will come to order.

Thank you for joining us here today. Welcome to our Human Resources Subcommittee hearing. Today we are here to discuss the Maternal, Infant, and Early Childhood Home Visiting program, known as MIECHV, which helps support State and local efforts to provide voluntary, evidence-based, outcome-focused home visiting services to parents and children at risk of adverse experiences. The program's objectives include promoting school readiness of young children, increasing economic self-sufficiency of families, improving prenatal health and birth outcomes, and preventing child abuse and neglect.

This hearing will examine a range of home visiting models, review how States operate and fund programs, and highlight how an evidence-based home visiting program can produce positive outcomes for children and families.

Federal funding for home visiting was first proposed in 2004 by Republican Senators Chris Bond and Jim Talent, both from Missouri. However, the first Federal funds for evidence-based home visiting were provided in fiscal year 2008 after Congress agreed to fund President George W. Bush's proposal to test this approach and measure the outcomes. The MIECHV program was fully authorized in fiscal year 2010 to continue these efforts and is now up for reauthorization this year.

I, like other Members of this Subcommittee, have had the opportunity to see firsthand what home visiting looks like in my community. Last Monday, I spent time with the Panhandle Public Health District's Healthy Families America program, which aims to improve the economic success and school readiness of vulnerable children and families in three Nebraska counties: Scotts Bluff, Morrill, and Box Butte. Dawn, one participant I met with on Monday, shared her experience of working with a home visitor who helped her find a stable home and a steady income in order to provide for her growing family. These are the types of outcomes we should be expecting and receiving from the use of limited taxpayer resources. Unfortunately, outcomes like these are the exception rather than the rule when we look around at how we help struggling families.

New Federal social programs have been evaluated to determine if they are working, and almost none have conditioned funding on evidence of effectiveness. In our Better Way agenda, we proposed measuring how well programs are working so we can focus funding on programs which produce real results. When we spend limited

taxpayer dollars to help those in need, we must make sure we are spending money on effective programs. To do otherwise is a disservice to both taxpayers as well as beneficiaries. MIECHV is one of the only social programs where funding is tied to proving evidence.

For a home visiting model to be funded, an evaluation must show the program has demonstrated significant, positive outcomes in areas such as reducing child abuse and neglect, improving maternal and child health, and improving economic self-sufficiency. Many of these approved models are now being further studied through a rigorous random assignment evaluation to better measure their impact so we know families are receiving real help. States have also been held accountable for demonstrating positive outcomes for children and families. If they don't show improvements in four of six areas specified in law, they have to explain how they plan to improve their services to get results, which again provide real help to struggling families.

A top priority for this Subcommittee in this Congress continues to be ensuring greater opportunity for Americans. Last week, I was grateful to learn more about how the Home Visiting program empowers Nebraska parents to provide a better life for their children, and I look forward to hearing more about similar efforts across the country today as we look forward to MIECHV reauthorization.

I now yield to the distinguished Ranking Member, Mr. Davis, for the purpose of an opening statement.

Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman. And I want to thank you for holding this hearing on evidence-based home visiting. I would like to ask unanimous consent to submit a group of stories that have—well, not really stories, but experiences that have been submitted about families in my district, and I would like to submit those for the record.

Chairman SMITH OF NEBRASKA. Without objection.

[The submission of Mr. Davis follows:]

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March 13, 2017

Examples of the Success of MIECHV-funded Services in Illinois

Illinois Pregnant and Parenting Youth in Care Pilot funded by MIECHV

The I Pick Home Visiting pilot provides home visiting to abused and neglect youth in the foster care system who are pregnant or parents. The pilot brings together the child welfare and early childhood systems to improve outcomes for youth in foster care and their children.

Maternal Infant Early Childhood Home Visiting (MIECHV) funding is supporting an innovative pilot program that provides evidence-informed home visiting services to young adults in the foster care system who are pregnant or who are already parents. The I Pick Home Visiting (IPPYC) pilot began in October 2016 and provides home visiting to eight communities in Illinois with the largest concentration of young adults in the foster care system who are parents or who are pregnant. Since October, 30 young parents have been referred to the program and eight are currently receiving services, with another eight parents and their children soon to be enrolled.

- Laura* became pregnant during her first year at Illinois State University (ISU). Originally from Chicago and as a youth in foster care, Laura had no support in the Bloomington-Normal area. Rather than drop out of school as she was advised to do by her foster care caseworker, Laura decided to continue at ISU and was referred to the Healthy Families home visiting program supported by MIECHV funding. Since her case was opened in February of this year, Laura has been linked with a doula who will assist her at her birth, attended WIC and doctor appointments, and connected to the Bloomington Crisis Nursery for postpartum support. The home visitor has also helped Laura to create a postpartum plan in concert with her professors at ISU to ensure she can continue to attend classes and complete assignments. Laura meets regularly with her home visitor and has expressed that she now feels more confident and prepared for the birth of her child.

Home visiting funded through MIECHV

These examples come from the MIECHV-funded Healthy Families home visiting program in Bloomington and Normal, Illinois in McLean County.

- After becoming pregnant at the young age of 16, Sarah* turned to the Healthy Families home visiting program in Normal, IL for support. Sarah's home visitor provides her with parenting education, encouragement, and access to child care so that she can remain in school and complete a Certified Nursing Assistant (CNA) program, all while parenting. Not only is Sarah at the top of her class in the CNA program, but she also maintains a 4.0 GPA in her other high school classes. Sarah has given up her extracurricular activities in order to care for her one-year-old son in the evening. Sarah says that being with her son is better than

any other activity she could be doing. Even at 16, this young mom is planning a brighter future for herself and her son.

- Erika* always planned to start college at a four-year university after high school, but with the birth of her son, her plans changed. Erika's home visitor worked with Erika to establish her family goals and help her achieve those goals, which include getting a college education. By providing young mothers with access to basic needs like clothing and diapers, the Healthy Families program allows mothers to focus on larger goals rather than worry about where they will get the next diaper. This past fall, Erika successfully enrolled at Heartland Community College in Bloomington. Over the past few months, she's had near perfect attendance and recently passed all of her classes with A's and B's. Although Erika misses her son while she's in class, she knows the sacrifice is for the good of her and her family. Erika has often has stated that getting an education is important to her because she wants to be a good role model for her son.

- Facing eviction from her Bloomington home, Alicia* turned to Healthy Families to help fight the eviction because she thought the eviction reason to be untrue and unfair. Alicia's home visitor helped her read the lease to understand her rights as a tenant, and also provided her with support to let her know she wasn't in the wrong or deserving of being treated that way. Healthy Families also linked Alicia with free legal counsel and the agency's Crisis Nursery care to take care of her children while she's in court. Alicia stated she primarily wanted to keep her home for her children's sake because she didn't want them to be raised in a shelter, which would've been her only other housing option had she been evicted. Through perseverance, resilience, and consistently seeking connection to resources, Alicia won her court case against her landlord and was able to remain in her home. Alicia was overjoyed to have won the case and states how relieved and blessed she is that her family is able to remain in their home together.

The examples below are from the South Side Early Learning Network (SELN), a MIECHV-funded coordinated intake and direct services collaboration serving the Greater Englewood community on Chicago's South Side. Much of the Greater Englewood community is in Mr. Davis' 7th Congressional District.

Henry Booth House *provides home visiting services as part of the South Side Early Learning Network funded by MIECHV.*

- Kyra and her boyfriend, Jared, have been participants in the home visiting program for nearly three years. In 2014, Kyra was a first-time mom with no income, living with her mother, while Jared lived in an unstable situation. With home visiting support, Kyra attended all of her prenatal appointments. After her son was born, Kyra wanted to work and was able to enroll in a job readiness program and obtain childcare through one of the Henry Booth House daycare centers. When her child turned one year old, Kyra started her first job as a cashier. During home visits, Jared began to see the importance of his role as a father and decided to return to school to get his high school diploma. With assistance from the home visitor, Jared is currently employed and a full-time student. Kyra and Jared also both learned how to budget and save money, which allowed the family to recently move into their first apartment. They are planning to get married in 2017. With home visiting support and encouragement, Kyra and Jared are stronger parents and a stronger couple.

ChildServ *provides home visiting services as part of the South Side Early Learning Network funded by MIECHV.*

- When Mary Ann enrolled in the home visiting program, she was pregnant and living in a homeless shelter. After expressing that living in the shelter was causing her stress, the home visitor went over breathing exercises with Mary Ann to help calm her anxiety. Through the home visiting program, Mary Ann attended all of her prenatal visits and was provided with a lead for a job and received interview coaching. Today Mary Ann is a pharmacy technician at Walgreens. With the assistance of her home visitor, Mary Ann is no longer homeless and now lives in a one-bedroom apartment, where she continues to attend group meetings and home visits.

Women's Treatment Center *provides home visiting services as part of the South Side Early Learning Network funded by MIECHV.*

- A young mother to three children, including two in foster care, Jessica was referred to Women's Treatment Center (WTC) in 2015. A victim of domestic violence, Jessica was referred to a therapist through WTC to help her recover from the traumatic experience of being shot by her mother's significant other. Jessica also received help with her special needs children. The home visitor made weekly visits and provided parenting coaching to Jessica. Jessica went to court in 2016 for reunification and her children were returned home. The judge remarked that he was impressed with the home visiting program and was confident that Jessica would continue to receive parenting support through the program.

- After her children were placed in foster care due to her alcohol addiction, Kate enrolled in the home visiting program at Women's Treatment Center. With the support of her home visitor, Kate was referred to a domestic violence support group that helped her separate from her abusive husband. Since she began the program, Kate has been dedicated to her weekly visits and her parenting education curriculum. Kate will go to court in April for reunification with her children, who are expected to be returned home. At a previous court hearing, the judge stated that he was very impressed with the progress that Kate has made.

Family Focus *provides home visiting services as part of the South Side Early Learning Network funded by MIECHV.*

- Brittany* enrolled in the home visiting program at the age of 16 with a one-year-old child. Growing up, Brittany experienced multiple, severe forms of trauma and was raised by caregivers who faced substance abuse, mental illness and poverty. As a result, Brittany struggled to have positive interactions with her baby. She was physically assaulted by her adult relatives several times while holding her son. As he grew into a toddler and continued to be exposed to violence and conflict in his home, the young child exhibited developmental delays, severe tantrums, aggression towards others and self-harming behavior. With the help of a therapist, Brittany began to understand how both she and her baby were impacted by the violence around them. She was able, through therapy and with coaching from the home visitor, to start making healthy decisions and to access resources to keep both her and her child safe. She grew more able to nurture him and to help him feel safe. Motivated by a

desire to give her child a better childhood than she had, and helped along by home visiting services, Brittany graduated high school on time and was the first in her family ever to enroll in college. She moved into a supportive housing program that provided a safe, peaceful environment for her and her child, and enrolled her child in a high-quality preschool. While the family still faces challenges, Brittany is employed and looking forward to moving into her own apartment. Brittany's son, who will start kindergarten next year, is helpful, inquisitive and playful. Moreover, his preschool teachers have not identified any delays or concerns regarding his learning or his emotional-behavioral functioning in school.

**All names have been changed to protect the identities of the individuals*

For more information, please contact Paula Corrigan-Halpern, Vice President, Public Policy + Strategic Initiatives at Children's Home + Aid, pcorriganhalpern@childrenshomeandaid.org or 312-424-6822.

Mr. DAVIS. Before I came to Congress, I worked in community health centers and saw firsthand how home visits by community health workers helped engage people to change behaviors and embrace preventative health approaches. I introduced my first bipartisan home visiting bill over a decade ago in 2005. And so I look forward to continuing this bipartisan work with you and other Members of this Committee.

Frederick Douglass said, “It is easier to build strong children than to repair broken men.” And I agree. Infants are more likely to enter foster care than any other age group, twice as likely as 1-year-olds and more than five times as likely as 11-year-olds. Several home visiting models, including Healthy Families America, which is headquartered in Chicago, have proven that home visiting is a tool that can keep these children safe at home.

Children at risk of foster care are not the only ones who benefit from home visiting. In my congressional district, nearly 60 percent of children 5 and under live in low-income families. Some of them are fortunate to be served by the Home Instruction for Parents of Preschool Youngsters, our HIPPY program, which has a long track record of working with parents of all backgrounds to prepare children to succeed at school.

The Federal Maternal, Infant, and Early Childhood Home Visiting program, or MIECHV, did not invent home visiting. My home State of Illinois has invested in home visiting for 30 years, and we are not alone. MIECHV has played a vital role in strengthening these State and local efforts. Where home visiting did not exist, MIECHV offered the neediest families this lifeline for the first time. In States with home visiting, like Illinois, MIECHV improved program coordination, reinforced the emphasis on proven models, and expanded availability of services. In my congressional district, MIECHV directly provides home visiting services to 219 additional families and has supported innovative pilot projects for homeless families and parenting foster youths.

MIECHV is built on a foundation of decades of research. The Department of Health and Human Services has identified 17 different models that meet its stringent tests for proven results. States, territories, and tribes can choose from a range of evidence-based models that allow them to target the right help to the right families at the right time. Some States even transition families from one model to another as children grow. In Illinois, MIECHV funds a central intake process to make sure families are directed to the most effective models for their needs.

Although home visiting models focus on different aspects of child well-being and use visitors with different qualifications, they have important commonalities. Home visitors form positive relationships with families to help them find strength in themselves and in their communities. They link families with critical supports like transportation assistance, substance abuse, and mental health treatment, child care, and economic support, and they measurably improve outcomes for children. MIECHV has already made a difference for tens of thousands of children and families. And as we continue to invest and home visiting models continue to learn from rigorous research evaluations, from careful data tracking, from the families and communities they serve, and from each other, I believe

we will be able to do even more to build strong children who grow into successful adults.

So I thank you, Mr. Chairman, and I yield back the balance of my time.

Chairman SMITH OF NEBRASKA. Thank you, Mr. Davis.

And without objection, other Members' opening statements will be made a part of the record.

I would like to welcome our witnesses here today. Thank you for joining us. This is a conversation that I think can help many folks, and so, certainly, it is a conversation that we can benefit from as we learn more from you.

I will introduce the panel we have here today. First, we have Ms. Beth Russell, nurse home visitor, Lancaster General/Penn Medicine. And Ms. Rosa Valentin. She is a client with Lancaster General/Penn Medicine. And Mr. Eric Bellamy, home visiting manager, Children's Trust of South Carolina. And Ms. Diana Rauner, president of The Ounce of Prevention Fund in Illinois.

Witnesses are reminded to limit their oral statements to 5 minutes. You will see the light there. With the yellow light there, you can look to perhaps, as they say, bring it in for a landing. And all of your written statements will be included in—your full written statements will be included in the record.

Right now, we will begin with Ms. Russell. You may begin when you are ready.

STATEMENT OF BETH RUSSELL, NURSE HOME VISITOR, NURSE-FAMILY PARTNERSHIP, LANCASTER GENERAL HEALTH/PENN MEDICINE, LANCASTER, PENNSYLVANIA

Ms. RUSSELL. 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 and Lancaster General Health/Penn Medicine in support of evidence-based home visiting and the Maternal, Infant, and Early Childhood Home Visiting program.

I am Beth Russell, and I have worked as an NFP nurse home visitor for nearly 5 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 here with me today, Rosa Valentin.

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.

As a nurse home visitor, I serve many 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 4 months into

an unplanned pregnancy and wanted to do the right thing for her baby. She was anxious and unsure if she could be a 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 the 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 anxiety she needed to share. "I needed to vent," Rosa would say. I was there to listen at each visit and become the person Rosa could open up to.

I had Rosa make a list of her needs and goals and 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 that provides education support for parents, and Teen Elect, which helps pregnant and parenting students complete their educational goals. Rosa was already attending Cyber School, a program that allows her to complete her 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 has helped her. Through lots of individual conversation and reflection, Rosa 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, postnatal, and for her child, were important to her and helped her to be reassured when she was concerned.

Now 2 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 health care. 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 her education, employment, and life course de-

velopment 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 as 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. The 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.

The MIECHV program is a strong and cost-effective Federal policy that is joining States and local agencies to support these valuable services to at-risk moms. Without congressional action, this program which funds my work and is helping young mothers 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 5 years with the increased funding that is needed to reach more families.

Thank you again, Chairman Smith, Ranking Member Davis, and Members of the Subcommittee for the opportunity to testify today and for your support of evidence-based home visiting programs.

[The prepared statement of Ms. Russell follows:]

STATEMENT OF
BETH RUSSELL
NURSE HOME VISITOR, NURSE-FAMILY PARTNERSHIP
LANCASTER GENERAL HEATH/PENN MEDICINE
LANCASTER, PENNSYLVANIA

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.

Chairman SMITH OF NEBRASKA. Thank you, Ms. Russell.
Ms. Valentin, you may begin.

STATEMENT OF ROSA VALENTIN, CLIENT, NURSE-FAMILY PARTNERSHIP, LANCASTER GENERAL HEALTH/PENN MEDICINE, LANCASTER, PENNSYLVANIA

Ms. VALENTIN. Good morning, Chairman Smith, Ranking Member Davis, and Members of the Subcommittee. Thank you for the opportunity to testify on behalf of the Nurse-Family Partnership program in support of evidence-based home visiting, and the Maternal, Infant, and Early Childhood Home Visiting program.

My name is Rosa Valentin, and I am a client with the Nurse-Family Partnership program delivered by Lancaster General Health in Lancaster, Pennsylvania. I am the incredibly proud mother of my daughter, Angelica, who is 20 months old and here with me today.

As a client, I have received regular visits about every other week from my NFP nurse home visitor, Beth Russell, starting when I was just 4 months pregnant. I am 16 years old and have lived in Lancaster my entire life with my mother and father. Two years ago, when I was 14 years old, I found out I was pregnant with Angelica. I was in shock. What am I going to tell my mother? Thankfully, my mom was supportive of my decisions to have the baby, and from the minute I saw her arms, legs, and fluttering heartbeat, I knew that I wanted to protect her from any harm and do what was best for her.

I heard about the NFP program through my doctor's office. Because I was a first-time mom and met the other eligibility requirements, they referred me to Lancaster General Health's NFP program and Beth. We set up an appointment for Beth to come to my home and talk more about the program. I was shy at first, but Beth helped me to start thinking about my goals and programs that were available to help me as a teenager. I started to look forward to our visits. Up until the point where I got pregnant, I had taken care of my little cousins as babies, but that was about it.

On June 23, 2015, at 2:39 p.m., my life changed. My baby girl was born weighing 6 pounds, 3 ounces, and measuring 19½ inches long. She had jet-black hair and black eyes. Now I had a lot to learn about taking care of my own baby, not to mention navigating my own personal challenges. I had experienced a lot of disrespect from my peers about my pregnancy, and although my mom and dad have always been there for me, I didn't have the support of my entire family. And although I initially expected Angelica's father to be a part of raising her, and I thought we would be together as a family to experience her milestones, ultimately he was not in the picture. This was very difficult for me, and I struggled to move past that, but I had to take care of my baby and reach my goals.

Beth helped me do just that. She has been there for me emotionally, sometimes just as a listening ear for venting or to provide suggestions on dealing with stressful situations so that I can get back to being the mom I needed and wanted to be.

Angelica is the love of my life. After I brought my baby girl home, it seemed like all I wanted to do was spend time with her, and there was so much to learn about taking care of a new baby.

Beth showed me how to bathe her for the first time and answered all of my questions about what was going on with my baby.

It was difficult to keep up as a new mom. I was still a high school student and started to fall behind on my online classes. Beth helped me not to lose sight of my goals for school. "This is what you wanted for yourself," she reminds me. She helped me to develop a routine for my daughter and find time for myself to study. It was exhausting taking care of a new baby, but Beth helped me to stay focused. I will go to college.

Beth also helped me find programs to support my parenting and educational goals and stick with them. When I initially questioned how long I could stick with breastfeeding, she encouraged me to set goals and do what I felt was right. My initial goal was 6 months, and today, I am still nursing my 20-month-old daughter, although trying to wean.

Like every new mom, I had concerns, and Beth has always been there to address them. Beth has also been a resource for my mom, who is usually involved with our home visits because she helps me take care of Angelica. It has meant so much to me to have a nurse at my side, someone who I could trust for advice when I was experiencing round ligament pain late in my pregnancy and was concerned about the baby, or had cramping while breastfeeding. Beth was also very helpful when I was worried about Angelica's weight because others thought she was too small or if she was learning things at the right pace. Beth was always able to reassure me that Angelica was growing well and passing her developmental screenings. She also helped me understand birth control options after pregnancy, and when I was under a lot of stress and needed counseling, Beth helped me understand why it was important to talk to somebody.

What I think is important for me to provide for Angelica is consistency. I am trying to follow the four C's of parenting: clear, calm, consequences, and consistency, and use encouraging words to help her realize what to do instead of what not to do. These concepts are all so important for me as my baby grows into a toddler. Every day I am so excited for all the new things she is learning and showing me. Angelica makes me proud every day, and I am so proud to see how much she has learned and how much she has grown.

When I found out I was pregnant, I was a freshman in high school. Now here I am with a beautiful blue-eyed, 20-month-old little girl, looking forward to my senior year and the Career and Technology Center's program for cosmetology. After I graduate, I would like to go on to college and graduate school and have a career as a prenatal nurse.

Even though being a mom at times isn't easy, Angelica is my motivation to do better, finish school, and have a career. I am lucky to say that I had the support to help me along the way. I truly hope that Congress will continue supporting the Maternal, Infant, and Early Childhood Home Visiting program, which supports great programs like Nurse-Family Partnership.

Thank you, Chairman Smith, Ranking Member Davis, and Members of the Subcommittee for the opportunity to testify today.

[The prepared statement of Ms. Valentin follows:]

STATEMENT OF
ROSA VALENTIN
CLIENT, NURSE-FAMILY PARTNERSHIP
LANCASTER GENERAL HEALTH/PENN MEDICINE

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

MARCH 15, 2017

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

My name is Rosa Valentin, and I am a client with the Nurse-Family Partnership program delivered by Lancaster General Health/Penn Medicine in Lancaster, Pennsylvania. I am the incredibly proud mother of my daughter, Angelica, who is 20 months old and here with me today. As a client, I have received regular visits about every other week from my NFP Nurse Home Visitor, Beth Russell, starting when I was just four months pregnant.

I am here on behalf of the mothers, children, and families like us that benefit from the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. I am honored to be here today to thank Chairman Smith and the Members of this Subcommittee in person for their commitment to improving the health and well-being of children with dedicated funding for evidence-based home visiting programs. This program has meant so much to me and my family, and I know that if every Nurse-Family Partnership mom could be here today to talk about their experience, they would be, because it is truly a life changing experience to be part of this program.

I am 16-years old I and have lived in Lancaster my entire life with my mother and father. Two years ago, when I was 14-years old, I found out I was pregnant with Angelica. I was in shock. I was in denial. I was scared, sad, disappointed; all I thought about was, "What am I going to tell my mother?" Thankfully, my mom was supportive of my decisions to have the baby. And from the minute I saw her arms, legs, and fluttering heartbeat I knew that I wanted to protect her from any harm and do what was best for her.

I heard about the Nurse-Family Partnership program through my doctor's office. Because I was a first-time mom and met the other eligibility requirements, they referred me to Lancaster's NFP program and Beth. We set up an appointment for Beth to come to my home and talk more about the program. I was shy at first, but Beth helped me to start thinking about my goals and programs that were available to help me as a teenager. I started to look forward to our visits.

Up until the point where I got pregnant, I had taken care of my little cousins as babies, but that was about it. On June 23rd, 2015 at 2:39 p.m., my life changed. My baby girl was born weighing 6lbs, 3oz, and measuring 19 ½ inches long. She had jet-black hair and black eyes. Now I had a lot to learn about taking care of my own baby, not to mention navigating my own personal challenges. I had experienced a lot of disrespect from my peers about my pregnancy and although my Mom and Dad have always been there for me, I didn't have the support of my entire family. And although I initially expected Angelica's father to be a part of raising her, and I thought we would be together as a family to experience her milestones, ultimately he was not in the picture. This was very difficult for me and I needed to move past that in order to take care of my baby and reach my goals.

Beth helped me do just that. She has been there for me emotionally, sometimes just as a listening ear for venting, or to provide suggestions on dealing with stressful situations so that I can get back to being the mom I needed and wanted to be.

Angelica is the love of my life. After I brought my baby girl home, it seemed like all I wanted to do was spend time with her and there was so much to learn about how to take care of a baby. Beth showed me how to bathe her for the first time, and answered all of my questions about what was going on with my baby. It was difficult to keep up as a new mom. I was still a student high school and started to fall behind on my online classes. Beth helped me not to lose sight of my goals for school. She helped me to develop a routine for my daughter and find time for myself to study. It was exhausting taking care of a new baby, but Beth helped me to stay focused.

I want to go to vocational school next year, and Beth has helped me to always keep that goal in sight. "This is what you wanted for yourself," she reminds me. I will go to college.

Beth also helped me find programs to support my parenting and educational goals—like Teen Elect and A Woman's Concern—and stick with them. When I initially questioned how long I could stick with breastfeeding, she encouraged me to set goals and do what I felt was right. My initial goal was six months, and today, I am still nursing my 20-month-old daughter, although trying to wean!

Like every new mom, I have had concerns, and Beth has been there to help me address them. Beth has also been a resource for my mom, who usually is involved with our home visits because she helps me take care of Angelica, and is helping me achieve my goals. It has meant so much to me to have a nurse at my side, someone who I could trust for advice when was experiencing round ligament pain late in my pregnancy and was concerned about the baby, or had cramping while breastfeeding. Beth was also very helpful when I was worried about Angelica's weight because others thought she was too small or if she was learning things at the right pace. Beth was always able to reassure me that Angelica was growing well and passing her developmental screenings. She also helped me understand birth control options after pregnancy, and when I was under a lot of stress, and needed counseling, Beth helped me understand why it was important to talk to someone.

Beth also encouraged me to think about the type of parent that I wanted to be. I thought about people who are parents in my life—some are too strict, some have no rules at all—and thought about what I thought was the best approach. I've decided I want both—rules, but not too many. What I think is important for me to provide for Angelica is consistency. I am trying to follow the "Four C's of parenting" (choices, consequences, consistency, and care) and use encouraging words that help her realize what to do instead of what not to do. These concepts are all so important for me as my baby grows into a toddler. Every day I am so excited for all the new things she is learning and showing me. She loves to look at books and point out things; she loves to play and she is very smart. We love to read together, and I know that I am doing the right things for her. Angelica makes me happy every day, and I am so proud to see how much she has learned and how much she has grown.

When I found out I was pregnant, I was a freshman in high school. Now, here I am with a beautiful blue-eyed 20 month-old little girl, looking forward to my senior year in the Career and Technical Center's vocational program for Cosmetology. After I graduate I would like to go on to college and graduate school and have a career as a Perinatal Nurse.

I know that I am a better mom today because of this program and Beth. It's been really special to look back at what I have done while I have been in the NFP program. I feel like so much has changed since I first began, and it is encouraging for me to see how far I have come. Nurse-Family Partnership really gave me the opportunity to be a good parent, and this gives me a proud feeling every day. If it was possible, I would appreciate the program extending to 3 years! Beth has been so helpful and I wish she didn't have to go after the 2 years. I don't know what it must be like to be a teen mom without this support, and I know there are so many more new moms just like me who are in need of it. Having a nurse like Beth, who I could trust with questions about my health when I was pregnant, breastfeeding when I was a new mom, child development as she grows, and life goals – helped me to be a successful parent.

Even though being a mom at times isn't easy, Angelica is my motivation to do better, finish school, and have a career. I am lucky to say that I had the support to help me along the way. I would certainly refer a friend to the NFP program because of all the opportunities and benefits that come with the program. NFP is the best program that anyone could have; having a nurse by your side through every step of the way to reassure you that you are not alone is something that every first time mom needs to hear.

I truly hope that Congress will continue supporting the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which supports great programs like Nurse-Family Partnership. Thank you, Chairman Smith, Ranking Member Davis, and the Members of this Subcommittee for the opportunity to testify today.

Chairman SMITH OF NEBRASKA. Thank you, Ms. Valentin. Well done.

Mr. Bellamy, please proceed.

STATEMENT OF ERIC BELLAMY, HOME VISITING MANAGER, CHILDREN'S TRUST OF SOUTH CAROLINA

Mr. BELLAMY. Good morning. Chairman Smith, Ranking Member Davis, and Members, please let me preface with I apologize for bringing this crazy weather from South Carolina to DC. But thank you for inviting me to represent South Carolina's perspective on MIECHV. I represent Children's Trust of South Carolina, the agency designated by the Governor to administer the State's MIECHV funding.

Thanks to MIECHV, South Carolina serves families in 39 of 46 counties. We still have a long way to go in reaching all the children and families who could benefit from home visiting. But that task would be significantly harder without MIECHV funds, specifically the direct services and the underpinnings for quality and accountability that MIECHV provides.

MIECHV funds voluntary, evidence-based home visiting to disadvantaged families with young children. Families receiving home visiting saw significant improvements in measures such as birth outcomes, child development screenings and referrals, prevention of child abuse and neglect, school readiness. These outcomes and the program's broader success are the results of a law that provides State and tribal grantees with a firm foundation in evidence-based practice and the flexibility to match these practices to individual community needs.

In 2010, Governor Sanford designated Children's Trust as the lead agency to implement and administer the State's MIECHV grant. Like other States, we conducted a needs assessment to determine which communities were most at risk and which proven interventions would best be suited to meet their needs. Our needs assessment identified counties with significant populations of families at risk for poverty, poor birth outcomes, child abuse and neglect, and low school readiness. Even in a State the size of South Carolina, no one approach meets the needs of all children and families.

We selected four evidence-based models to meet the needs of children and parents: Healthy Steps, Family Check-Up, Healthy Families America, and Nurse-Family Partnership. We have since added Parents as Teachers, and in 2013, we expanded from 12 counties to 38 counties. To date, over 6,200 South Carolina families have received MIECHV home visits.

This implementation process illustrates many of the strengths of the legislation. States tailor their approach to address statewide goals for improving early childhood outcomes. States can choose to address prenatal and infant health, child abuse and neglect prevention, and/or school readiness goals. States can also select any combination of approved models to deploy in targeted communities. Each State's home visiting network looks a little different. However, every MIECHV program is supported by the same evidence base and is held to the same requirements that document outcomes and demonstrate continuous quality improvement.

South Carolina can say with confidence and evidence that MIECHV continues to make important progress in improving the health and economic well-being of our vulnerable families. But MIECHV does more than fund direct services to children and families. It underpins the statewide foundation on which high-quality services depend. South Carolina's MIECHV grant allowed us to create the data system that collects and reports information on outcomes and provides funding for professional development and training for home visitors. These resources are available to all home visitors in the State, regardless of how their programs are funded.

Another defining strength of MIECHV is the robust and tiered evidence base. MIECHV's rigorous evidence standards give State legislators and philanthropies an objective validation for investing in home visiting. In South Carolina, we saw a significant increase in the philanthropic dollars flowing into existing home visiting programs after MIECHV was signed into law. While private philanthropy provided modest support for home visiting prior to MIECHV, in the years since 2011, we have seen an increase in support from organizations such as Duke Endowment Foundation, the Blue Cross and Blue Shield Foundation, the Boeing Foundation, and other private funders.

I realize my time is up, though there is much more that I could say. If you remember only one thing from South Carolina, I hope it is this: MIECHV is evidence-based policy that works to empower families, coordinate services, and unify systems.

I appreciate your time and attention this morning. I will be happy to answer any questions you may have. Thank you.

[The prepared statement of Mr. Bellamy follows:]

House Ways and Means Subcommittee on Human Resources Hearing on Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

March 15, 2017

Remarks by Eric Bellamy,
Home Visiting Manager, Children's Trust of South Carolina

Chairman Smith, Ranking Member Davis, and members, thank you for the privilege of testifying before you this morning. My name is Eric Bellamy. I am the at the Children's Trust of South Carolina, the agency designated by the Governor of South Carolina to administer the state's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding. I would like to thank you, Mr. Chairman, for inviting me to join this panel to represent a South Carolina perspective on home visiting and MIECHV. South Carolina is also a founding member of the Association of State and Tribal Home Visiting Initiatives (ASTHVI), an organization created to promote best practices, information sharing, and peer assistance among state and tribal administrators of home visiting programs. I thank ASTHVI for my colleagues' collective wisdom, which I also hope to convey to you today.

Last, but not least, I would be remiss if I did not acknowledge South Carolina's own Congressman Tom Rice, a member of this committee. Thanks to MIECHV funding, South Carolina has been able to establish home visiting programs in a majority of counties in the 7th Congressional district; indeed, MIECHV supports home visiting in 39 out of 46 counties in the state. While we still have a long way to go in reaching all the children and parents who could benefit from home visiting services, that task would be significantly harder without MIECHV funds, specifically the direct services and the underpinnings for quality and accountability that MIECHV provides.

The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) is widely pointed to as a model of effective, evidence-based policy. MIECHV funds voluntary, evidence-based services to disadvantaged families with young children in all fifty states, five territories, and the District of Columbia. Families receiving home visiting services are documented to show significant improvements across a number of key measures including birth outcomes, child development screenings and referrals, prevention of abuse and neglect, and school readiness. These outcomes, and the program's broader success, are the result of a law that provides state and tribal grantees with a firm foundation in evidence-based practices and the flexibility to match those practices with individual community needs.

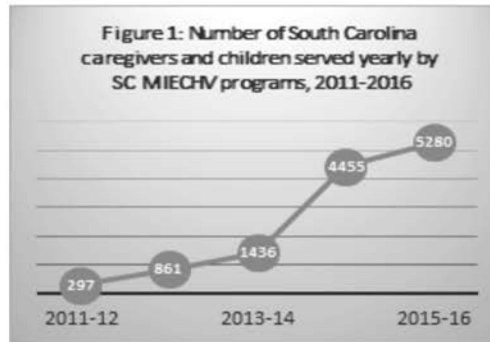
In 2010, Governor Sanford designated Children's Trust of South Carolina as the lead agency to implement and administer the state's MIECHV grant. Like each of the forty-nine

other states, South Carolina conducted a state-wide needs assessment to determine which communities were most at risk, and which proven interventions were best suited to meet their needs. One size does not fit all nationally, and even in a state the size of South Carolina, no one home visiting model meets the needs of all children and families. From our needs assessment, we initially identified five catchments, with outreach to twelve counties, with significant populations of families at risk for poverty, poor birth outcomes, child abuse & neglect and low school-readiness and developed a state plan to respond. Children's Trust determined that four of the models meeting HRSA's criteria for evidence-based programs could best meet the needs of children and parents in South Carolina's most disadvantaged communities: Healthy Steps, Family Check-Up, Healthy Families America, and the Nurse Family Partnership. In 2013, Children's Trust wrote for and received an expansion award through MIECHV. This has allowed us to now fund five evidenced-based models, including Parents as Teachers, and expand services through 16 local implementing agencies. As I mentioned, 39 out of 46 counties in the state are served by a MIECHV-funded model, and over 6,200 individual families have received MIECHV services to date.

The implementation process that South Carolina launched in 2011 illustrates many of the defining strengths of the MIECHV funding. States enjoy a high degree of flexibility to tailor their approach to meet community needs and address state-wide goals for improving early childhood outcomes for vulnerable families. Because the law includes multiple purposes, states can choose to address prenatal and infant health, child abuse and neglect prevention, and/or school readiness goals. States can also select any combination of the seventeen federally-approved, evidence-based models to deploy in targeted communities. As a result, each state's home visiting network looks different. But every MIECHV program is supported by the same evidence base and is held to the same requirements to document outcomes and demonstrate continuous quality improvement.

We can say with confidence – and evidence – that the MIECHV program in South Carolina continues to make important progress in improving the health and economic well-being of South Carolina's most vulnerable families and the early childhood workforce. Children's Trust has contracted with the Rural Health Research Center within the School of Public Health at the University of South Carolina to ensure that all supported programs are measured against legislative benchmarks and to implement a comprehensive evaluation process that assesses family, community, agency, and state-level systems, including workforce development.

6,261 caregivers and children have enrolled in South Carolina MIECHV programs since program inception in 2011. In the first reporting year of the program (2011-2012), South Carolina MIECHV implementing sites served 297 caregivers and children statewide (Figure 1). Enabled by expansion funding awarded in 2013, the South Carolina MIECHV programs enrolled over 2,900 new parents and children, and served almost 4,500 new or continuing caregivers and children in the 2014-2015 reporting year. In the most recent reporting year (2015-2016), an additional 1,630 new caregivers and children were enrolled and a total of 5,280 caregivers and children were served.



- Number of counties served: Expanded to 39 of 46 South Carolina counties;
- Performance measures: Improved or maintained 23 out of 34 performance measures and improved 78 percent of program benchmarks from 2014-2016;
- Home visits: 17,549 home visits in 2015-2016 and 48,426 home visits since 2010
- In 2015-2016:
  - 69 percent of families served were 100 percent under the Federal Poverty Line;
  - 66 percent of families served were from minority racial groups (52.4 = African American; 13.5 = Latino/Other);
  - 75 percent were headed by a single parent;
  - 99 percent of parents served received guidance about injury and safety;
  - 94 percent of children completed scheduled well-child visits;
  - 93 percent of families with a need at enrollment received and completed a referral;
  - 84 percent of parents improved positive parenting skills;
  - 99 percent of women had no second pregnancy within 12 months of giving birth;
  - 82 percent of post-partum women were screened for maternal depression.

Children's Trust elevated and expanded evidence-based home visiting in the state by concentrating on the areas of greatest need with strategic home visiting integration into primary healthcare and/or medical homes. Target areas and populations include those with the greatest need, with specific focus on child maltreatment, maternal and infant health, and school readiness. But MIECHV does more than fund direct services to children and families. It provides critical funding for the construction and maintenance of a statewide foundation on which high quality services depend. In South Carolina, our MIECHV grant allowed us to create the data system that collects and reports information on the outcomes our program produces for children and families. MIECHV also provides funding for professional development and training for home visitors. These resources are available to all home visitors in the state, regardless of how their programs are funded. This raises the quality of the entire home visiting

workforce in the state, and gives us a pool of effective, qualified family support workers to draw from as funding and caseloads fluctuate. In year five of program implementation, Children's Trust provided effective leadership and guidance for implementing agencies by offering multiple individual and collective learning opportunities for home visitors and site staff. These opportunities included a year-long continuous quality improvement (CQI) learning collaborative that addressed developmental screening and family engagement, and a statewide MIECHV retreat for all lead implementing site staff.

The South Carolina home visiting workforce is experienced and skilled, with the majority of home visitors having three or more years of social work experience (57 percent), healthcare experience (72 percent), or home visiting experience (62 percent). Home visitors are well-educated, with 95 percent having a college education or higher, and are also racially diverse: 53 percent-white; 42 percent-African American; 5 percent-"other." We continue to develop the skills of our family service workers. In 2015-2016, Children's Trust offered nineteen professional and workforce development opportunities for home visitors, including: a statewide Home Visiting Summit (289 participants); All-Sites spring meeting; virtual trainings/webinars on issues such as cultural competence, oral health, and child development; model trainings; reflective supervision training; and other supplemental offerings.

Another defining strength of the MIECHV legislation is the robust and tiered evidence base it has created, and which it continues to build. Each model on the Home Visiting Evidence of Effectiveness (HomVEE) list has met rigorous standards and produced peer-reviewed studies documenting their evidence of effectiveness. As the models are implemented in states, additional data is continually collected. States report data annually on benchmarks that represent the full scope of the MIECHV Program. This ongoing data collection ensures that individual programs across the country are faithfully replicating the model as it was evaluated and approved by HomVEE. The benchmarks also show the impact of MIECHV, holding states accountable for the federal investment they are charged with administering.

Besides ensuring model fidelity and accountability for outcomes, MIECHV's evidence base also helps states leverage other sources of funding for home visiting programs. Prior to the enactment of MIECHV, home visiting was adopted community-by-community. There was no national authority to evaluate model effectiveness and set standards for replicating those programs at scale. MIECHV created the first nationally accepted definition of an evidence-based program, and gave state legislatures and philanthropies an objective validation for investing in home visiting. Following the enactment of MIECHV, many states introduced legislation allowing, and often dedicating, state funds to be spent on evidence-based home visiting programs. In South Carolina, we saw a significant increase in the philanthropic dollars flowing into existing home visiting programs after MIECHV was signed into law. While private philanthropy provided modest support for home visiting prior to MIECHV, in the years since 2011 we have seen an increase in support from organizations such as the Duke Endowment Foundation, the Blue Cross and Blue Shield Foundation, the Boeing Foundation, and other private funders.

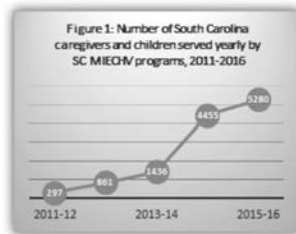
I realize my time is up, though there is so much more than I could say. If you remember only one thing from this hearing, I hope it is this: MIECHV is evidence-based policy that works; to empower families, to coordinate services and unify systems. I appreciate your time and attention this morning, and would be happy to answer any questions you may have.

SOUTH CAROLINA HOME VISITING

Home visiting in South Carolina is supported by a variety of public and private sources that collectively believe in its value. Importantly, one large philanthropy has served as a catalyst for other funding sources.

South Carolina received a total of $8.4 million in Maternal, Infant, and Early Childhood Home Visiting (MIECHV) formula grants from 2010-2016. The state applied for, and won, competitive funds of $13.8 million in 2013, to expand services and to bring programs and practices to scale.

South Carolina is using Pay for Success, which combines nonprofit expertise, private funding and rigorous evaluation to transform how government leaders respond to chronic social problems. Pay for Success will bring Nurse-Family Partnership to an additional 3,200 first-time mothers and their babies enrolled across the state over the next four years. The project is led by South Carolina Department of Health and Human Services in partnership with Nurse-Family Partnership, Children's Trust of South Carolina, and other supporting entities.



Additional funding has been awarded by:

- Duke Endowment Foundation: $14 million (2009–2015)
- Blue Cross/Blue Shield Foundation: $7 million (2009–2015)
- Boeing Foundation $1 million (2014–2016)
- Other private funders: ~$2.1 million (since 2010)

EVIDENCE OF SUCCESS

In total, 6,261 caregivers and children have enrolled in SC MIECHV programs since program inception in 2011. In the first reporting year of the program (2011-2012), SC MIECHV implementing sites served 297 caregivers and children statewide (Figure 1).

Enabled by expansion funding awarded in 2013, the SC MIECHV programs enrolled over 2,900 new parents and children, and served almost 4,500 new or continuing caregivers and children in the 2014-2015 reporting year.

In the most recent reporting year (2015-2016), an additional 1,630 new caregivers and children were enrolled and a total of 5,280 caregivers and children were served.

Evidence of Success:

The state contracts with the University of South Carolina for data collection, impact evaluation, and qualitative studies of state and local programs. In 2015-2016:

- 66% of families served were from minority racial groups (52.4 = African American; 13.5 = Latino/Other)
- 69% of families served were 100 percent under the Federal Poverty Line
- 75% were headed by a single parent
- 99% of parents served received guidance about injury and safety
- 94% of children completed scheduled well-child visits
- 93% of families, with a need at enrollment, received and completed a referral
- 84% of parents improved positive parenting skills
- 99% of women had no second pregnancy within 12 months of giving birth
- 82% of post-partum women were screened for maternal depression

Overall, the MIECHV program in SC continues to make important progress in improving the health and economic well-being of South Carolina's most vulnerable families and the early childhood workforce.

Contact:

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Children's Trust of South Carolina
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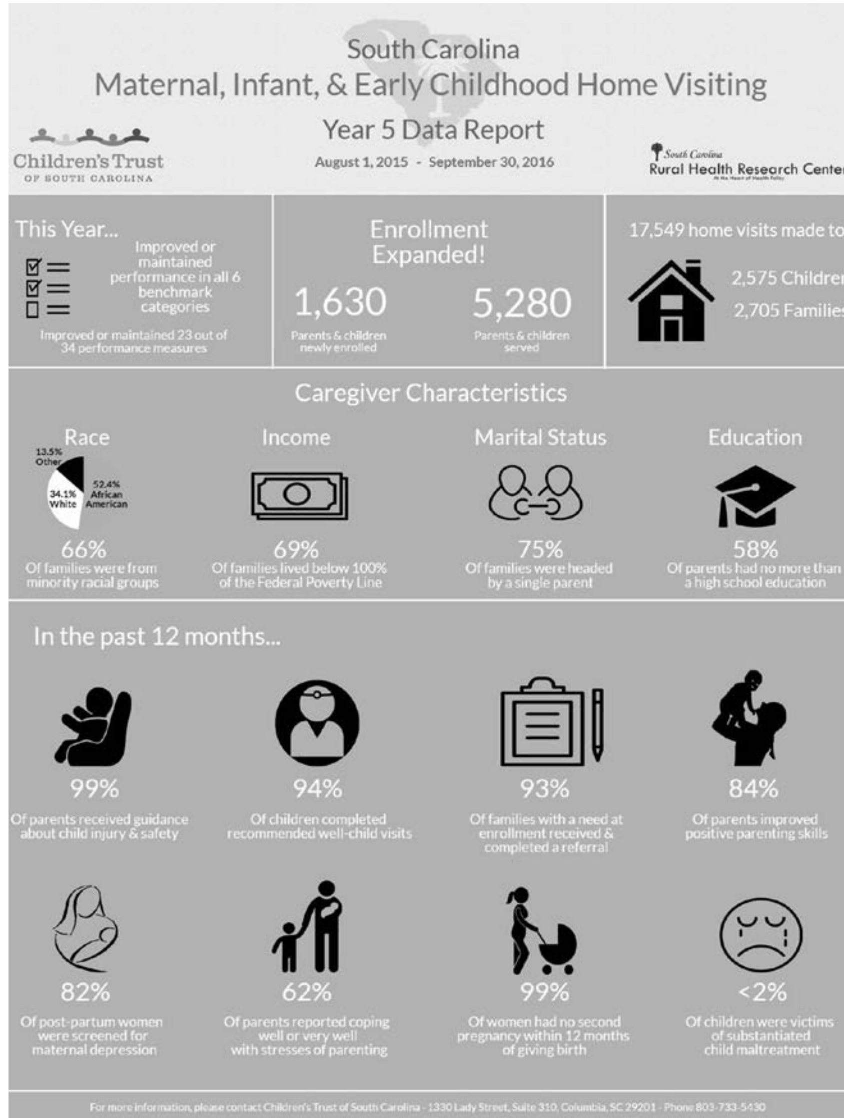
Investment: MIECHV-Supported Programs

In South Carolina, 39 out of 46 counties are served by the MIECHV program, through 17 local implementing agencies. Participating families are 52.4% African American and 13.5% are Latino or other minorities.

The models currently funded through MIECHV are:

- Family Check Up
- Healthy Families America
- Healthy Steps
- Nurse Family Partnership
- Parents as Teachers


South Carolina
Maternal, Infant, & Early Childhood Home Visiting
Year 5 Data Report
August 1, 2015 - September 30, 2016
Children's Trust OF SOUTH CAROLINA
South Carolina Rural Health Research Center
This Year...
Improved or maintained performance in all 6 benchmark categories
Improved or maintained 23 out of 34 performance measures
Enrollment Expanded!
1,630
Parents & children newly enrolled
5,280
Parents & children served
17,549 home visits made to:
2,575 Children
2,705 Families
Caregiver Characteristics
Race
13.5% Other
52.4% African American
34.1% White
66%
Of families were from minority racial groups
Income
69%
Of families lived below 100% of the Federal Poverty Line
Marital Status
75%
Of families were headed by a single parent
Education
58%
Of parents had no more than a high school education
In the past 12 months...
99%
Of parents received guidance about child injury & safety
94%
Of children completed recommended well-child visits
93%
Of families with a need at enrollment received & completed a referral
84%
Of parents improved positive parenting skills
82%
Of post-partum women were screened for maternal depression
62%
Of parents reported coping well or very well with stresses of parenting
99%
Of women had no second pregnancy within 12 months of giving birth
<2%
Of children were victims of substantiated child maltreatment
For more information, please contact Children's Trust of South Carolina - 1330 Lady Street, Suite 310, Columbia, SC 29201 - Phone 803-733-5430

Chairman SMITH OF NEBRASKA. Thank you, Mr. Bellamy.
Ms. Rauner.

STATEMENT OF DIANA MENDLEY RAUNER, PH.D., PRESIDENT, THE OUNCE OF PREVENTION FUND

Ms. RAUNER. Chairman Smith, Ranking Member Davis, and Members of the Subcommittee, thank you for the opportunity to testify in connection with your hearing on the reauthorization of the Maternal, Infant, and Early Childhood Home Visiting program. My name is Diana Rauner and I am here today in my role as the President of The Ounce of Prevention Fund, a public-private partnership serving children and families from before birth through age 5. I am also a developmental psychologist, the Co-chair of the Illinois Home Visiting Task Force, and the First Lady of the State of Illinois.

I began my career in investment banking and private equity investing, so I know something about return on investment. And I came to the field of early childhood because of concerns about the huge social and economic costs of educational inequities. I chose to focus on early childhood development because investments in the first years of life are simply the most efficient and effective ways to develop human capital. With the right investments, human capital development can provide great economic and social gains for individuals and for society.

James Heckman, a Nobel Laureate at the University of Chicago, recently said, "The real measure of child poverty isn't money, it's love." Voluntary home visiting programs that support parents in their critical responsibilities to help their children become healthy, successful citizens are the most effective human capital investments we can make because they compound the positive behavior of parents and children.

I wish to voice my strong support for the MIECHV program and respectfully urge you and your colleagues to reauthorize MIECHV. The funding Illinois receives from MIECHV has significantly enhanced our State's robust early childhood and home visiting systems and is a vital component of our infrastructure. Illinois has long valued evidence-based home visiting programs as an effective and efficient strategy for strengthening expectant and new vulnerable families, by increasing children's readiness for school, reducing the risk of child abuse and neglect, and improving economic self-sufficiency.

Over the past three decades, Illinois has developed a cross-sector statewide home visiting system, serving over 17,000 families per year, making it a nationally recognized model of a State system supporting a variety of evidence-based models and innovative practices. Please refer to my written testimony which provides a more thorough picture of home visiting in Illinois.

For today's purposes, I would like to elaborate a little on what MIECHV funding has allowed us to do in Illinois. We have reached more at-risk families. Last year, nearly 1,000 additional families received more than 12,000 home visits. We have improved our home-visiting workforce through infant mental health consultation that teams mental health professionals with home visitors, and additional training for home visitors, regardless of funding, to en-

hance their understanding of critical topics, such as domestic violence, substance abuse, and child abuse prevention.

MIECHV has increased coordination and collaboration across funding streams. For example, MIECHV's focus on identifying the outcomes that help best support families is something that all Illinois funders are now considering in their systems. MIECHV has pioneered coordinated intake, which ensures that families referred to home visiting are matched with a program and the model that best meets their particular needs and that they have access to other services as well. This concept of coordinated intake introduced through MIECHV has generated such interest that several communities not funded directly through MIECHV have chosen to develop coordinated intake systems with technical assistance from our MIECHV team.

We have been able to test innovations, including projects focused on some of our most vulnerable families, such as homeless families and pregnant and parenting youth in care, and in randomized control evaluations to examine the effectiveness of doula-enhanced home visiting. We hope these innovations will be useful to other States as they are proven.

Decades of research show that high-quality, evidence-based home visiting programs produce long-term positive outcomes for children and families. Data from Illinois show that home visiting services are increasing breastfeeding rates and birth intervals between births, particularly among teen parents; improving parenting practices; and ensuring that children are routinely screened for developmental delays. Research demonstrates that these outcomes, while measured in the short-term, set children and families on a positive trajectory for the long-term. The MIECHV program has increased the focus on these outcomes which is raising the bar for all home visiting programs in our State.

In closing, I would like to reiterate my strong support for the MIECHV program. MIECHV undergirds and enhances our entire home visiting system and improves the lives of at-risk families and children in Illinois. It must continue, and I hope you view me, The Ounce, and the First Five Years Fund, our project, as a resource in that regard.

Thank you for your time and consideration of my testimony. I will be happy to answer your questions.

[The prepared statement of Ms. Rauner follows:]

March 13, 2017

Subcommittee on Human Resources
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Chairman Smith, Ranking Member Davis, and Members of the Subcommittee on Human Resources:

Thank you for the opportunity to testify before you in connection with your hearing on the reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. I am the President of the Ounce of Prevention Fund (the "Ounce"), Co-Chair of the Illinois Home Visiting Task Force (HVTF), and the First Lady of the State of Illinois (the "State" or "Illinois"), although I testify before you in my capacity as the President of the Ounce. In doing so, I wish to voice my strong support for the MIECHV Program, and respectfully urge you and your colleagues to reauthorize MIECHV. The funding Illinois receives from MIECHV has significantly enhanced our State's robust early childhood and home visiting systems and is a vital component of our infrastructure.

Since 1982, the Ounce has persistently pursued a single goal: that all children living in America—particularly those born into poverty—have quality early childhood experiences in the crucial first five years of life. In addition to our work in early childhood center-based services, the Ounce is the leading provider of professional development and training for home visitors in the State, and with our community-based partners, the Ounce offers voluntary home visiting services to nearly 1,900 families throughout Illinois.

The HVTF is a standing committee of Illinois' Early Learning Council, which works with the Governor's Office to provide overall leadership in early childhood systems development. The HVTF is a diverse, collaborative group of nearly 200 members drawn from federal, state, and local governments; academia; representatives from national home visiting models; service providers; advocates; parents; and others. The HVTF's goals are to expand access to evidence-based home visiting programs for all at-risk children; improve the quality of home visiting services; and increase coordination between home visiting programs at the state and local level, as well as between home visiting and all other publicly-funded services for mothers, infants and toddlers. The HVTF also serves as the advisory body for the State's MIECHV grants. Positioning this work under the Early Learning Council is one example of how home visiting is connected to the other major early childhood services in Illinois such as preschool, child care and Early Intervention Part C services.

Illinois has long valued evidence-based home visiting programs as an effective and efficient strategy for strengthening expectant and new families who are vulnerable to poor health, educational, economic and social outcomes by increasing children's readiness for school, reducing the risk for child abuse and neglect, and improving economic self-sufficiency. Over the past three decades, Illinois has reflected this value by developing a cross-sector statewide home visiting system that provides these essential services to over 17,000 families per year, making it a nationally-recognized model of a state system supporting a variety of evidence-based models and innovative practices.

Thank you for the opportunity to submit my written testimony. We appreciate the Subcommittee's efforts to better understand how MIECHV funding is impacting children and families, including ours in Illinois. In order to share Illinois' experience with home visiting and MIECHV, I will focus on four issues: (i) why home visiting is effective in Illinois; (ii) why MIECHV is vital to our home visiting system in Illinois; (iii) the need for

home visiting services in Illinois; and (iv) the long-term benefits of home visiting in Illinois on a micro and macro level.

The Effectiveness of Home Visiting in Illinois

In Illinois, home visiting is an effective intervention for children and families due to a number of factors, including the following:

- Our statewide approach and philosophy, which welcomes and uses a variety of evidence-based models that are selected based upon individual community and family needs;
- Our well-trained home visiting workforce;
- Our ability to direct services to at-risk and vulnerable populations; and
- Our ability to leverage other supports and services.

The MIECHV program has greatly enhanced the overall home visiting system as well as each of these areas and has provided the opportunity for Illinois to better serve young children and their families.

Statewide Approach and Philosophy. Illinois' home visiting system is both structured and funded in such a way as to welcome all evidence-based models to the table, and then allow individual communities and programs to select the model(s) best suited to their specific needs. In Illinois, our home visiting system uses a range of effective evidence-based models, including Parents As Teachers (PAT), Healthy Families America (HFA), and Early Head Start-home based (EHS). These models are funded through our *entire* home visiting system, which includes funding from MIECHV, the Illinois Department of Human Services (IDHS), the Illinois State Board of Education (ISBE), and Chicago Public Schools (CPS). It is one of the hallmarks of our Illinois system that we allow communities to choose a model based on their needs.

On the family level, a priority of the Illinois home visiting system is to ensure that each family is connected with the home visiting program that best suits its individual needs. For example, in the initial meeting with the family, an eligibility screening tool is used that takes into account the family's current needs and geographic considerations. Particularly for our at-risk families, it is important that a good match is made right from the start because if we do not, the family may not continue with the services and we may lose the opportunity to partner with them during a critical time in their child's development.

The coordinated intake system introduced to Illinois communities through the MIECHV program has played a critical role in ensuring that families referred to home visiting are matched with the program and the model that best meets their particular needs and that they have access to myriad other services that will help to support them. This concept has generated such great interest that several communities not funded directly through MIECHV have chosen to become "voluntary" communities and develop coordinated intake systems with technical assistance from the MIECHV implementation team.

Home Visiting Workforce. Home visiting programs are grounded in the belief that young children, families, and staff grow and learn best in the context of trusting, supportive relationships. Home visiting staff are hired with education and training in early childhood development, as home visiting services are anchored in child development and psycho-social support to mother, baby, and extended family. Using a relationship-based model of intervention, trained home visitors focus on promoting a strong mother-infant attachment right from the start. Home visiting programs and funders dedicate considerable resources to supporting home visiting staff, through professional development, access to professional consultants, and reflective supervision.

Through purposeful and systematic efforts, Illinois has a well-trained and diverse home visiting workforce with a variety of cultural, linguistic, and educational backgrounds. The State's home visiting system has demonstrated a commitment to building a highly-skilled home visiting workforce capable of improving outcomes for the children of Illinois. For example, the Ounce is the recognized training provider for all home visitors in core model training (i.e., HFA and PAT programs in Illinois), as well as wraparound trainings that help to enhance their practice. Funding for Ounce training is provided through MIECHV, IDHS, ISBE and CPS.

MIECHV funding is also being used to provide supplemental training around specific issues in response to stated needs from the field, such as intimate partner violence, child abuse prevention, substance abuse, and maternal stress through the *Futures without Violence, 4Ps Plus,* and *Mothers and Babies* curricula, respectively. MIECHV funding is also being used to build the capacity of home visiting staff through Infant Mental Health Consultation (IMHC), which is a multi-level preventative intervention that teams mental health professionals with home visitors and supervisors. While these specialized trainings and IMHC are provided to all MIECHV funded programs in Illinois, they are also available to any home visiting program in the State, and they serve as an example of how MIECHV funding helps the entire home visiting system in Illinois.

Directing Services to At-Risk Populations. The latest Illinois MIECHV data show that we are serving families who need home visiting services the most and who benefit the most from them. For example, 988 additional families in federal fiscal year 2016 received home visiting services due to MIECHV funding. These families face a variety of risk factors, including pregnancy before age 21, child and maternal emergency room visits, child maltreatment, poverty, domestic violence, substance abuse, and educational and vocational disadvantage.

In order to direct services to at-risk populations, all home visiting programs use eligibility screening tools and the home visiting system implements the models with fidelity. We continue to try to direct services to some of our most vulnerable families, such as homeless families and pregnant and parenting youth in care, through the use of pilot and demonstration projects (as described in more detail below under "MIECHV's Vital Role in Illinois").

Leveraging Other Supports and Services. Home visitors in Illinois play an important role in referring families to other services when available. For example, home visitors can serve as a bridge to services for families. Because they see families regularly, home visitors are often the first to witness and respond to emerging family concerns, such as maternal depression, child development issues, or household needs, all of which can negatively affect the developing parent-child relationship. In turn, parents, because of their trust in the home visitor, are more likely to share their own concerns and to accept linkages to other services, including early intervention and center-based early childhood programs for their children, and education, job-training, and counseling programs for themselves.

In order to help home visitors become more informed with regard to other systems and services in Illinois, a series of cross-trainings have been held and continue to be organized to better support cross-system collaboration. In addition, as mentioned above, MIECHV-funded communities as well as several non-MIECHV funded communities in Illinois implement coordinated intake, which serves as a hub for home visiting to streamline services within each community.

MIECHV's Vital Role in Illinois

Even though Illinois has long valued evidence-based home visiting programs and receives funding from sources other than MIECHV, MIECHV funding has allowed Illinois to enhance its existing infrastructure through each of the following:

- Reach more at-risk families;
- Make a greater investment in our home visiting workforce;
- Increase coordination and collaboration across funding streams; and,
- Test innovative practices.

Reach More At-Risk Families. MIECHV funding has enabled Illinois to build on existing state investments in home visiting and expand our direct services to families. In federal fiscal year 2016, 988 additional families (of which at least 93% were low-income) received a total of 12,296 home visits in English, Spanish and Arabic through MIECHV funding.

Make a Greater Investment in our Home Visiting Workforce. MIECHV funding has allowed Illinois to make a greater investment in our home visitors through the use of IMHC and enhanced and additional professional development opportunities. See above "The Effectiveness of Home Visiting in Illinois – Home Visiting Workforce" for a more detailed overview.

Increase Coordination and Collaboration across Funding Streams. One of the hallmarks of the Illinois home visiting system has always been the collaborative approach that the funding streams take towards ensuring the quality of the home visiting system. With the introduction of the MIECHV program in Illinois, this coordination and collaboration has increased significantly, in turn enhancing the support of the home visiting system. For example, there is an increasing focus on better aligning the data systems used for home visiting programs and on identifying the most critical and compelling data elements that should be collected and reported. These partnerships, enhanced through MIECHV, are essential in continuing to support the home visiting system.

Test Innovative Practices. Illinois has used MIECHV funds for a variety of innovative projects. MIECHV funding enables Illinois to create laboratories for researching and testing pilots and demonstration projects, as well as valuable trainings, tools and approaches that can be applied more broadly to the entire home visiting system as well as other systems, such as child welfare. Showing the beneficial impacts of these innovative projects on a smaller scale will build a case for expanding them to more programs across the State.

Each of the following innovative projects receives MIECHV funding. These novel strategies have generated significant interest from other states and are already producing results that will be used to drive improvements in practice and continue to strengthen the evidence base of home visiting.

- ***Home Visiting for Homeless Families Demonstration (HVHF) Project*** – Young children who experience homelessness face a host of challenges that threaten their health, development, and ability to succeed in school. Unfortunately, many of the homeless services families may be accessing do not provide child-centered comprehensive services that address child well-being and parent-child attachment. At the same time, these families also face barriers to accessing early childhood services and supports that can improve outcomes, such as evidence-based home visiting. Through high-quality home visiting services, the HVHF Project seeks to improve the developmental trajectories (i.e.,

improvements in breastfeeding rates, developmental screenings, well-child visits, and maternal efficacy rates) of children experiencing homelessness in Chicago. The HVHF Project's approach is to train homelessness providers on home visiting, hire a home visitor whose caseload is exclusively homeless families, and provide training to a shelter on implementing the PAT model. The HVHF Project will collect data that will indicate impact and inform future efforts. To date, learnings include the importance of using the educational definition of homelessness, and that there is significant interest from other parts of the country in doing a similar project.

- ***Illinois Pregnant and Parenting Youth in Care Home Visiting (I-PPYC-HV) Pilot Project*** – Nationally and in Illinois, young children ages birth to five comprise nearly half of all child maltreatment cases. Research shows that early exposure to abuse and neglect can have negative impacts on development and learning. Home visiting has been shown to be an effective intervention in preventing maltreatment. The I-PPYC-HV Project provides pregnant and/or parenting youth in child welfare care with access to voluntary home visiting services that are provided by eight programs located in Illinois. The I-PPYC-HV Project will serve 30 young families over a two year period. The goals of the I-PPYC-HV Project are to promote nurturing parent-child relationships and healthy child development, enhance family functioning by reducing the risk of abuse and building protective factors, break the intergenerational cycle of abuse, neglect and trauma, increase coordination between the child welfare and home visiting systems in Illinois, and create a model that can be replicated throughout Illinois.
- ***Illinois Universal Newborn Support System (UNSS)*** – Based upon the principle that all families need some level of support when a baby is born, a pilot project is being launched to create a system that would offer all newborns and their parents a home visit to provide them with information, supports, and resources to strengthen the capacity of parents to meet their children's needs. Based on an individual family's level of need and personal resources, assistance will range from providing information on how to care for newborns, to offering assistance with breastfeeding, to finding appropriate child care, to referring families to parent support groups, to making referrals to high-intensity services such as home visiting.
- ***Expansion of Doula Services*** – Eight home visiting programs in underserved communities are testing the impact of incorporating a community doula model into their traditional home visiting services. This project helps parents build strong bonds with their babies before the child is born, and preliminary findings show an improvement in maternal and child health outcomes.
- ***"Fussy Baby" Training*** – The Erikson Institute's Fussy Baby Network (FBN) Enhancement Training provides support for families who have concerns about their baby's crying, sleeping, feeding or temperament during the first years of life. The training uses a family-centered approach, and preliminary findings support that this training helps the home visitor be more attentive and attuned to the families they serve and improvements were shown in parental well-being outcomes. The FBN evaluation and scale-up aims to strengthen the capacity of multiple program models to improve child outcomes and will introduce innovations to the statewide system.
- ***Developing a Uniform Quality Rating Tool*** – The Erikson Institute is partnering with over 20 home visiting programs to create a home visiting program quality rating tool, which will develop uniform indicators of quality across Illinois home visiting agencies and models. This research will offer a cross-model approach to quality and quality improvement for the State's multiple-model system.
- ***Randomized Control Trial (RCT) of Doula-Enhanced Home Visiting*** – This research undertaken by the University of Chicago with four well-established home visiting programs uses high-quality research methods to examine the effectiveness of doula-enhanced home visiting for improving maternal and child health, parenting and child development. The RCT will contribute further to the research base

for the doula model, which is being implemented in multiple states as an enhancement to evidence-based home visiting models. Preliminary results of the RCT are promising.

The Need for Home Visiting Services in Illinois

In Illinois, we serve approximately less than 10% of eligible families with our home visiting services, based solely on income level (i.e., 185% of the federal poverty level). We know, however, that income alone does not demonstrate a need for home visiting services. Furthermore, given the complexity of issues and trauma that many of our families face, we know there are numerous and complicated risk factors beyond poverty and, therefore, an even greater need than we can measure using income levels. While 988 additional families in Illinois received home visiting services in federal fiscal year 2016 due to MIECHV funding, we know that the need for home visiting services is greater.

The Long-Term Benefits of Home Visiting

National and Illinois-specific research studies show that high-quality evidence-based home visiting programs result in myriad positive outcomes for children and their families, including the following:

- Increasing rates of breastfeeding, immunization, well-child visit, and developmental screenings;
- Promoting language development and school readiness;
- Improving rates of high school graduation; and
- Increased rates of talking, reading and positive interactions between parent and child.

In addition to the positive short-term benefits of home visiting programs, there is a host of positive longer-term outcomes associated with these services, including reduced risk of chronic health problems later in life (such as obesity, diabetes, heart disease, alcohol consumption, smoking, etc.).

In Illinois, data have consistently indicated that home visiting services are having a significant impact in increasing breastfeeding rates, increasing inter-partum intervals (particularly among teen parents), helping families establish medical homes, and ensuring that children are routinely screened for potential developmental delays. Specifically, among MIECHV-funded programs in 2016, 100% of families were screened for needed services, 93% of children received recommended well-child visits, and 93% of children were screened for developmental delay before 12 months of age. These outcomes, while measured in the short-term, have critical implications for the healthy long-term trajectory of children and families. The MIECHV program has encouraged an increased focus on identifying the outcomes associated with home visiting and improving those outcomes for young children and their families, which (as mentioned above), has created a focus on the same concept among all funders of home visiting in Illinois.

In closing, I would like to reiterate my strong support for the MIECHV Program. Not only does MIECHV undergird and enhance our entire home visiting system, but the lives of at-risk families and children in Illinois have improved directly as a result of our MIECHV funding, and it must continue. Thank you for your time and consideration of my testimony. Please do not hesitate to reach out to me if I can provide any additional information as you move forward with this process.

Sincerely,

Diana Mendley Rauner, PhD
President, Ounce of Prevention Fund

Chairman SMITH OF NEBRASKA. Thank you, Ms. Rauner.

Thank you to all of our witnesses here today. We appreciate your insights. They are important for us. So now we will go through questions here from myself and the Members.

I will begin. Mr. Bellamy, in your testimony, you hit on a very important point about the program that I think is sometimes overlooked, and it is a point about how Federal funding programs based on evidence can really support States, and even the nonprofit sector, in their efforts to focus on what works. In your testimony, you highlight how the MIECHV program itself is important, but also that the evidence standard is set up and the signal it sent was just as important as it identified the models that were shown to be most effective. For example, I know once MIECHV-specified programs must be evidence-based and show results to receive funding, Nebraska, my home State, tied their own State funding to a similar standard so now all home visiting in Nebraska is evidence-based.

Can you tell us a bit more about how the evidence standard in MIECHV has influenced the State practice in funding home visiting?

Mr. BELLAMY. Yeah. I think the fact that MIECHV has set a level of standardization has really influenced how funders look at what they will fund around evidence-based practices. We have adopted in our South Carolina MIECHV program that we would only fund evidence-based programs. And private funders, as well as our State, has looked at that standardization authorization for those evidence-based programs to really look at setting a target and really being able to identify those practices as we move forward.

At this point, funding has not moved in our State as far as looking at specific evidence-based practices. We want to build a continuum of services in our State around evidence-based practices, so we want to continue to really build a systematic approach to it.

Chairman SMITH OF NEBRASKA. In your interactions with other States perhaps, have you learned what other States have done, or could you point to anything like that perhaps?

Mr. BELLAMY. Tough for me to say. Well, in conversations with my peers in other States, there have been States that have identified ways to look at their standardization. They have worked with their legislation to really put into action some of their standards in evidence-based standardization. It would be difficult for me to pinpoint exactly where those States are at this time, but, yes, there have been other standardizations looked at in how they have adopted those practices.

Chairman SMITH OF NEBRASKA. Thank you.

Anyone else on the panel wish to comment? Ms. Rauner.

Ms. RAUNER. I would just add that one of the ways that MIECHV has helped with standardization is in terms of standardization of the workforce, common understanding of what qualities are necessary across the models for training and professional development, ongoing professional development, and credentials. And that has, again, raised the standards and raised uniformity across programs and across funding streams.

Chairman SMITH OF NEBRASKA. Thank you.

Anyone else? If not, that is fine.

I now recognize the Ranking Member, Mr. Davis, for any questions he might have.

Mr. DAVIS. Thank you very much, Mr. Chairman. And I also want to thank all of the witnesses.

Mr. Bellamy, let me ask you, I don't run into that many men in this line of work. What drew you to it, if you would?

Mr. BELLAMY. To the work that I do?

Mr. DAVIS. Yes.

Mr. BELLAMY. That is a very good question, Mr. Davis. You know, years ago, I started out in doing teen pregnancy prevention work and worked with adolescents in direct services, and it really influenced my passion with working with younger populations. But, essentially, what it boils down to is the fact that I thoroughly believe that early intervention is a predictor of some very good things in later years, and I think our youngest population is the most vulnerable population, and we need to target those strategies, whether it be men, women, whatever the case may be. And I am just passionate about what I do and the work that I do and, hopefully, I can bring a different perspective sometimes from where I sit as a State lead.

Mr. DAVIS. Thank you. Thank you very much.

Dr. Rauner, it is not every day that I run into a First Lady of the State who also has a full-time working job and is involved with all kinds of other social service entities.

The Ounce of Prevention is supporting some innovative home visiting programs, especially dealing with pregnant and foster youth. How does this work strike you in terms of its benefit to society?

Ms. RAUNER. Well, I personally believe that the development of every child's potential is the social justice issue of our time. It is an economic challenge and a moral challenge for us to ensure that every child can participate in the American Dream and in the American economy and as a full citizen of our Nation. And, again, research is quite clear that the period of the first few years of life has the greatest opportunity for setting children on the proper trajectory for development. And, again, because it is an intervention that affects both children and their parents, it has the opportunity to build and develop two lives, and I think that is one of the most powerful pieces of this work for me. It certainly drives the work that I have been doing for decades.

Mr. DAVIS. Thank you very much.

Ms. Valentin, I think you are, indeed, a role model. As a former teacher, youth worker, father, grandfather, great-grandfather, I used to counsel teenagers, and I think you represent the best quality of thinking and decisionmaking that I have run into. Could you share with us how your experiences have actually assisted you, what you may have done even for others?

Ms. VALENTIN. My experience with this program has been amazing. You know, an unplanned pregnancy, a first-time mom, any mom, young or older, you know, you just need to have that support and need to know certain things. And this program has helped me so much with even the littlest things, not so much about the child but about me or helping, you know, my family and stuff like that. So it has been really helpful, and I hope that everybody—

I mean, I know if everyone could be here right now, they would share their experience, because this is truly amazing.

Mr. DAVIS. Thank you very much. And I yield back, Mr. Chairman.

Chairman SMITH OF NEBRASKA. Thank you, Mr. Davis.

Mr. Smith from Missouri.

Mr. SMITH OF MISSOURI. Thank you, Mr. Chairman. And thank you to the witnesses for making it here today despite the 2-inch winter blizzard that we had up here. Clearly not like Missouri and Illinois weather.

I want to thank the Chairman for holding this important hearing on the Maternal, Infant, and Early Childhood Home Visiting, or MIECHV, program. Many times the Federal Government tries to do too much. Our third President, Thomas Jefferson, got it right when he said: "The government closest to the people serves the people best." But MIECHV works because it offers States like Missouri the flexibility to administer the program in the way that best suits their needs.

MIECHV's flexibility allows Missouri's Governor, Eric Greitens, to implement three of his major priorities. He wants to improve healthcare access, reduce opiate abuse, and reduce infant mortality. By choosing to run the Nurse-Family Partnership as part of the program, Governor Greitens is able to follow through on his promise to address the high infant mortality rates in the Bootheel of Missouri. For example, in my district in Pemiscot County in the Bootheel, we have the worst health outcomes of any county in Missouri. It is 115 of 115. Of course, there are 114 counties in the city of St. Louis, that is why it is 115.

Pemiscot County experiences the highest infant mortality rates in all of Missouri. We know that one out of eight mothers don't make it to full term when pregnant, and two-thirds of infant mortality is due to preterm births. We know that we can do a lot better. That is why Missouri's Department of Health and Senior Services has begun to administer the Nurse-Family Partnership program in Butler, Dunklin, Pemiscot, and Ripley Counties in the Bootheel. This targeted approach can help reduce infant mortality rates in our most distressed counties. Unfortunately, Pemiscot County needs the most help of anywhere in the State, but fortunately, because of the MIECHV and by working with Governor Greitens, we can improve health outcomes, save lives, and reduce costs.

As an evidence-based program, we know taxpayer dollars are being spent in the right place because the Nurse-Family Partnership program is shown to decrease preterm births and reduce infant mortality.

Ms. Russell, I would like to learn a little bit more about the nuts and bolts of the program. How do you prepare for your first visit with a mother?

Ms. RUSSELL. The Nurse-Family Partnership program is a blueprint program, and we do have a curriculum that we follow. However, each mom is very different. So, personally, I prepare for the first visit by just keeping an open mind, knowing that what I walk into in one home might be very different than what I walk into in another home. So my priorities across the board are always

ensuring that she already has prenatal care established, and if she does not, ensuring that I can help make referrals to get her prenatal care started. And then from there we look at some of the— is she utilizing the appropriate community resources like she should be? Are they part of the WIC program? Do they have food they can eat? And ensuring that we will refer to those services as needed.

Once I am sure that all of her basic needs are met, we can start to learn a little bit more about who she is as a person and what is important to her. We have, as nurses, outcomes that we would like to see as far as keeping everybody healthy and safe. But it is also important, and Nurse-Family Partnership agrees with this as well, that it is important that we find out what the client's heart's desire is and help them reach that as well.

So the first visit is very much getting to know them, trying to be as laid back as possible, and letting them share with us what they are willing to share, and then building on from there in each visit from that point on.

Mr. SMITH OF MISSOURI. The Nurse-Family Partnership requires a 2-year commitment. Why such a duration?

Ms. RUSSELL. As Rosa can attest to, there are many struggles that come up in those first 2 years of parenting. Pregnancy in itself is a struggle, and there is a lot to learn as far as education to stay healthy and have a healthy baby as a result of the pregnancy. And then building on that, infancy has its own struggles with learning what your baby needs from you and how to respond to those needs in an appropriate way, as well as ensuring that the baby is getting access to care and immunizations and well-baby visits. And then the toddler years also create some more struggles as they are now mobile and they are doing different things that their parents aren't sure they are supposed to be doing or are safe for them.

And then from a clinical aspect, the baby's brain grows so much in those first 2 years and is almost fully grown at that point, so we want to have as many positive influences on the baby in those first 2 years as possible.

Mr. SMITH OF MISSOURI. Thank you, Mr. Chairman. I yield back.

Chairman SMITH OF NEBRASKA. Thank you, Mr. Smith.

Next is Ms. Chu from California.

Ms. CHU. Thank you, Mr. Chair.

In Los Angeles County, we utilize both the Healthy Families America and the Nurse-Family Partnership models of home visiting. And in 2015, home visitors made over 29,000 home visits to around 5,500 parents and children in California. The program in my State and in L.A. County has placed an emphasis on connecting pregnant women and new mothers with mental health services. That is, in my opinion, a fantastic way to leverage existing programs aimed at improving mental health and wellness for children and families with the unique methods of the home visiting program.

So, Ms. Russell, based on your experiences working with the Nurse-Family Partnership model in Pennsylvania, can you describe a few ways in which you have relied on a broader array of available

social services, such as mental health evaluation and treatment, to carry out your mission, and do you have examples?

Ms. RUSSELL. Sure. As part of the Nurse-Family Partnership program, we do regular incremental screenings for depressive and anxiety disorders. So based on those screenings, we can refer as necessary. So we do those during pregnancy and then continuing through the child's first 2 years of life, on a schedule. But we can also do them as needed. So if we come into a home and we find that the mother's affect and tone are just not quite like they had been before, we can screen as needed, which is one thing that is great for us as nurses. We have been given those tools in our undergraduate degrees to recognize some of the problems that might present if a mother is having trouble with her mood but maybe isn't quite ready to recognize that in herself, just like Rosa had been through. So through those routine screenings and through our basic assessment skills that we learn in our undergraduate programs, we are able to keep a really close eye on that.

Unfortunately, in Lancaster, our mental health resources are not as strong as we would like them to be. We are able to make referrals, but many times they do have to wait for a couple of weeks or a couple of months until they can be seen by a provider. So in the meantime, we are able to educate on some coping mechanisms that they can use in their own home until they are able to get into a more structured environment for counseling services.

Ms. CHU. And do you think mental health issues are a frequent kind of issue that comes up for pregnant women?

Ms. RUSSELL. I would say yes. I do feel that they are very, very prevalent in our population. Nurse-Family Partnership collects data that could give you the real percentages as far as that goes, but every day I am working with at least one mom who is having trouble with her mood at that current time.

A general day for me is three to four visits with three to four different patients, so that is one a day that is probably having some sort of trouble, which is about 25 percent to 50 percent of my caseload. So it is very prevalent, unfortunately.

Ms. CHU. And how about substance abuse counseling? Is substance abuse an issue that comes up frequently?

Ms. RUSSELL. Yes. Yes. Substance abuse is also an issue that comes up, whether that might be a past history and the mother is now no longer using but is working on ways to prevent herself from continuing to use, or whether they actually are using a substance during their pregnancy.

So for us as nurses, it is important that we educate on how it will not only affect her, but affect her unborn child or if she is already parenting, how that will affect that child's growth and development as well.

Ms. CHU. Okay. Ms. Rauner, in placing emphasis on connecting pregnant women and new mothers with mental health services, States like California try to detect and remediate potential issues very early in a child's life. However, data from the L.A. County Health Services underscores the challenges facing many mothers, which is that nearly one-third of women who were recently pregnant or had delivered a baby lacked a regular source of health care.

So how do home visitors help to provide effective early intervention for pregnant women and new mothers who do not have easy or regular access to health care?

Ms. RAUNER. Well, certainly, one of our efforts has been to connect new mothers to all the services that they need. With respect to mental health programs, we also have been able to use MIECHV funds to build mental health consultation in for our home visitors so that they are actually able to be supportive when we don't have access to services.

But access to early intervention services, to health care services, and other connections is a very vital part of what the home visitor is doing in any community. And certainly, we make that a high priority for all of the models that are in place in Illinois.

Ms. CHU. Okay. I yield back.

Chairman SMITH OF NEBRASKA. Thank you, Ms. Chu.

We will move on to Mr. Reichert from Washington State.

Mr. REICHERT. Thank you, Mr. Chairman.

First of all, I want to thank the witnesses for being here and for the time that it took to put your comments and statements together. And I thank the staff. The Democrats and the Republicans have people that are sitting back here. They put this whole thing together, and I want to congratulate them on bringing some excellent witnesses today to testify. It is important for us to hear, not only from people like Rosa—if it is okay if I call you Rosa—and the experts in the field that do the work, but it is so critical to hear from those who are the recipients and then those who provide the work, the services, like Beth.

So how many of the witnesses have testified before Congress before?

How many have testified before other members of maybe a city council or a county council?

I knew that Ms. Rauner would raise her hand. She has experience in this world.

You have all done a great job, but I think we really need to recognize Rosa's testimony. She is the first 16-year-old to testify—I have been here 12 years. I just look like I have been here 40. I have been here 12 years, but this is the first 16-year-old witness, Mr. Chairman, that we have had, and she did outstanding. I don't know if it is against the rules or not, but we should give her an applause.

[Applause.]

The heck with the rules sometimes, right?

So I wanted to ask Rosa, and you don't have to answer this if you don't want to, but why did you choose Angelica for—I have kind of maybe a thought on that, but why did you choose Angelica for your daughter's name?

Ms. VALENTIN. Angelica was my grandmother's name, which is also my middle name. My middle name is Angelica Marie, so I named her Angelica Marie.

Mr. REICHERT. Okay. I had two choices, but I bet you your grandmother was named Angelica and your middle name is Angelica because——

Ms. VALENTIN. Of my grandmother, yes.

Mr. REICHERT [continuing]. Because you are angels. My daughter's name is Angela, and we weren't supposed to have children, so we chose Angela because she was our little angel. So I am sure you think of Angelica that way, right?

Ms. VALENTIN. Yes.

Mr. REICHERT. So what I would like to ask Rosa is just—you know, we are having a conversation here. It gets a little formal sometimes, but, you know, just from your first contact with Beth and how this came about—because the courage it took for a 14-year-old to decide to go through with the birth of your child, and now here you are today, going to school, looking for a nurse's profession in the future, I think is just an amazing feat, and it shows so much maturity, but you couldn't have done it without Beth and your parents.

Ms. VALENTIN. Yes.

Mr. REICHERT. Don't worry about the rest of your family. They will get on board eventually. Eric is laughing. I have been there. I am the oldest of seven. You know, every now and then, they kind of float in and out of your life.

Just tell me in your own words what the whole thing is all about for you. How did it really help you?

Ms. VALENTIN. I just felt like I needed more support. You know, my mom was always there to help me, but she was like, you know, this wasn't planned, but we are going to make the best of it, and we are going to get you through this no matter what bumps come through the road. Like, we are going to get through it. You are going to finish school. You are going to be on track to finish, and you are going to be a great mom.

So this program, you know, at first, I was going to Healthy Beginnings, but Healthy Beginnings wasn't associated with the hospital I was in, the OB–GYN, so I was referred to Nurse-Family Partnership. And I am so glad that I was referred to Nurse-Family Partnership because it has been, you know, so great—I am so grateful to, you know, have this program, have a nurse by my side that, you know, can answer any questions and stuff like that. So it has been really helpful.

Mr. REICHERT. Good. Beth, do you want to add something quickly to that?

Ms. RUSSELL. I am just so proud of Rosa. She does not do public speaking very well, and one of her goals that she set for herself was to try to interact with people more because with doing the cyber program, she really doesn't get much interaction with people outside of her home, so this is a really huge step for her.

Mr. REICHERT. I mean, you did awesome. Look, at 16 years old, I wouldn't have been in your seat. I guarantee you that.

We get a second round of questions, so I am going to come back to the others to just ask some technical questions. But I just want to really emphasize the courage it took to move forward with your life, the courage it took to be here today. I truly would not have been doing what you are doing today. I couldn't have done it. And you can't even vote. You might be a Congresswoman some day.

I yield back.

Chairman SMITH OF NEBRASKA. Or perhaps you have higher aspirations.

Mr. REICHERT. We will make that the first female President then.

Chairman SMITH OF NEBRASKA. There you go. Thank you.

Ms. Sewell.

Ms. SEWELL. Thank you, Mr. Chairman.

I wanted to associate myself with the remarks of my colleague. I think that your grace and your courage and your maturity is something to be marveled at, Rosa, so thank you for being here today.

Before I begin my questions, I wanted to quickly express my desire to make sure that MIECHV is re-funded and reauthorized. In my State of Alabama, 5,220 families and 6,280 children receive home visiting services. In my district, 12 out of the 14 counties are eligible to receive MIECHV funds. Moreover, the MIECHV funding programs are primarily—are the primary source of funding for home visits in Alabama. The Federal funding is.

My district also has a wide variety of evidence-based models, including the Parents as Teachers, Nurse-Family Partnership, and the Home Instruction for Parents of Preschool Youngsters program. In fact, 86 percent of Alabama families receive home visiting services from a model that has been rated as evidence-based by HHS.

For my constituents, many of whom live in underserved rural communities, the home visiting services that MIECHV programs fund are essential. And as we have learned from the special relationship between Beth and Rosa, home visitors also provide important emotional support when young parents may feel all alone. In Alabama, over 50 percent of the single mothers with children under 5 live in poverty. These mothers and their children need these kinds of programs.

I want to thank all the panelists for taking the time to be here today.

And my question I wanted to first address to Mr. Bellamy. South Carolina, like Alabama, has both urban and rural communities. One of the biggest questions or complaints, challenges, that I hear a lot from my constituents that live in underserved rural communities is lack of transportation. Can you talk to me about how the MIECHV-funded programs are administered in your State in rural communities and what are some of the challenges, and how your State overcomes those challenges?

Mr. BELLAMY. Yes, ma'am. Many of the same challenges, Ms. Sewell, that we have in South Carolina for sure, transportation being one of them. The beauty of MIECHV and home visiting is meeting families where they are literally. And also, MIECHV has also given us an opportunity to expand services into these rural communities that really needed it and target those families that were most in need, so the needs assessment that states that we could really look at where we needed to target services. In most of—in South Carolina, most of our State is a rural State, so we put in practices and allow the ability for programs to be able to have sufficient funding to do home visits and travel to outlying counties and work with contiguous communities that may be rooted in really a more resource-richer community.

Ms. SEWELL. And I noticed that you guys expanded the number of counties that were covered, and that expansion is, I would as-

sume that South Carolina like Alabama, most of the funding for MIECHV comes from the Federal Government, and our State matches maybe, it is sort of a 2 to 1 match. Talk to me about how you guys—it seems to be a capacity problem in my State, that there are far more eligible families that could benefit from MIECHV than are actually reached. In my home county of Dallas County, I grew up in Selma, and Selma has 67 percent of the families with children under 5 in poverty. But yet 2.9 percent are actually covered by the MIECHV funding, so there is a capacity issue.

I would like to get you involved, Ms. Rauner, if you could talk a little bit about how Illinois addresses the capacity issue and making sure that these great programs actually reach more families.

Ms. RAUNER. Yes, thank you. Well, in Illinois, despite many years of investment, both from our State Board of Education and our State Department of Human Services as well as of course, MIECHV, we are still only serving 10 percent of all eligible children in our State. And Illinois, as well, is an urban and a rural State and has—of our 102 counties, most of them are quite rural.

We have used MIECHV dollars specifically to build community collaborations in both urban and in rural States. And we have looked through our needs assessment at some of the places that are most isolated and, again, have some of the most—the highest infant mortality rates. So the MIECHV program has allowed us to create community collaborations in those communities that bring together the available resources.

Ms. SEWELL. So you pool funds? Are you pooling funds?

Ms. RAUNER. Pooling funds, but also making sure that we are effectively using all the resources that the community has. And to the extent that we find gaps in resources, being able to advocate and reach out to other agencies to support those.

So we have actually connected our MIECHV programs with our infant mortality Title V programs. We have been able to use some of our child welfare dollars, again, to identify places where there are real gaps in services.

Ms. SEWELL. Thank you.

Chairman SMITH OF NEBRASKA. Thank you. And now I will begin our second round. Fortunately, we have the time resources to deal with this, with the second round.

Ms. Russell, I would like to focus a little bit on your insight and, kind of, frontline involvement there. I mean, the list is quite long in terms of what can be achieved with these effective models of home visiting. And, you know, from obviously economic self-sufficiency in a very broad way to increased work reduce arrests, less welfare dependence in general. Can you, perhaps, highlight or give us more specifics on your work in terms of how you might begin providing or connecting with a client and what that looks like compared to maybe evolving through and in making adjustments along the way and the observations that, perhaps, that you have had along the way as well?

Ms. RUSSELL. So in regards to connecting with her and her goals for herself, we start that the first day we meet each other. It is a very important part of the Nurse-Family Partnership program to ensure that we are not only with them during these 2½ years but we have given them the information that they need to

create their own foundation for the future as well. So very early on we do meet, and we talk about goals.

Each time we meet with them, we have an agreement form, and they have a little, what we call, a mini goal on there of something that they want to accomplish before we see them the next time. And sometimes that is a parenting, sometimes that is something much larger as far as applying for schooling and enrolling in programs like that.

So we do discuss goals very early on and remind them of those goals every time we see each other. Sometimes they come to us and they say, oh, I forgot about that, and then we remind them kindly, again, that this is important to them. And they will very much pull through with what is important to them. And that is probably the most beneficial part of Nurse-Family Partnership is knowing that they are accomplishing what is important to them as well as we are encouraging them to accomplish what is also important to them and other parts of the program, other importance as well as self-sufficiency in the future.

Chairman SMITH OF NEBRASKA. Okay. And I know that sometimes we struggle with wanting accountability in various programs and also allowing enough flexibility to spawn innovation, you know, a creative approach and so forth. Are there any times when you might feel somewhat confined in—with the services you offer because of, perhaps, some restrictions or Federal requirements or even State requirements?

Ms. RUSSELL. Yeah. I feel like I can say no to that, because the beauty of Nurse-Family Partnership is that we can be a little bit flexible with when and where we meet our clients. So if it is snowy, and I can't get to her where I need to be—our plowing, unfortunately, is not so great—so we might see each other a couple of days later, but we can connect by phone and have a short interaction by phone if we need to.

If I have a patient or a family member who is homeless, we can meet at a public library or at a park or a cafe. So coming to them makes it very flexible for us to be able to meet our requirements with how often we are supposed to visit with our families, because we can truly meet them wherever our cars will allow us to go.

If there is ever a concern with our clients where maybe they are having some difficulties, and they can't physically meet with us, again, we are able to have phone encounters as well to still check in on them and make sure everything is going the way it needs to be, and if they have everything they need before we can physically see them again for a true home visit.

Chairman SMITH OF NEBRASKA. And can you say—I think you may have said earlier, but can you say a typical number of clients you see in a day.

Ms. RUSSELL. In a day, I try for three to four. Sometimes I see more than that, just depending on what they need. But if I had perfect control of my schedule, I would see about three to four a day, and then we just fill in as needed based on what the clients are in need of at that time.

Chairman SMITH OF NEBRASKA. Okay. Thank you.

Mr. Davis.

Mr. DAVIS. Thank you. Thank you, Mr. Chairman.

And, again, I thank the witnesses.

Dr. Rauner, let me ask you. Sometimes substance abuse is a problem in the home. How does the Ounce of Prevention deal with substance abuse issues when you run into them?

Ms. RAUNER. Well, substance abuse is a major challenge for many of the families that we are serving, and one of the most important things we can do is train our home visitors to ensure that they have the skills necessary to identify, address, and refer patients and clients to appropriate services.

Now, we know that services are sometimes difficult to come by. And one of the important things, again, that collaboratives allow us to do is begin to look at where the gaps in services are and how we begin to advocate for and push for greater services to address particularly substance abuse. We know in our State that, as in many, that the opioid crisis has really changed the dynamics for many of our communities. We also know there are many patients who are suffering from mental health issues that are, of course, associated with substance abuse. And so we are very focused on ensuring that our home visitors are appropriately trained and, also, that they are connected to a system that can—to which they can refer—they can refer clients.

Mr. DAVIS. And for each one of you, if you could, how do you deal with the challenge of getting male involvement or more male involvement in the activities?

Ms. RAUNER. Well, I would just say that one of the benefits of home visiting is that it is an opportunity to coach both mothers and fathers in their role even when the parents are not living together and may not actually be together anymore as a couple.

But one of the things—I tell one story of a family actually in, Mr. Davis, in your community, that has been benefiting from home visiting services. Again, a mother and a father, young individuals who were not together, were not living together. The mom living at home and trying to continue with her education and get a job, and the dad living in a pretty unstable circumstance.

Over the course of a couple of years of participation in a home visiting program, a Healthy Families program, where the mom and dad were able to participate in those programs together. So he would come over and spend time with the home visitor when she would visit the child. They actually—he actually decided it was important for him to get his life back on track, get back into school and become a caretaker for his child. And the couple have decided to get married. He is in school. She is employed, and they are getting ready to move into their own home. So I think this is an example of how home visiting can support parents as they are developing, frankly, into adults and making the challenging commitments that they need to make to their children and to each other.

Mr. DAVIS. Thank you.

Yes.

Mr. BELLAMY. I think it is—I think fatherhood and male involvement is essential to the holistic approach to serving families, even though, oftentimes, mothers are the focal point and the entry point to many of our programs, we really need to continue to look at how we are supporting the entire family with our programs.

You know, oftentimes, as I said, we may have couples or families that may be divided and not living together, but we—the beauty of MIECHV is that it has allowed for innovation within models to really push for the models to look at different ways that they can continuously improve the initiatives, improve their programming. And fatherhood initiatives has been one that has—is building momentum on a continuum. And I think as we move forward, it is something that many States will look at stronger strategies to involve their fatherhood initiatives and local fatherhood initiatives within the States to be a part of, again, that holistic approach to really bring in the family and being self-sufficient as a family.

Mr. DAVIS. Thank you very much.

Mr. Chairman, I yield back.

Chairman SMITH OF NEBRASKA. Thank you, Mr. Davis.

Mr. Smith from Missouri.

Mr. SMITH OF MISSOURI. Thank you, Mr. Chairman.

Ms. Russell, Nurse-Family Partnership is just one service, but I am sure you connect your clients with numerous other needs. How do you coordinate with these other programs?

Ms. RUSSELL. In Lancaster, we are very grateful to be under the Lancaster General Health and Penn Medicine umbrella, so this allows us opportunities to communicate within that umbrella to other services that are available to families. But we also over some time really built strong relationships with other community resources, and we tend to have meetings with them on a regular basis to remind each other that all of our programs exist and that we should be working together as best we can to support our families.

So we do have as easy as a basic list of resources that are available in the area that we can take out to the families, but we are also the ones that are making the phone calls and sending the faxes to get all that information across to them.

So we have built some really great connections in our community just by meeting each other at different events, organizing different coalitions to bring all the resources together for our families.

Mr. SMITH OF MISSOURI. So whenever you, like, coordinate some of these programs and services to the families, is there a reporting mechanism where they report back to you, or do you check back up with them to make sure that those services are following through to help assist them, or how does that work?

Ms. RUSSELL. Yes. If I send a referral somewhere, I do request that the referral organization contact me once the client has made contact, but then I also will check in with my client when I go to the home visit to ensure that they have either called that referral source or that they have received a call back that they have gotten that service.

And we do track all of that in our data ETO tracking as well so that the main NFP site can see where we are sending referrals and what types of referrals we are in most need of.

Mr. SMITH OF MISSOURI. Thank you.

And the Nurse-Family Partnership model requires services be delivered in a certain way so that they are effective, and the MIECHV statute requires programs be operated in the way they

were designed and studied. What do you do as a nurse visitor to ensure fidelity to the model?

Ms. RUSSELL. So to prepare for each home visit, I will first start by reviewing what we had done at our last home visit just to see what we had talked about, refresh my memory so I don't forget as well, and then build on there.

So we have multiple different facilitators of educational sheets and activities, interaction activities, we can do with the family to do things hands-on. And, generally, what we try to do is ask the client, the next time I see you, is there anything specific you would like to talk about, is kind of how we end our visit. And if they are unable to name something, we have a choice sheet that they can choose from.

So that gives us the opportunity to deliver what the program is asking us to deliver, because the options that we are giving her to talk about are part of that blueprint curriculum for Nurse-Family Partnership.

Mr. SMITH OF MISSOURI. Thank you. I would like to speak to Rosa.

As one of the youngest Members in Congress and the youngest Member on this Committee, I am very impressed with you being here today. My first touch at ever speaking to anyone in government was before my small city council of a town of less than 5,000 people, and I was about your age and was fortunate enough to be able to still serve that city in Congress now. So I can only imagine what your future lies ahead if your first venture is to speak before what I believe is the most important Committee in Congress.

I am very impressed, and I look forward to seeing the great things that you will accomplish. And I just want to say, I am extremely proud and humble to be part of this.

And Ms. Rauner, as my neighbor to the east, I was highly impressed whenever I see a first lady that is a working first lady other than—just, you know, career and family, it is both a double task. But I would encourage you to meet with our first lady, Ms. Sheena Greitens, who is also a working first lady, and help mentor her as well. I think you would have a lot in common. Thank you for being here.

Chairman SMITH OF NEBRASKA. Thank you. Well said.

And Mr. Reichert from Washington State.

Mr. REICHERT. Thank you, Mr. Chairman.

Even though Mr. Smith is the youngest, we—you know, he has a lot of potential unless more senior Members are, you know, trying to work with him. He is coming along nicely.

You know, I—so I wanted to—so the first question I wanted to get to was for Mr. Bellamy.

Evidence-based, you have all mentioned that. We see that it is necessary, you know, from Rosa's testimony also. You know, as it applies to how it is used across the State, I think, my question: Doesn't it become complicated when you are looking at rural versus urban, and then you have to evaluate what services to provide? For example, you know, nurses or counselors that, sort of, help and how you get that—those resources to those different areas needing just different types of services and the population is spread out?

Mr. BELLAMY. Yeah. It can be a little tricky. But, again, I think the power in this is being able to identify appropriate programs for families and really tailoring those programs and interventions that are—that families are going into more specific to that family.

So when we target areas, we look at—you know, when we talk about needs assessment, we talk about areas that we want to go. We may look at, you know, specific programs that may work well there; however, again, the autonomy lies within those local implementing agencies. And we want to continuously work with them and partner with them to make sure that they have that ability to identify appropriate services.

So, again, in South Carolina, we really wanted to build a continuum service, that is why we didn't look at one specific model that we wanted to implement across the State or support across the State. We wanted to look at prenatally up to age 3, up to age 5 and look at the different services that we can implement within those communities to help with those services.

Mr. REICHERT. And that, really, is the important point here I think to make is every community is different. And you are in those communities, tailor making those services to each community is really the key and success.

I really like what you said, Ms. Rauner, about early childhood, the human capital development is absolutely critical. I am a 33-year law enforcement career retiree and ending up here in Congress. I was a cop in Seattle for 33 years ending up as a sheriff and being in homes and working with young people my entire career. That human capital is so critical.

Readiness for school, preparing people for the future gives hope and opportunity. And that is what is missing in today's world, that hope and opportunity, and ending that cycle of, you know, just coming from families, and getting into situations where it takes away hope. And—which goes back to the fatherhood issue.

You know, if young men don't have hope, they lose opportunities. They kind of disappear, and we have to save those young people.

The question I have for you—both of you and Ms. Rauner, first, was on the substance abuse issue. I think two or three of you mentioned that. What is the most common substance that is abused? I know opioids are the biggest problem today, but what are some of the others? Alcohol, tobacco, would that be some? Is marijuana in that?

Ms. RAUNER. Yes, I would certainly—I am not sure I have the exact data on that. I would certainly say that alcohol, and marijuana, and tobacco are some of the biggest—the most prevalent. What we also know is that substance abuse is very likely and very often associated with depression and mental health issues. And so, again, support for the underlying issues can, in fact, be an important part of both preventing and addressing substance abuse.

Mr. REICHERT. Yes. Again, I just want to thank all of you for being here today and for your testimony. This is such an important issue. And you can see from the comments on the dais here, you read in the papers and see in the media the lack of cooperation that some have described whereas, sort of, the state of, you know, separation in some—on some issues. But this is one issue where

you can see total agreement on this panel for both Democrats and Republicans.

We want to help. We think it is absolutely critical. And I thank you all for being here, and especially, again, Rosa.

And I hope I can see Angelica before—okay—before I leave today.

I yield back, Mr. Chairman.

Chairman SMITH OF NEBRASKA. Thank you, Mr. Reichert.

And, again, thank you to our witnesses. And if you don't mind, colleagues, we might want to grab a quick photo with our witnesses here momentarily.

But, again, thank you, to all of you, for sharing your unique perspectives. And we know that your personal experiences and professional expertise are very helpful. I think we have Angelica visiting here right now. Very good.

Please be advised that Members will have 2 weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record.

With that, the Subcommittee stands adjourned.

[Whereupon, at 10:25 a.m., the Subcommittee was adjourned.]

[Questions for the Record follow:]

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HUMAN RESOURCES

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

March 20, 2017

MEMORANDUM

Witness: Eric Bellamy
Home Visiting Manager
Children's Trust of South Carolina
1330 Lady Street, Suite 310
Columbia, SC 29201

From: Andrew Rocca, Legislative Assistant
Subcommittee on Human Resources

Subject: Questions for the Record for the hearing entitled, "*The Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program*."

Thank you for testifying before the House Ways and Means Subcommittee on Human Resources during the hearing entitiled, "The Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program." In order to complete the record of the hearing, **please respond to the attached Questions for the Record (QFRs) submitted by Mr. Reed of New York**.

Pursuant to the Committee rules, we ask that responses to the QFRs be returned to the Committee by 6:00 PM on Monday, April 3, 2017. Please submit your responses via e-mail as a Word attachment to Andrew.Rocca@mail.house.gov by that date.

If you have any questions concerning this matter, please feel free to contact me at the email above or via phone at (202) 225-1025.

Rep. Reed QFR for Mr. Eric Bellamy

1. While the main focus of home visiting programs tends to be health of the mother and child, one of the program models that South Carolina uses is Parents as Teachers which has a strong educational focus including school readiness and success. Can you speak to some of the educational results that you've seen in your state?

   The MIEHCV initiative has allowed South Carolina to improve in school readiness and educational capacities through several, concerted strategies. These efforts are rooted in the ability to provide funding for evidenced based service pervision in local communities with the most need. Additionallly, South Carolina, like many other states has worked extremely hard to integrate and strategically target such outcomes as education and school readiness, by building a continuum of services through several models and improving efforts with other early childhood systems.

   A strong foundational knowledge of child development, and engaged parenting behaviors are essential precursors to school readiness. In improved scores compared to 2014-2015 (84%, compared to 76% last), four out of every five MIECHV-enrolled caregivers demonstrated quantifiable improvement in scores reflecting support for child learning and development, knowledge of child development and the developmental progress, and parenting behaviors that strengthen parent-child relationships.

   The SC MIECHV programs also works to facilitate the upward mobility of participating families. This year, more families were identified as having specific needs at enrollment (33%, compared to 28%), and among those who were referred for services, 93% received those services. This year approximately 52% of families reported an increase in income or related benefits after 12 months of MIECHV enrollment. Among families who had no health insurance at program enrollment, more obtained health insurance during the course of their participation in the MIECHV program (56%, compared to 51% last year). Furthermore, 24% of mothers improved their level of educational attainment.

   The early identification of and intervention for developmental delays is crucial to a child's long-term well-being and school success. Among MIECHV-enrolled children who reached 12 months of age during program enrollment and were identified with possible developmental delays in communication, general cognitive skills, gross and fine motor skills, social and emotional behaviors patterns, and positive approaches to learning, the majority received appropriate and timely referrals.

2. In my State of New York, only eight counties are served directly by MIECHV- all focused on high density areas. What are some of the challenges in serving rural populations that are not faced serving urban populations? What ways have you found success in reaching poor rural areas?

Two of the biggest challenges that we have experienced with serving families in rural settings are transportation needs and access and equity to identified service needs. Many of the families that are served in our SC MIECHV program often lack the ability to follow up or physically report to services, once needs are identified through the home visiting framework.

To offset this, we have worked with our funded sites, through contiuous quality improvement efforts, to strive for innovatitive ways to work with and build local collaboration to assist in serving these families. Additionally, we provide supplemental training and workforce development efforts to continmuously strengthen the capacity and competency of this workforce.

From our initial MIECHV plan, we have established a 'hub-and-spoke' approach to building our state program. This approach is designed to connect lesser, often more rural communities and counties (e.g the "spokes") with areas that are more established or "richer" in resources (e.g. the "hubs"), contiguously. This approach has helped our program build partnerships and collaborations on both the macro and micro levels. As well, there has been a continued culture growth of a unified approach to home visiting across the state, systemically and systematically—with MIECHV funded programs and non-MIECHV programs. This has truly allowed for our families to be better connected to services in a more equititable manner.

3. In taking a look at what you've been able to accomplish in South Carolina, how important is analyzing outcomes in determining funding for programs? When we, as the Human Resources Committee, take a look at anti-poverty programs, would you advise us to implement similar evidence-based requirements like those found in MIECHV?

The SC MIECHV program continues to serve some of SC's most vulnerable families. This year, almost 70% of enrolled households lived below 100% of the Federal Poverty Level, 11% of caregivers were under 20 years of age; 58% of caregivers had a high school diploma equivalent or less, and 15% of families spoke a primary language other than English. The ability to build system and data processes that help us track these outcomes is imperative to the overall success of programs. Outcomes tell us two stories--the have, and the have not—or what we have done and what we need to do. We need to use outcomes, both quatititative and qualitative, to contiuously assist in improving our programs and targeting those families and areas most in need.

I believe the continued focus on evidenced based programming and the standardization that it can offer is a key element in true systematic internvention and holistically serving all families. Another key competent to this is for states, territories and programs to have a stronger sense of conitued autonomy to building their programs and knowing that there will be a continuity of financial support for their efforts. It is extremely difficult to build programs based on short-term support—because these often lead to only short-term outcomes.

April 6, 2017

Representative Davis,

Thank you again for the opportunity to testify before the House Ways and Means Committee Subcommittee on Human Resources regarding "The Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program" on March 15th. It was a pleasure to speak with you about Illinois' robust home visiting system and the opportunity that MIECHV has provided to enhance that system in order to increase the positive impacts of home visiting on the children and families that we serve.

I am writing in response to the following Question for the Record presented by you: "Ounce of Prevention is currently supporting innovative home visiting programs targeted at pregnant and parenting foster youth, and homeless youth. Can you tell us more about how you tailored the programs to focus on those very high-risk groups, how those projects are improving outcomes, and what you think might be the long-term benefits?"

As I mentioned in my oral and written testimonies, MIECHV undergirds and enhances our entire home visiting system and improves the lives of at-risk families and children in Illinois. We have always focused on identifying better ways to serve the most high-risk young children and their families, and MIECHV has provided us with a critical opportunity to further explore this for two key populations: pregnant and parenting youth in care, and homeless youth. Below I have included detailed information on these projects in response to your question.

Home Visiting-Child Welfare Pilot Project

The Illinois Pregnant and Parenting Youth in Care – Home Visiting (I-PPYC-HV) pilot project is a collaboration between state- and local-level stakeholders in both the home visiting and child welfare systems. The project was born out of an interest from the state agencies that fund and operate these programs to better serve pregnant and parenting youths in the care of the state, recognizing that due to the trauma they themselves have endured their children are statistically more likely to enter the child welfare system. For example, a study from Chapin Hall at the University of Chicago found that nearly 40%[1] of the children of these mothers entered the child welfare system in Chicago alone[2]. To that end, the primary long-term goal of this pilot project is to mitigate the intergenerational cycle of child abuse and neglect and the resulting trauma that it causes for families throughout the life course.

The pilot project launched in October 2016 with the goal of enrolling thirty families across eight sites in home visiting programs implementing the Healthy Families America (HFA) model. As of the writing of this response, 27 families have been referred to home visiting programs and nine are already receiving services. Outreach and referrals continue between the service providers for the child welfare system and the home visiting programs. Additionally, home visitors at all of the sites have received trainings to increase their knowledge about the child welfare system and its requirements and approach. Finally,

[1] This statistic is based on the percentage of families with any investigation for children under 5. 17% had an indicated report, and 11% were placed in foster care.

[2] Dworsky, A. (2015). *Child welfare services involvement among the children of young parents in foster care*. *Child Abuse and Neglect*, 45, 68-79.

through the MIECHV formula grant, a project coordinator has been hired, housed at Children's Home + Aid, in order to ensure that the pilot program runs smoothly and that programs receive the assistance that they need to be successful.

One of the key realizations early on in the development of the pilot project was the difficulty of reaching these very high-risk families before the baby turned two weeks old, which would have rendered them ineligible for the HFA model. Therefore, we engaged the national HFA office in a conversation about extending eligibility for the purposes of this pilot in order to reach these families. The national HFA office was excited about this pilot project and agreed to extend eligibility until the baby is one year old, which is an important adaptation for us when trying to reach these families. The national HFA office remains very engaged in the pilot and is planning to feature it in an upcoming newsletter. Another critical component of the project, given the high risk factors associated with the population being served, is the provision of infant mental health consultants to work with the home visitors participating in the pilot as well as training in the FAN approach. As these youth have likely experienced trauma, infant mental health consultants as well as this specialized training can support home visitors in working with these youth.

Chapin Hall at the University of Chicago will conduct an evaluation of the pilot project, which will examine whether the pilot program was effective in mitigating the intergenerational cycle of child abuse and neglect by creating a healthy attachment relationship between the mother and her baby. As the project is still in its initial stages, there is not yet data available on the short-term outcomes for the family. However, Chapin Hall plans to measure the following short- and long-term outcomes:

- Short-term outcomes:
  - Mothers receive postpartum health care and breastfeed for at least three months after giving birth (if they were enrolled before giving birth);
  - Parents quit smoking/using tobacco;
  - Mothers are screened for maternal depression and referred for treatment if appropriate;
  - Parents demonstrate more positive parenting and child rearing attitudes;
  - Children receive well-child checks as recommended by the AAP and a developmental screening;
  - Children are achieving general developmental milestones at the expected ages; and,
  - Children with developmental delays are referred for services.
- Long-term outcomes:
  - Mothers do not experience a subsequent pregnancy prior to emancipation;
  - Parents without a high school credential earn their high school diploma or GED and enroll in postsecondary education or training program or become employed;
  - Parents have health insurance coverage and are connected to a medical home following emancipation;
  - Parents demonstrate more positive parenting and child rearing attitudes;
  - Children are not the focus of a child maltreatment investigation or an indicated child maltreatment report;
  - Children are not placed in the care of the Illinois Department of Children and Family Services;

- Children are achieving general developmental milestones at the expected ages;
- Children are enrolled in an accredited early learning program or licensed day care by age 3; and,
- Children have health insurance coverage and are connected to a medical home following parent's emancipation.

Home Visiting for Homeless Families Demonstration Project

Young children who experience homelessness face a host of challenges that threaten their health, development, and ability to succeed in school. For example, a brief published in January of this year by the U.S. Department of Health and Human Services and OPRE concluded, among other things, that "compared to national norms, young children who have stayed in shelter have higher risk for developmental delays and higher rates of behavioral challenges"[3]. Unfortunately, many of the homeless services families may be accessing do not provide child-centered comprehensive services that address child well-being and parent-child attachment. At the same time, these families also face barriers to accessing early childhood services and supports that can improve outcomes, such as evidence-based home visiting.

The Home Visiting for Homeless Families Demonstration Project (HVHF) is a project led by the Ounce of Prevention Fund that seeks to improve the developmental trajectories of children experiencing homelessness in Chicago through high-quality home visiting services. Beginning in the fall of 2013, the Ounce recruited local home visiting and homeless service providers to volunteer to pilot three approaches to enhance the ability of home visiting programs to engage and serve homeless families:

1. Adding one new home visitor with specialized training in working with homeless populations to a home visiting program, who carries a reduced caseload to accommodate the intensive support that homeless families require;
2. Training all home visitors in participating home visiting programs to provide services to one or two homeless families as part of their overall caseload; and,
3. Training a homeless service agency so that home visiting can be integrated into the current services being provided through that agency.

All approaches include support for increased collaboration between home visitors and homeless service providers, additional training and technical assistance on identifying and working with homeless families, and an evaluation component to help identify effective approaches that could be replicated more broadly.

Another key feature of the pilot project has been to adapt home visiting models to allow more flexibility, with permission from home visiting models and funders. Some of the most common and significant barriers for home visitors include lack of training on serving homeless families and awareness of homelessness among home visitors; homeless families' tenuous connections to traditional referral

[3] Brown, S.R., Marybeth Shinn, and Jill Khadduri. (2017). *Well-Being of Young Children Experiencing Homelessness*, 2.

sources, such as public health departments and medical providers; difficulty in identifying and referring homeless families during the prenatal period or early months of infancy; and home visiting model and funder requirements, such as requirements that visits occur only in the home and restrictions on providing services only in a designated service area, which makes it very difficult to stay connected to highly mobile families. Accommodations to the models are dependent upon the needs of the family and may include: increasing options for the location of the home visits, extending enrollment to children who are older than typically permitted, and allowing home visitors to follow homeless families as they move outside of the typical service area. Finally, to alleviate programs' concerns that performance indicators might decline as a result of serving this higher-risk population, we've communicated to programs that we are viewing the pilot as a learning experience and thus we are not establishing requirements regarding benchmarks at this point.

As with the I-PPYC-HV pilot project, this is a relatively nascent project and so at this point it is difficult to definitively measure the short-term impact the intervention has had so far. Anecdotally, participants in the HVHF project have reported that the flexibility afforded to home visiting programs in implementing home visiting services has allowed programs to engage and stay connected to homeless families that they otherwise would not have been able to work with. In addition, home visitors have been able to play a critical role in connecting families to more resources and supports. Furthermore, a focus group analysis indicates that home visitors find supervision and support critical to serving these families, that it is important to have a common understanding of the definition of "homelessness", that the ability to be creative and persistent in reaching these families is important, and that there are some challenges in implementing the curricula as it is currently due to the unique challenges these families face. We view this innovation as an iterative process, and this anecdotal evidence is informing what additional supports need to be put in place to better allow home visiting services to be tailored to the needs of homeless families.

Our hypothesized long-term benefit is that the developmental trajectories for children from homeless families (children whom we know to be at-risk of a number of poor developmental outcomes) will be improved as a result of access to intensive home visiting services and that we will identify recommendations to improve policy and practice.

In conclusion, we are proud of these initiatives and look forward to seeing their long-term benefits for our most vulnerable young children and their families. I would be happy to answer any additional questions you may have, and to continue to share any information that would be helpful for you as you move forward.

Sincerely,

Diana Mendley Rauner, Ph.D

President, Ounce of Prevention Fund

[Submissions for the Record follow:]

Written Statement to Ways and Means Human Resources Subcommittee Hearing

On the Geography of Poverty, February 15, 2017

Charles Bruner, Ph.D.

The House Ways and Means Human Resources Subcommittee held an important hearing on February 15, 2017 on the topic of the geography of poverty. This topic deserves continued attention – and additional focus upon issues of age and race within difference geographic areas. It also deserves further drilling down not only to a county level, but to a neighborhood and census tract level.

This is needed to correct one statement in the release for that hearing that may be part of the perception about poverty but simply is not borne out by a detailed look at the facts:

> The traditional geography of poverty is changing. In recent years, poverty has shifted from cities to the suburbs, while poverty rates in rural areas are consistently higher than rates in urban communities.

In fact, Elizabeth Kneebone's testimony from the Brookings Institution at the hearing itself showed that, in terms of Americans in poverty, both suburbs and cities have experienced steady increases in the numbers of people in poverty from 1970 through 2015, while the number of people in poverty in rural areas has declined. Of course, population growth during this period has been primarily in metropolitan areas, and this only speaks to the numbers of people in poverty and not to their rates.

The Institute for Research on Poverty at the University of Wisconsin, however, shows poverty rates by center city, suburb, and rural/small town America over a similar time period (1967-2013). While in 1967 the highest poverty rate was in the rural/small town areas (20 percent, compared to 15 percent for center cities and 7 percent for suburbs), by 2013 center city rates (18.9 percent) had surpassed those in rural/small town areas (16.5 percent), while suburban areas had shown the largest percentage increase (to 11.9 percent).

The figures from both these reports come from United States Census data, which is the source for virtually all information about poverty in the United States.

Further analyses of poverty over this period from the Census also show that there have been dramatic reductions in poverty among seniors, while the poverty rate among children has increased. Moreover, while 61 percent of seniors in poverty are white and non-Hispanic, 69 percent of children living in poverty are either non-white or Hispanic. More of the poverty in rural areas is in the senior population, while much more of the poverty in the center cities is among children, particularly very young children.

When analysis is kept at the county level, the differences between center cities and suburbs generally are missed, as well as differences within neighborhoods in center cities or types of rural areas. When poverty is examined at the census tract level, the tracts with the highest child poverty rates (where 50 percent of the child population or more is in poverty) mostly are in center cities. Higher poverty areas for rural and small towns that do exist almost entirely are in the South and Southwest or on reservation land.

These high poverty tracts, whether in center cities or elsewhere, generally are the most distant from job opportunities, educational and recreational supports, and access to good housing and transportation. They generally are highly segregated racially and places subject to historical discrimination.

Finally, they are rich in young children. In census tracts with child poverty rates of 10 percent or less, 5.9 percent of all residents are young children (0-4). In census tracts with child poverty rates over 50 percent, 8.6 percent of all residents are young children (even with the undercount of young children in the census). These census tracts need commensurately more opportunities for children to grow and develop – physically, educationally, and socially – into healthy and productive adults – but generally have far fewer.

Part of the subcommittee release was a statement from Chairman Adrian Smith (R-NH), that stressed the importance of finding different solutions related to different geographies and needs to reach one common goal:

> *Our instinct might be to think rural Nebraska and urban Chicago are so vastly different they have nothing in common. But what we are charged to do in this subcommittee is to find ways for individuals and families to succeed, and those challenges are universal, even if they require different solutions ... It's important we realize and respect the differences between the constituencies we represent, as too often Congress proposes national, one-size-fits-all solutions when local flexibility is really what's needed.*

As this work proceeds, it is essential to tackle poverty issues with particular attention to differences of who is living in poverty across geographies – seniors and young children; white non-Hispanic and nonwhite and/or Hispanic persons.

Further, if America society is to eliminate or dramatically reduce poverty over the long-term, it is critical that children growing up today, whether or not their households can escape poverty, have the opportunity – particularly health, safety, and education – to themselves grow up to be free from poverty as adults and as they raise their own children. While it remains important to address the needs of seniors to live in safety and dignity, with their basic needs met, the long-term solutions to poverty ultimately will be determined by to the extent to which children can grow into adulthood healthy, educated, and ready to take on responsibilities of work, career, and parenthood.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

March 29, 2017

Statement of
The American Academy of Pediatrics

Testimony for the record to the
House Ways and Means Subcommittee on Human Resources

"Hearing on the Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting Program"

American Academy of Pediatrics • Department of Federal Affairs
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Chairman Smith, Ranking Member Davis, and Subcommittee Members:

The American Academy of Pediatrics (AAP) is a non-profit professional organization of 66,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. We are grateful for the opportunity to provide testimony for the record about the child health benefits of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). The House Ways and Means Committee has a significant opportunity to reauthorize this successful program and increase its resources to expand its impact, and we look forward to working together with Committee Members on this effort.

The AAP has long supported home visiting programs for the impact they have on children's health, development, and wellbeing.[1] Child health and developmental outcomes depend on the capabilities of families to provide a nurturing, safe environment for their infants and young children. A variety of factors can disrupt that capability, including health and educational disparities, parental trauma, poverty, and parental mental health and substance use disorders. Home visiting programs offer a mechanism for ensuring that at-risk families have social support, linkages with public and private community services, and ongoing health, developmental, and safety education. These programs make a major difference in the health and economic trajectories of child beneficiaries and their families, and MIECHV is a critical public policy intervention to improve access to these programs. As the Ways and Means Committee considers reauthorization of this important program, we offer this testimony on how to

[1] American Academy of Pediatrics Council on Community Pediatrics, 2009. The Role of Pre-School Home Visiting Programs in Improving Children's Developmental and Health Outcomes. *Pediatrics*. DOI: 10.1542/peds.2008-3607. Available online at http://pediatrics.aappublications.org/content/pediatrics/123/2/598.full.pdf

best support the MIECHV program so that it can continue to make a difference in the health and wellbeing of children.

Benefits of MIECHV-Funded Programs

MIECHV has consistently held itself to the highest standards of evidence-based practice. MIECHV funds programs focused on a variety of important child outcomes, including preventing maltreatment, fostering child development, promoting school readiness and improved long-term academic outcomes, and supporting the development of educational and work-related skills for parents. Home visiting programs provide families with social support through the development of a trusting relationship between the home visitor and parents. These relationships are designed to promote parent effectiveness and help engender strong bonds between the adults and children within families. Case management, referrals to community-based services, skill building for parents, child development education, and improvement in maternal health are all common components of programs, and help to break down silos and leverage other child welfare services. Working together, these components can bring about a variety of positive maternal and child health outcomes, including: improved parenting skills; improved home environment; ameliorated child behavioral problems; improved child intellectual development; enhanced maternal life course such as employment and education; reduced frequency of unintentional injury and the presence of home hazards; increased breastfeeding rates; and improved detection and management of postpartum depression.

Home visiting programs also generate substantial cost savings in health, education and social services. Home visiting programs are associated with reduced emergency department visits, decreases in foster care assignments, fewer hospitalizations, and reduced child protective services interventions, all of which lead to substantial cost savings. Children of families who participate in evidence-based home visiting services are also more likely to have gone for their preventive health care visits and are more likely to have all necessary vaccinations. Home visiting for support and observation of newborns with

low birth weight who are sent home early has been shown to be cost-effective. It saves significant costs for the health insurer while improving overall health status. Home visiting also has good evidence for its return on investment, which demonstrates the long term economic benefits that result from this child health program. At its core, quality pediatric care is prevention. Home visiting recognizes this crucial aspect of children's health and development, generating benefits to children, parents, and society across the life span. Home visiting programs not only improve the health of children and mothers now, but also reduce chronic health needs later in life.

Evidentiary Standard

MIECHV is flexible and adaptable, so that states and local communities can tailor solutions to the needs of their population. What makes this flexibility work, while still achieving these important outcomes, is the program's rigorous evidentiary standards. Currently, 17 home visiting models receive federal funding support through MIECHV. The diverse availability of models to meet population needs is a testament to the appropriateness of the current evidentiary standards in the MIECHV program. MIECHV uses rigorous requirements while also creating a pipeline for building the evidence base for demonstrating program effectiveness. This balance is critical to maintaining quality without inappropriately presenting barriers to implementation of promising practices. Current MIECHV policy employs an appropriate evidentiary standard. We urge you to maintain the current rigorous evidentiary standards in these reauthorization discussions.

Mental Health and Substance Abuse

During the hearing, Subcommittee Members expressed great interest in home visiting's role in addressing parental behavioral health, and particularly the effects of the opioid epidemic. The public health issue of prenatal drug exposure resulting from maternal substance use is

significantly affecting children's health and causing family disruption. In 2016, the U.S. Department of Health and Human Services reported that from 2012 to 2015, the percentage of child removals where substance use was a contributing factor rose from 28.5 percent to 32.2 percent.[2] Home visiting plays an important role in supporting parental health through screenings and linkages to community treatment services, such as postpartum depression screenings and substance use disorder treatment. In addition, home visitors serve a vital social support role to parents receiving these services. Parental substance use and its impact on child health and wellbeing is a growing public health crisis, and there is evidence that evidence-based home visiting programs can reduce substance use in pregnant women. Home visiting is an important part of the continuum of successful policy responses to this issue.

Home Visiting and the Pediatric Medical Home

Home visitors can also have an essential role in augmenting the services of the traditional pediatric medical home. Home visitors can be health care advocates and improve access to providers of care. In addition, they can be partners with pediatricians and other clinicians, working in the home setting to provide essential education and supportive services to at-risk children and families and to improve adherence to medical preventive and treatment regimens. Home Visitors can enhance developmentally oriented anticipatory guidance with content that meets families' individual needs. Home visiting programs can work as a complementary service to pediatricians' care that enhances children's health and developmental trajectories. Supporting and facilitating the relationship between families and their children's pediatricians is a critically important aspect of home visiting. Current MIECHV flexibility already allows for the strengthening of these relationships, and there is a significant opportunity to expand

[2] See https://www.acf.hhs.gov/media/press/2016-number-of-children-in-foster-care-increases-for-the-third-consecutive-year

this approach in the future. We suggest that Congress and the U.S. Health Resources and Services Administration (HRSA) work collaboratively to encourage MIECHV-funded programs to intentionally incorporate collaboration between the home visitor and the child's pediatrician into their approach. Increased emphasis on this collaboration can maximize the child health benefits of MIECHV.

Funding

MIECHV is a successful program that is benefitting children and families across the country. To continue expanding the reach of the program to cover those who would benefit, additional federal resources are necessary. The AAP supports increasing annual MIECHV funding from $400 million to $800 million to expand the program's capacity, support further innovation in developing effective models, and to address ongoing public health needs, including the impact of the opioid crisis on children and families. While this important program reaches many families it is currently far below serving all eligible families, and these resources will help expand the program's reach.

Part of what makes MIECHV successful is the ways in which home visiting programs serve as a linkage point for families to other critical community resources. Home visiting has greater impact when a community has the capacity to meet needs that the home visitors identify in the families they serve. The success of MIECHV is context dependent, so we urge Congress to provide these additional funds without reducing support for other important health and human services programs serving vulnerable children and families.

Conclusion

Thank you again for the opportunity to provide testimony for the record on the reauthorization of MIECHV. Home visiting is an essential child health intervention that makes a difference in the lives of children and families. We look forward to continuing to work together on this important issue as the reauthorization process continues.

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March 29, 2017

Attention: Committee on Ways and Means

Thank you for this opportunity to submit information in support of the reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. In Illinois, MIECHV has been instrumental in moving toward cohesion for what was a somewhat misaligned field of practice.

I represent Baby TALK, an organization that has worked for over 30 years to deliver services to families prenatally with children through age five in Macon County, Illinois. In addition, Baby TALK has trained practitioners in our evidence-based model and relationship-based approach in over 30 states. In Illinois, Baby TALK practitioners serve over 5,000 children and while Baby TALK is not currently one of the funded MIECHV models, all home visiting practitioners have had the benefit of accessing current and relevant training that supports their professional development and the work they do with families. In turn, Baby TALK has provided newborn encounter training to MIECHV Coordinated Intake workers statewide to support Illinois' efforts towards universal screening for families with newborns.

In addition, in Macon County, the MIECHV community systems component has enhanced our Early Childhood Coalition and helped formalize a more structured coordinated intake process for all low income families interested in home visiting and other early care and education services in the area. It is important to note that MIECHV does not only impact the children and families enrolled in programming, but the entire home visiting sector. This funding stream has enabled Illinois to grow, align and integrate our home visiting system increasing positive outcomes for children and families. We hope that this committee will see the value of reauthorizing this program which supports the provision of meaningful services to vulnerable populations.

Sincerely,

Shauna Ejeh
Executive Director

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HOUSE WAYS AND MEANS SUBCOMMITTEE ON HUMAN RESOURCES

HEARING ON MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING (MIECHV) REAUTHORIZATION HEARING
MARCH 15, 2017

Statement for the Record Submitted by:

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March 28, 2017

Involved fatherhood is linked to better outcomes on nearly every measure of children's wellbeing, from cognitive development and educational achievement to self-esteem and pro-social behavior.[1] When fathers are committed to the lives of their children, those children are also more likely to be healthy, productive, empathetic, and emotionally secure.[2] Fathers play a crucial role in child development, but historically, social programs aimed at poverty alleviation, health, and parenting have been geared almost exclusively toward mothers and children.[3] Programs for fathers, by contrast, have traditionally sought to increase their financial contributions to the family, with little attention given to their broader role in the family.[4]

For the last five years, my team at the Child and Family Research Partnership (CFRP) and I have conducted multiple evaluations of the MIECHV-funded Texas Home Visiting (THV) program including two studies focused specifically on father involvement. Findings from these evaluations are detailed in the following pages, but are highlighted here:

- Multiple barriers (e.g., work schedules) often prevent fathers from participating in home visits, but fathers engage with home visiting programs in other ways including attending other program activities, completing homework or practicing lessons with the mother and child, or asking mothers about the visit.
- Fathers value home visiting programs and cite their child's improved school readiness and health outcomes as being particularly important.
- Program staff can be trained to increase father participation including specifically inviting fathers to visits and program events, and being flexible with the timing and location of home visits to accommodate fathers' work schedules.
- Father participation in home visiting programs is positively linked to family retention, which provides both parents increased opportunity to benefit from the program. Families in which fathers have participated in at least one home visit stay in the program over six months longer than families in which fathers never participate, controlling for family, program, and community factors.

My team and I also evaluate other federally- and state-funded fatherhood programs that aim to increase the quantity and quality of fathers' involvement in their children's lives, improve the co-parenting relationship between the child's parents, and support fathers' financial stability. Fathers report the connections to other fathers in the class, the class facilitator, and community resources, and learning to be patient with their children as the primary value of participating in the program. Additional insight to the value of the program, as reported by fathers, is provided in these videos: (https://youtu.be/bIwEgSrztbQ and https://youtu.be/PTfYns31q04).

CHILD & FAMILY
RESEARCH PARTNERSHIP
THE UNIVERSITY OF TEXAS AT AUSTIN
LYNDON B. JOHNSON SCHOOL OF PUBLIC AFFAIRS

March 2017

CFRP POLICY BRIEF

Engaging Fathers in Home Visiting: Lessons from Texas

Involved fatherhood plays a crucial role in child development, but programs aimed at parenting, including home visiting programs are often targeted at mothers. Two evaluations of the MIECHV-funded Texas Home Visiting (THV) program demonstrate that fathers engage with home visiting programs in many ways, even if they do not attend home visits; program staff can increase father participation simply by inviting fathers to participate; and father attendance at visits and program events is positively related to family retention. This brief highlights key findings from each evaluation.

Father involvement in children's lives is associated with positive outcomes for children across multiple domains, from cognitive development and educational achievement to self-esteem and pro-social behavior.[5,6] In response to this growing body of research, policymakers and practitioners have become increasingly interested in finding ways to support fathers to be more involved with their children. Home visiting programs (HVPs) provide an opportunity to help mothers and fathers support their children during a critical time for child development. Despite this potential value, HVPs typically only target mothers and little is known about the specific strategies that are effective for engaging fathers in programs.

The Texas Department of Family and Protective Services Prevention and Early Intervention (DFPS PEI) division contracted with the Child and Family Research Partnership (CFRP) to conduct two evaluations of father participation in home visiting programs. In the first, the goal was to develop a better understanding of the strategies that are effective for increasing father participation, as well as the family and program characteristics that enhance and limit the effectiveness of different father engagement strategies. In the second, the goal was to determine whether father participation in home visiting programs is associated with higher rates of family retention and whether attrition patterns—including when families leave, which families leave, and why families leave—are associated with whether or not fathers participate in the program. For both evaluations, CFRP used a mixed-methods approach, analyzing

administrative and survey data collected from families participating in THV across the state, and qualitative data collected through interviews with program staff and focus groups with fathers. Findings from both evaluations are highlighted below.

Father Participation Evaluation

The Father Participation Evaluation (FPE) was guided by five research questions:

1. How do fathers participate in home visiting programs?
2. What are the barriers to father participation in home visiting programs?
3. What program strategies are associated with higher levels of father participation in home visiting programs?
4. How do home visitor characteristics enhance and limit the effectiveness of father engagement strategies?
5. How do family characteristics enhance and limit the effectiveness of father engagement strategies?

On average, the MIECHV-funded home visiting sites in Texas experienced similar levels of father participation found in other early childhood programs with a home-based component. There is substantial variation, however, in the levels of father participation among the MIECHV-funded sites in Texas, and many sites have successfully encouraged relatively high levels of father participation among families. Although study design and data limitations prevented CFRP from assessing whether the trainings and technical support the state provided had a significant effect on home visitors' practices and levels of father participation associated with these practices, qualitative analyses of data collected from staff indicate that the trainings encouraged staff to prioritize father engagement in a way that they had not done in the past.

Consistent with prior research, CFRP identified that the main barrier to fathers' participation is fathers' work schedules. Some fathers also noted, however, that they did not know they were welcome to participate described being hesitant to participate because they perceive the program to be more in line with the maternal roles and responsibilities in their family. In addition, non-resident fathers and fathers who are not in a relationship with their child's mother may face distinct barriers to participation that are not well captured in our study.

Offering to schedule visits at a time when fathers can attend is the most effective strategy for encouraging fathers to attend at least one home visit, which is consistent with parents' reports that fathers' work schedules are the largest barrier to father participation. Once a father has attended a visit, explaining the benefits of father participation to fathers is the most effective approach for increasing the number of visits that he attends. CFRP found that parents' relationship is the primary family characteristic that mediates the effect of the father engagement strategies, and none of the home visitor characteristics included in this study explain the effectiveness of the strategies.

Based on these analyses, the evaluators recommend that programs interested in encouraging father participation use "invite dad" strategies, such as explaining the benefits of father participation to parents and offering to schedule visits when fathers can attend. Perhaps the

simplest strategy that sites can use to increase father participation is for home visitors to consistently initiate conversations about engaging fathers with the mothers with whom they work. If sites are interested in consistently engaging fathers in home visits they may need to make programmatic and policy changes beyond outreach and occasional scheduling accommodations, such as adopting more flexible scheduling policies.

Importantly, the evaluators also learned that the majority of fathers are engaging with the home visiting programs in ways that researchers and programs have not traditionally measured, suggesting a need to expand measures of father participation in future research to more accurately capture the diverse ways fathers are participating in programs. Evidence-based home visiting program models should define their measurements based on the curriculum, but they may also include measures such as father attendance at program activities, homework completed by fathers, lessons mothers re-taught to fathers, or lessons fathers practiced with their child or their child's mother. Collecting these more nuanced measures of father engagement in the program will be necessary for building a better understanding of the ways fathers are participating and for linking father participation to family outcomes.

Father Participation and Retention Evaluation

The Father Participation and Retention Evaluation (FPRE) had five research aims:

1. When do families leave HVPs?
2. Which families are most likely to leave HVPs before completion?
3. How do families participate prior to dropping out?
4. Why do families leave HVPs before completion?
5. Do these retention patterns vary by father participation?

To gain a better understanding of attrition in HVPs, CFRP examined when families leave HVPs, who leaves, how families participate prior to leaving, and why families leave. Findings suggest that higher-risk families, including families with mothers who are poorer and younger, receive more visits initially but are more likely to leave prior to one year of enrollment and are more likely to leave for undesirable reasons such as home visitors no being able to find them. These findings are consistent with prior research on family retention in HVPs which found that higher-risk families have greater initial engagement in the programs but reduced long-term engagement.

Finally, CFRP explored the link between father participation and family retention in home visiting. Consistent across analyses, father participation, specifically observable participation including attendance at home visits or parent/group meetings, was positively linked to family retention. The link was still significant even after controlling for important family characteristics that might suggest the link only reflects selection bias—that the families who have engaged fathers have certain characteristics that may also make them more likely to participate longer. These findings suggest that engaging all family members, particularly fathers, in home visiting programs can

promote family retention. Although more research is needed, our analysis demonstrates a clear association between father participation in HVPs and longer family enrollment.

Based on these findings, CFRP developed three recommendations. First, CFRP recommends that researchers and practitioners define and measure father participation more broadly than simply participation that is visible to HVP staff. Second, CFRP recommends that practitioners examine who leaves their program, when, and why in order to develop effective and targeted retention strategies for families who may be at the highest risk of leaving. Third, CFRP recommends that practitioners focus specifically on engaging fathers in home visiting programs as a retention strategy.

For Additional Information:

Both mothers and fathers provided important perspectives on father participation in HVPs that were collected through surveys and focus groups. Summaries of both perspectives are provided here:

1. Lessons from mothers: http://childandfamilyresearch.org/publications/b0010514/
2. Lessons from fathers: http://www.childandfamilyresearch.org/content/uploads/CFRPBrief_B010.0613_HVLessonsFromDads1.pdf

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The Child and Family Research Partnership (CFRP) is an independent, nonpartisan research group at the LBJ School of Public Affairs at The University of Texas at Austin, specializing in issues related to young children, teens, and their parents. We engage in rigorous research and evaluation work aimed at strengthening families and enhancing public policy.

Endnotes

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[1] Rosenberg, Jeffrey, and Wilcox, W. Bradford. United States Department of Health and Human Services. Administration for Children and Families. Child Welfare Information Gateway. *The Importance of Fathers in the Healthy Development of Children.* Office on Child Abuse and Neglect, U.S. Children's Bureau, 2006. Retrieved from https://www.childwelfare.gov/pubs/usermanuals/fatherhood/chaptertwo.cfm; Bronte-Tinkew, Jacinta et al. *Involvement among Resident Fathers and Links to Infant Cognitive Outcomes.* Journal of Family Issues. Volume 29 Number 9. September, 2008. 1211-1244.; Cabrera, N. J., Shannon, J. D., & Tamis-LeMonda, C. (2007). Fathers' Influence on Their Children's Cognitive and Emotional Development: From Toddlers to Pre-K. *Applied Developmental Science*, *11*(4), 208-213; Black, M. M., Dubowitz, H., & Starr, R. H., Jr. (1999). African American Fathers in Low Income, Urban Families: Development, Behavior, and Home Environment of Their Three-Year-Old Children. Child Development, 70 (4), 967-978.; Carlson, Marcia J. and Katherine Magnuson. (2011) Low-Income Fathers' Influence on Children. The Annals of the American Academy of Political and Social Science. 635:95. 95-116.; Carlson, Marcia J., Sara S. McLanahan, and Jeanne Brooks-Gunn. (2007, September) Fathers' Involvement and Young Children's Behavior in Fragile Families. Extended Abstract; Carlson, Marcia J., Sara S. McLanahan. (2009, May 11) Fathers in Fragile Families. Center for Research on Child Wellbeing. Working Paper WP09-14-FF.; Harris, Kathleen Mullan, Frank F. Furstenberg, and Jeremy K. Marmer. (1998). Paternal Involvement with Adolescents in Intact Families: The Influence of Fathers over the Life Course. Demography. 35 (2), 201-216.; Carlson, M. J. (2006), Family Structure, Father Involvement, and Adolescent Behavioral Outcomes. Journal of Marriage and Family, 68: 137–154.

[2] United States Department of Health and Human Services. (2011, July). *Promoting Responsible Fatherhood: Effective Parenting*. Federal Research Site. Retrieved from http://fatherhood.hhs.gov/Parenting/index.shtml

[3] Haskins, R., & Sawhill, I. (2009). Creating an Opportunity Society. Brookings Institution Press, 191; Solomon-Fears, Carmen. (2015). Fatherhood Initiatives: Connecting Fathers to Their Children. (CRS Report No. RL31025). Retrieved from Congressional Research Service. https://www.fas.org/sgp/crs/misc/RL31025.pdf; Osborne, C., Workgroup, R. F., Austin, J., Dion, M. R., Dyer, J., Fagan, J., & Scott, M. E. Framing the Future of Responsible Fatherhood. Evaluation Research for the Fatherhood Research and Practice Network. Responsible Fatherhood Workgroup.

[4] Ibid.

[5] Sarkadi, A., Kristiansson, R., Oberklaid, F., & Bremberg, S. (2008). Fathers' involvement in children's developmental outcomes: a systematic review of longitudinal studies. *Acta Paediatrica*, *97*, 153-158. doi:10.1111/j.1651-2227.2007.00572.x

[6] Rosenberg, Jeffrey, and Wilcox, W. Bradford. United States Department of Health and Human Services. Administration for Children and Families. Child Welfare Information Gateway. *The Importance of Fathers in the Healthy Development of Children.* Office on Child Abuse and Neglect, U.S. Children's Bureau, 2006. Retrieved from https://www.childwelfare.gov/pubs/usermanuals/fatherhood/chaptertwo.cfm; Bronte-Tinkew, Jacinta et al. *Involvement Among Resident Fathers and Links to Infant Cognitive Outcomes.* Journal of Family Issues. Volume 29 Number 9. September, 2008. 1211-1244.; Cabrera, N. J., Shannon, J. D., & Tamis-LeMonda, C. (2007). Fathers' Influence on Their Children's Cognitive and Emotional Development: From Toddlers to Pre-K. *Applied Developmental Science*, *11*(4), 208-213; Black, M. M., Dubowitz, H., & Starr, R. H., Jr. (1999). African American Fathers in Low Income, Urban Families: Development, Behavior, and Home Environment of Their Three-Year-Old Children. Child Development, 70 (4), 967-978.; Carlson, Marcia J. and Katherine Magnuson. (2011) Low-Income Fathers' Influence on Children. The ANNALS of the American Academy of Political and Social Science. 635:95. 95-116.; Carlson, Marcia J., Sara S. McLanahan, and Jeanne Brooks-Gunn. (2007, September) Fathers' Involvement and Young Children's Behavior in Fragile Families. Extended Abstract.; Carlson, Marcia J., Sara S. McLanahan. (2009, May 11) Fathers in Fragile Families. Center for Research on Child Wellbeing. Working Paper WP09-14-FF.; Harris, Kathleen Mullan, Frank F. Furstenberg, and Jeremy K. Marmer. (1998). Paternal involvement with

adolescents in intact families: The influence of fathers over the life course. Demography. 35 (2), 201-216.; Carlson, M. J. (2006), Family Structure, Father Involvement, and Adolescent Behavioral Outcomes. Journal of Marriage and Family, 68: 137–154.

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March 20, 2016

House Ways and Means Human Resources Subcommittee
1102 Longworth HOB
Washington D.C. 20515

Dear House Ways and Means Human Resources Subcommittee:

As one of the largest and oldest nonprofit children and family service providers in the country, Children's Home Society of Washington is writing in support of reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. We believe that funding for evidence-based home visiting programs is critical to improving the lives of children and their families.

As leading early learning provider in the state of Washington, Children's Home Society of Washington offers the MIECHV-funded home visiting model Parents as Teachers, which boosts the early development, learning and health of young children by supporting and engaging their parents and caregivers. In addition to showing positive outcomes for children, Children's Home Society of Washington has integrated economic mobility coaching into Parents as Teachers to help families move out of poverty and reach self-sufficiency. We strongly support the reauthorization of the MIECHV program that funds high quality services for children, which are evidence-based, and provides accountability in tracking the provision of services and benefits for children.

We look forward working to with you to ensure that MIECHV funding remains intact and to continue to explore additional improvements within MIECHV-funded programs to ensure better outcomes for children and their families. Thank you for your continuing leadership on behalf of these children.

Sincerely,

Sharon Osborne	Neal F. Lessenger
President/CEO	Board Chair

cc: Children's Home Society of Washington Board of Trustees

Children's Institute

childinst.org

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To: U.S. House Committee on Ways and Means, Human Resources Subcommittee
From: Elena Rivera, Health Policy & Program Advisor, Children's Institute
Date: March 20, 2017
Re: In support of reauthorizing the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program

Chairman Smith, Ranking Member Davis, and members of the Subcommittee:

My name is Elena Rivera, and I am the Health Policy & Program Advisor for Children's Institute. Children's Institute's mission is to ensure every child in Oregon is prepared for school and life. Thank you for the opportunity to provide testimony in support of reauthorizing the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Children's Institute champions early investments in kids and families from prenatal care to age eight to boost education and health outcomes for all of Oregon's children. My testimony reflects the perspective of a state that has benefited greatly from the MIECHV program and deeply understands the value of voluntary, evidence-based home visiting services in driving positive outcomes for kids and families.

The importance of maternal, infant, and early childhood home visiting

We know children experience their most profound cognitive, physical, social, and emotional growth in the first few years of life. Over 80 percent of brain development takes place by the time children reach three years old. When young children live in stable and healthy environments and have nurturing caregivers, they are more likely to be healthy and meet developmental milestones. The quality of children's early experiences during this crucial period of growth sets the foundation for all future learning and lifelong health.

Maternal, infant, and early childhood home visiting is a critical intervention for vulnerable families. Home visiting promotes healthy child development by serving expectant parents and their children through the first few years of life. Programs match skilled home visitors with families facing risk for poor outcomes to offer parents resources, information, and tools that strengthen parent-child relationships, ensure children are getting the health care they need, and promote early learning. Home visiting programs intervene early to prevent and reduce adverse childhood experiences that could have lifelong impacts on health, education, and economic outcomes, thereby saving the state millions in costly interventions later down the road and promoting a healthy and productive workforce.[i, ii]

MIECHV home visiting is a critical piece of Oregon's early childhood system

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Oregon has been awarded MIECHV funding since the initiation of the program in 2010. With this federal funding, our state serves vulnerable children and families in 13 counties through three evidence-based programs: Healthy Families Oregon, Nurse Family Partnership, and Early Head Start.

In Oregon, MIECHV programs have directly improved maternal and newborn health, decreased child injuries, abuse and neglect, decreased emergency room visits, increased child school readiness, decreased crime and domestic violence, and increased family economic self-sufficiency.[iii]
In addition to these outcomes of direct service provision, the MIECHV program has also been instrumental in driving system development work to build a comprehensive early childhood system that truly works for children and families. Oregon's MIECHV program is working to align with other state-funded home visiting programs, building collaboration with new regional Early Learning Hubs and Coordinated Care Organizations, and creating a more robust home visiting and early childhood data system. The value of this work cannot be overstated.

Reauthorize the MIECHV program

Oregon has achieved incredible progress in reaching children and families with critical and cost-effective home visiting services and in building an evolving comprehensive early childhood system. This work would not be possible without the MIECHV program. I urge the Subcommittee to strongly support reauthorization of the MIECHV program to ensure that progress in supporting maternal and child health and success across the country is not stalled.

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[i] Oregon Health Authority. Building Resiliency: Preventing Adverse Childhood Experiences. https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/Documents/OregonACEsReport.pdf
[ii] Nurse Family Partnership. What is Evidence-Based Policy? Using Public Dollars Wisely to Support Programs that Work. http://www.nursefamilypartnership.org/Public-Policy/Evidence-based-policy
[iii] Health Resources and Services Administration. Home Visiting Program: Oregon. 2015.

STATEMENT TO THE

U.S. HOUSE WAYS AND MEANS HUMAN RESOURCES SUBCOMMITTEE

ON REAUTHORIZATION OF THE MATERNAL, INFANT AND EARLY CHILDHOOD HOME VISITING (MIECHV) PROGRAM

BY

MAYNARD FRIESZ
ASSISTANT VICE PRESIDENT, GOVERNMENT RELATIONS
EASTERSEALS, INC.

MARCH 15, 2017

Chairman Smith, Ranking Member Davis, and Members of the Subcommittee:

I am pleased to share Easterseals' strong support of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and to provide examples of how our community-based affiliates are using MIECHV funds to improve the lives of children and families all across the country. Easterseals appreciates your leadership on the MIECHV reauthorization and respectfully asks that you take immediate steps to extend and fully fund the MIECHV Program.

Easterseals is a leading non-profit organization committed to helping individuals with disabilities and others reach their potential and thrive in their communities. Easterseals provides life-changing, community-based services, including home visiting, early childhood and other MIECHV-funded supports, to individuals and their families through a national network of 75 affiliates. More than one million people benefit annually from Easterseals services.

As a leading provider of child development and early intervention services, Easterseals understands that the first years of life lay the foundation for a child's long-term well-being and overall success. As part of our *Make The First Five Count* national campaign, Easterseals offers a free, comprehensive and confidential online screening tool for parents to track their children's growth and development. The tool has helped families understand and connect to available community services to help support their child's development. Research also shows that young families with regular and early access to a nurse, social worker or other trained professional improves health and child development outcomes and reduces child abuse and neglect.[i]

Congress created MIECHV to help meet the needs of and improve the well-being of low-income, expectant families and families with young children through voluntary home visiting and counseling services. Through the program, states, territories and tribal entities receive federal funding to deploy evidence-based home visiting models and promising approaches to help families from at-risk communities with high concentrations of poverty, crime, unemployment, substance abuse, high school drop-outs, and infant mortality. More than 912,000 home visits were made to families across the country as a result of MIECHV funding.[ii] In addition to improved child development, the home visits and counseling were instrumental in helping to increase parental earnings and to reduce emergency room visits and need for public benefits.[iii]

States regularly partner with community providers, such as Easterseals, to implement MIECHV best practices. Across the country, Easterseals uses MIECHV funding to improve lives and to demonstrate a strong return on investment.

ALABAMA: Easterseals Alabama assists families in western Alabama through two MIECHV-funded best practice models: Parents as Teachers (PAT) and Nurse-Family Partnership (NFP). Easterseals' PAT provides information and support to families in need in an 11-county area near Tuscaloosa. Easterseals West Alabama specialists help empower parents to recognize and support key child development milestones and to prepare their children for school. Easterseals West Alabama works with more than 150 families and over 200 children each year through PAT. NFP provides maternal and early childhood health support to vulnerable first-time moms in Tuscaloosa County. Through the program, a specially trained nurse meets with the mothers during pregnancy and until the baby turns two to help lay the foundation for parental and childhood success. Nationwide, NFP has been successful in promoting child health through healthy birth weights and immunizations.[iv] Easterseals West Alabama assists about 75 mothers annually through NFP.

ARIZONA: Easterseals Blake Foundation provides employment, behavior health, and supportive and community living supports to individuals with disabilities and others from Arizona. Easterseals Blake Foundation provides Parents as Teachers support to families living in Cochise, Pima, Pinal and Yuma counties. In addition, Easterseals family specialists assist first-time pregnant mothers in Pima County through NFP. Yasmen was one of the mothers who has participated in and benefited from Easterseals' supports through the MIECHV-funded Nurse-Family Partnership best practice. She was paired with an Easterseals Blake Foundation nurse during her pregnancy, which was a time of great transition and hardship for Yasmen having been placed in the care of extended family members. Despite the challenges, Yasmen was committed to being a great mom. She fully engaged in NFP classes and activities, receiving guidance, parent coaching and individualized support. She maintained a healthy, full-term pregnancy, delivering Mario, a beautiful, healthy young boy. Determined to create a better future for her family, Yasmen finished high school on-schedule and completed multiple college credits. She earned her Early Childhood Studies Certification—which she uses as a child care teacher—and plans to pursue further education in her chosen field. Her and Mario are on the road to success as a result of MIECHV investments.

ILLINOIS: Easterseals Serving Chicagoland & Rockford provides inclusive child care, autism, family support, and adult services for individuals with disabilities and families. In Illinois' Winnebago County, Easterseals Serving Chicagoland & Rockford promotes health and stable families by providing parenting and prenatal education, infant health counseling and home visiting to pregnant teenagers and young teen mothers living in Rockford and other Winnebago County communities. Administered by the Winnebago County Health Department, the evidence-based Teen Family Support Program has helped hundreds of teen parents like Triasia. About to give birth, the Rockford teen found it difficult to focus on her school work and felt overwhelmed by the responsibility of caring for a child. Easterseals specialists connected Triasia to a birth support partner and provided counseling and educational resources to prepare her for success in motherhood. While taking care of her daughter, Brooklynn, Triasia finished high school and today is working and attending college to be an elementary school teacher.

TEXAS: Easterseals Rio Grande Valley located in McAllen, Texas provides a range of services for children and adults with disabilities, including child care, early childhood intervention and adult therapy services. In addition, Easterseals Rio Grande Valley specializes in providing Texas families with the skills, information and supports they need to raise their young children with and without disabilities. Easterseals partners with the Texas Department of Health and Human Services on its Texas Home Visiting program, which uses four evidence-based models to assist eligible families. Through the program's Parents as Teachers model, Easterseals specialists work with parents through one-on-one and group meetings to address needs and provide parenting support. Easterseals Rio Grande Valley also helps prepare young children for kindergarten through reading, counting and other at-home educational activities.

Congress last authorized and funded the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program through the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10). Easterseals supported this bipartisan effort and urges the 115th Congress to expand access for at-risk families to MIECHV parenting supports and trained professionals. Thank you for your support of children and families and for your consideration of Easterseals' views on and support of a long-term reauthorization of MIECHV.

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[i] Department of Health and Human Services, FY 2017 HRSA Budget Justification, https://www.hrsa.gov/about/budget/budgetjustification2017.pdf
[ii] Department of Health and Human Services, FY 2017 HRSA Budget Justification, https://www.hrsa.gov/about/budget/budgetjustification2017.pdf
[iii] Department of Health and Human Services, FY 2017 HRSA Budget Justification, https://www.hrsa.gov/about/budget/budgetjustification2017.pdf
[iv] NFP in Alabama Fact Sheet, http://www.nursefamilypartnership.org/getattachment/locations/Alabama/AL_State_Profile-(1).pdf.aspx

Statement for the Record: Harvard Police Department Chief John Smith & Gage County Sheriff Millard Gustafson, Nebraska

House Ways & Means Subcommittee on Human Resources
Hearing on Maternal, Infant, and Early Childhood Home Visiting (MIECHV)
March 15, 2017 | 10:00 am

How Home Visiting Increases the Health and Wellness of our Communities
A police chief and sheriff in Nebraska make the case for reauthorizing the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

Approximately 3,500 children experience abuse or neglect each year in Nebraska. In our more than 50 combined years of law enforcement, we have seen many difficult scenarios involving these children. What is not immediately visible in these situations is that there are longer-term repercussions to child abuse and neglect. Children who are abused and neglected are twice as likely to become involved in crime later in life. However, if we reach out to families early, many child abuse and neglect cases are preventable. Guidance and support provided by advisors to parents in the early years of a child's life can make all the difference.

In voluntary home visiting, a coaching relationship between young parents and trained experts is developed. A professional who specializes in early childhood issues partners with parents to lay a strong foundation for the child's success. In home visiting, new moms and dads receive counseling and support on a range of critical parenting skills from pregnancy through the first years of the child's life.

Often times, it is everyday situations that are the greatest stressors of new parents. Having knowledge of what action to take when a baby will not stop crying, guidance for when a child is teething, proper sleeping positions, how to childproof a home; new parents often stumble and need help. Infants do not come with instruction manuals and coaching of vital daily skills increases the child's chance of good health and wellness.

The program, known as the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, is not only common sense but evidence-based. MIECHV allocates 75 percent of funding to proven home visiting programs and 25 percent to promising programs undergoing rigorous evaluation. Ways & Means Human Resources Subcommittee Chairman Adrian Smith noted the effectiveness of these models in improving family outcomes in a hometown site visit with Healthy Families America.

The benefits are far reaching, extending from family to community, with a demonstrable fiscal impact. A study of the Early Head Start program found that mothers who received home visits increased their earnings by $3,600 a year, likely because the program helped connect them with education and jobs. As a result of crime reductions and other outcomes, a cost-benefit analysis by the Nurse-Family Partnership found that high-quality home visiting programs achieve average savings of $6,000 for each family served, and welfare savings of $14,500 per family over a decade.

Home visiting is more than just a solution for one family, or one at-risk child. It is a solution for communities here in Nebraska, and across the country. This fall, Congress must act to reauthorize MIECHV and make decisions about its funding moving forward. We urge all representatives to contemplate the value of preventing abuse and neglect, preventing crime, and increasing the health and wellness of our communities. It is working here in Nebraska.

John Smith is Chief of the Harvard Police Department and Sheriff Millard Gustafson of the Gage County Sheriff's Office. They are both members of the national anti-crime organization, Fight Crime: Invest in Kids.

March 27, 2017

House Ways and Means Committee
1102 Longworth HOB
Washington, DC 20515

Dear Chairman Smith, Ranking Member Davis, and members of the subcommittee,

As the Director of Home Nursing Agency's Nurse-Family Partnership Program®, I wholeheartedly agree with the House Ways and Means Human Resources Subcommittee Chairman Adrian Smith that for a home visiting model to be funded, an evaluation must show the program has **demonstrated significant, positive outcomes in areas such as reducing child abuse and neglect, improving maternal and child health, and improving economic self-sufficiency.** We appreciate the opportunity to share how one central Pennsylvania mother established economic self-sufficiency, a healthy and thriving family and who is now *"paying it forward"* as a result of the mentorship provided by her Nurse Home Visitor.

Nurse-Family Partnership and Home Nursing Agency Background: Nurse-Family Partnership operates in 42 states with goals of healthy pregnancy outcomes, healthy child development and a positive life course development. During visits, nurses bring information on topics that the mother chooses to discuss in a comfortable, conversational style. A national, evidence-based program for first-time pregnant mothers that provide home visits and mentorship by a registered nurse, the Nurse-Family Partnership program is free for mothers and provides support from pregnancy through the child's second birthday.

Home Nursing Agency has evolved into a trusted leader in the community health network with nearly 1,000 employees serving more than 21,500 people throughout

western and central Pennsylvania. Also, the Agency has maintained its unwavering pledge to deliver uncompromising patient care despite the challenges and adversities on the healthcare front. The Agency's ability to serve was strengthened in 2013 when the Home Nursing Agency became part of **UPMC Community Provider Services**, which specializes in post-acute services.

Since Home Nursing Agency began offering Nurse-Family Partnership in 2002, more than 1,500 families have benefited from this free and voluntary program offering nurse home visitation. We serve families in the following counties: Blair, Cambria, Centre, Clearfield, Huntingdon and Jefferson.

Home Nursing Agency's Nurse-Family Partnership® program marks ten years of serving first-time mothers in Cambria County in Pennsylvania. In January, the program also surpassed the milestone of serving more than 500 Cambria County clients.

"I was so nervous and scared when I found out I was pregnant. The first baby I ever held was my own," explains Cambria County resident Megan, who praises her Nurse Home Visitor Chrissy with helping her through her pregnancy and her daughter Dandelion's early days.

"My husband and I got all of our questions answered."

Megan credits Chrissy with building her confidence as a mother, which led to pursuing a position as breastfeeding peer counselor for Cambria County WIC (Women, Infants and Children), where she now empowers other young mothers.

In addition to providing reassurance and answering her medical questions, Chrissy became a cheerleader and advocate who helped Megan to grow and **recognize her own potential**.

"NFP gave me more confidence as a mom," she says. "Chrissy would always **affirm me** and tell me what I was doing right, and she gave me a lot of confidence. That was part of why I reached out to look for a job."

While Megan desired to work outside the home to help support her family, she knew daycare costs would undercut her efforts. Chrissy shared the option of subsidy for eligible parents, and she helped Megan to look for a trustworthy daycare for her daughter.

"When I saw the ad in the paper for a Breastfeeding Peer Counselor for WIC [Women, Infants and Children], I thought that was something I can do," Megan said. Now she uses the **affirmative and supportive techniques** she learned from NFP to impact the lives of her clients.

"My role is personal like Chrissy's was with me. As I get to know my clients, they open up more to me. **My favorite thing is that I can empower women to believe in themselves.** They just need support to believe that."

"The key to Nurse-Family Partnership's success is the positive relationship that develops between the mother and her nurse," explains Lois Schultz, supervisor of Cambria County Nurse-Family Partnership who admitted the first client ten years ago.

"The mother and her nurse really get to know each other so the nurse can provide information and support that is very helpful for the mother and tailored to her needs."

We know the MIECHV program is an evidence-based program that helps to improve the lives of families in at-risk communities. Unlike most federal social programs, MIECHV funding is tied to real results like Megan.

House Republicans have long called for more programs to follow this evidence-based approach to ensure limited taxpayer dollars are actually delivering the intended results and helping those most in need. In fact, the House Republican "A Better Way to Fight Poverty" agenda specifically calls for more programs to replicate MIECHV's approach.

Thank you for the opportunity to submit testimony and to share Megan's story as the committee considers the reauthorization of MIECHV funding.

Respectfully submitted,

Lisa Ritchey, BSN, RN
Director of Nurse-Family Partnership®
Blair, Huntingdon, Centre, Cambria, Clearfield and Jefferson Counties

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Hearing on the Reauthorization of the Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program
Statement for the Record
Submitted by
The Home Visiting Coalition
3/29/2017

Chairman Smith, Ranking Member Davis, and members of the House of Representatives Committee on Ways and Means, Subcommittee on Human Resources: The Home Visiting Coalition, a diverse group of nearly 50 organizations working to promote continued federal investment in evidence-based home visiting, is honored to submit testimony in strong support of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program.

The investments that we make in our people today will pay dividends in the future. Nowhere is that statement truer than with children. Our children are the embodiment of our ideals and the promise of our nation. Iconic leaders of our nation have always focused on family. President Ronald Reagan said "The family has always been the cornerstone of American society. Our families nurture, preserve, and pass on to each succeeding generation the values we share and cherish, values that are the foundation of our freedoms." In that same vein, President John F. Kennedy said "Children are living messages we send to a time we will not see."

Home visitors help families send positive messages to future generations. By using practices proven to work, these talented providers bring to the surface the innate gifts parents possess to nurture children to become healthy, well adjusted, and ready to learn. The home visiting community knows that no parent is perfect, but believes that with the appropriate support, each parent can be the best parent for their child, and parents are ideally suited to be their baby's first and best teacher.

The Home Visiting Coalition commends you on your commitment to reauthorizing the MIECHV program. Home visiting programs provide support to vulnerable families in the earliest stages of their child's life to lay the foundation for the health, education, and social development and success of the entire family. The birth of a child introduces new challenges for every family. But for families facing poverty, a lack of education, and isolation from community resources, life can begin to feel overwhelming. To help more families achieve stability and to reach more children and communities, the Home Visiting Coalition recommends that MIECHV be reauthorized for a minimum of 5 years, with incremental increases in funding, over five years, until the program reaches $800 million per year.

When Congress enacted the MIECHV program, families who may have felt like they were going it alone had a sense of community restored. MIECHV changed the reality in high needs areas around the country, from one of isolation and families doing their best to get by, to a reality where there are people ready to help parents to do their best in proven and time honored ways. MIECHV supports families through home visitors who respect parent's rights, instincts, and traditions. MIECHV puts families first to strengthen communities and improve outcomes for kids and their families.

A cornerstone of evidence-based public policy, MIECHV provides funds for developing and implementing voluntary, evidence-based home visiting programs. Programs must meet at least four of six evidence-based benchmarks to qualify for use of federal funds. The benchmarks include: improving maternal and newborn health; reducing child injuries, abuse, and neglect; improving school readiness and achievement; reducing crime or domestic violence; improving family economic self-sufficiency; and improving coordination and referral for other community resources. According to the Health Resources and Services Administration (HRSA), as of 2015, 83% of MIECHV grantees demonstrated overall improvement in benchmark areas (HRSA, 2016); 81% of MIECHV grantees demonstrated improvements in maternal and newborn health; 85% of MIECHV grantees demonstrated improvements in school readiness and achievement; and 85% of MIECHV grantees demonstrated improvements in family economic self-sufficiency. Screenings for developmental delays in young children are twice the national average in 18 states with MIECHV programs.

In addition, several studies have proven that home visiting programs show a substantial return on investment, which may later save on state and federal expenditures. The Nurse Family Partnership (NFP) has a benefit-cost ratio of up to $5.70 per dollar invested (Karoly, Kilburn, & Cannon, 2005). The Durham Connects program model has a community benefit-cost ratio of up to 3.01 per dollar invested (Dodge, et al., 2014). Parents as Teachers (PAT) has an estimated benefit-cost ratio of 3.39 per dollar invested (Washington State Institute for Public Policy, 2015).

The aforementioned results are just a part of the reason that MIECHV enjoys bipartisan support. MIECHV funds 17 scientifically proven models that strengthen families over time, and families' participation is fully voluntary. Importantly, state and local grantees determine the best way to use MIECHV funding to effectively address the unique needs of their communities.

More than anything, it is the real people and families that have made this program so strong. Parents like Elizabeth Eddings, a mother of three originally from Alabama, are anxiously awaiting news that Congress has voted to once again support MIECHV. Ms. Eddings voluntarily enrolled in the home visiting program Parents as Teachers.
Through those regular visits with a trained parent educator, she was able to escape a damaging relationship, secure health interventions for her child, and start down the path to economic self-sufficiency.

“Thanks to my home visitor, who I understand is supported through the MIECHV program, my son has the help he needs,” says Ms. Eddings. “That’s why I’m in a position today to share with you why this program is so valuable to families and communities.” Ms. Eddings, along with thousands of other moms and dads across the country, is encouraged to know that the Ways and Means Committee’s Human Resources Subcommittee has begun the work to reauthorize MIECHV.

Without timely reauthorization, the critical services provided by MIECHV-supported home visiting programs will be drastically limited for families in need. Home visiting can make all the difference in the lives of individual families and, by extension, entire communities, breaking generations-long cycles of poverty, addiction, abuse, and despair. Regular visits by caring, experienced professionals can help parents turn their good intentions into solid parenting and coping skills. We are excited that the Ways and Means Committee is so strongly in favor of the MIECHV program and look forward to working with you further to reauthorize this essential program.

Thank you for the opportunity to submit this statement for the record.

The Home Visiting Coalition:
Alliance for Early Success
Alliance for Strong Families and Communities
American Academy of Pediatrics
American Psychological Association
Association of Maternal & Child Health Programs (AMCHP)
Association of State and Territorial Health Officials (ASTHO)
Center for Law and Social Policy (CLASP)
Child Care Aware of America
Child First
Children’s Defense Fund
Child Welfare League of America
Dalton Daley Group (DDG)
Division for Early Childhood of the Council for Exceptional Children
Early Intervention Program for Adolescent Mothers
Easterseals
Family Check-Up
Family Spirit

First 5 Association of California

First 5 California

First 5 LA

First Five Years Fund (FFYF)

First Focus

Futures Without Violence

Healthy Families America (HFA)/Prevent Child Abuse America (PCA)

Home Instruction for Parents of Preschool Youngsters (HIPPY USA)

IDEA Infant Toddler Coordinators Association (ITCA)

Institute for Child Success

March of Dimes

National Alliance of Children's Trust & Prevention Funds

National Association of Counties (NACo)

National Association of County and City Health Officials (NACCHO)

National Association of Nurse Practitioners

National Head Start Association (NHSA)

Nemours Children's Health System

Nurse-Family Partnership (NFP)

Ounce of Prevention Fund

Parent-Child Home Program

Parents as Teachers (PAT)

Partnership for America's Children

Play & Learning Strategies (PALS)

SafeCare

Save the Children

Save the Children Action Network

The Children's Partnership

The National Campaign to Prevent Teen & Unplanned Pregnancy

United Way Worldwide

Breaking Intergenerational Cycles of Substance Use Risk Through Early Childhood Home-Visiting Intervention: Lessons from the Family Spirit Program

The Johns Hopkins Center for American Indian Health is grateful to share its perspective on how important the MIECHV Program is for all Americans. There is strong evidence that home-visiting works to improve health and well-being for mothers and young children, particularly the youngest, poorest single mothers. We hope to share one perspective on how home-visiting is critical to breaking intergenerational cycles of substance use risk.

Background: Johns Hopkins Center for American Indian Health
The Johns Hopkins Center for American Indian Health (JHCAIH) is part of the Johns Hopkins Bloomberg School of Public Health, celebrating its 100th anniversary as the oldest and largest school of public health. JHCAIH was founded in 1991 to work in partnership with American Indian and Alaska Native communities to create sustainable solutions to overcome health disparities and promote health leadership and autonomy.

American Indian Youth Behavioral/Mental Health Disparities
Leading disparities affecting American Indian (AI) youth at the time of MIECHV legislation and still today include high rates of teen pregnancy, substance use, suicide, and school dropout. Led by substance abuse, these and other behavioral/mental health disparities in reservation-based communities lead to a high burden of years of productive life lost. These disparities are transferred to future generations in a cycle of despair that is perpetuated by high rates of teen pregnancy and challenging home environments.

Breaking the Cycle with Home-Visiting
To break this cycle, Family Spirit was developed in partnership with the White Mountain and San Carlos Apache Tribes and Navajo Nation as the first home-visiting intervention designed to address behavioral health disparities specifically among AIs. There are two important and highly effective design features of Family Spirit that were necessitated by working in tribal communities:

1. Family Spirit engages the local workforce capacity by employing paraprofessionals from the community to address a shortage of nurses and overcome language barriers. Tribal leaders knew that culturally-embedded change agents would be most effective, and, of course, many are mothers themselves.
2. Family Spirit was designed not just to tackle improved parenting but to work across generations to be sure mothers' behavioral health issues don't impede their ability to parent effectively.

The resulting Family Spirit Program is highly structured and strengths-based.

The Family Spirit trials sought to evaluate the intervention's effect on parental competence and maternal behavioral problems that impede effective parenting from birth to 36 months

postpartum and early childhood emotional and behavioral outcomes that predict risk for future substance use and related behavior problems. Thus, while Family Spirit was built from the ground up with rural reservation tribal communities, it has some vital importance to other U.S. populations.

From Promising to Evidence-Based Practice: An Iterative Process
Since evaluation of the Family Spirit Program began, a body of literature has been published to support it as an evidence-based program. A summary of publications is provided at the end of this statement, along with links to each journal article.

It took two decades of iterative work and three randomized controlled trials to design and prove Family Spirit. When the MIECHV legislation was passed, Family Spirit was still a "promising" but not evidence-based program. However, the third trial, called *Cradling Our Future,* which took place during the first phase of MIECHV, launched Family Spirit to evidence-based status. Family Spirit is now endorsed by both HomVEE and SAMHSA NREPP as evidence-based, which has led to tremendous scaling.

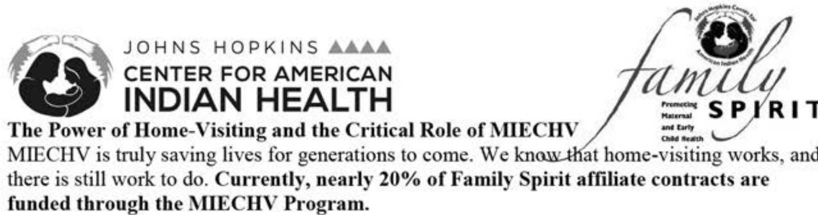
Family Spirit Impact: Pregnancy to Age 3
Mothers who received the Family Spirit intervention experienced significantly better parenting competencies and lower parenting stress. Simultaneously, they had decreased depression, substance use and related risk behaviors. And, as we had hoped, their children had significantly improve child behavior outcomes that predict fewer health disparities across their life span. Family Spirit children experienced highly significant and clinically relevant drops in developmental problems in three key domains (externalizing—aggression and impulsivity, internalizing—anxiety and depression, and dysregulation—fussy, disordered sleep and eating). Family Spirit children also met or fell below national norms for these behaviors despite living in the poorest and most stressed communities in America.

These early childhood behavior impacts extend across a child's lifespan. We know that children with poor externalizing and internalizing problems can later experience early onset substance use problems; young, risky first sex; poorer academic achievement; risk of suicide; and adolescent depression—all linked to the major health disparities affecting AI adolescents today.

What's Next for Family Spirit
Family Spirit has been replicated in over 80 communities across 16 U.S. states, including two non-Native sites—Chicago, Illinois and St. Louis, Missouri.

New modules are in progress to address other identified disparities, including early childhood obesity (RO1 funding from NIH to study new module) and early childhood caries (four times more prevalent among AI/ANs than U.S. general population.

Further, we aim to digitize Family Spirit. This is includes a pre-screening tool that would allow us to tailor the intervention to enrolled families. We also aim to adapt the curriculum for use on a digital platform.



The Power of Home-Visiting and the Critical Role of MIECHV

MIECHV is truly saving lives for generations to come. We know that home-visiting works, and there is still work to do. **Currently, nearly 20% of Family Spirit affiliate contracts are funded through the MIECHV Program.**

Family Spirit's Training and Implementation Manager reflects on the impact she has seen home-visiting have on the lives of families. One of the first mothers that she recruited as a home visitor was living in a place where she had no access to electricity, running water, or reliable transportation. She struggled as a single parent and credits her home visitor and the Family Spirit Program for learning to love being a mother. She says "Back then, I was ashamed of where I came from. As a Native American, we're at the bottom of the list. And now to be able to stand up and say 'I am a Native American, and I love being American. That's where I come from. That's my land.' This young mother knows that her positive outlook on life and confidence in raising her children and following her own dreams is going to impact her children, their children, and generations to come.

Here is a link to the full story of this mother as told by her home visitor:
https://www.youtube.com/watch?v=uDK7c990c6c

Summary of Family Spirit Publications (authors names have been removed to comply with submission guidelines)

OUTCOMES

These papers describe characteristics of the Family Spirit intervention and its effectiveness in improving parenting outcomes and mothers' and children's emotional and behavioral functioning from pregnancy to 3 years postpartum.

1. Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. Arch Pediatr Adolesc Med. 2006; 160(11):1101-1107.
2. Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. J Am Acad Child Adolesc Psychiatry. 2009;48(6):591-601.
3. Effect of a Paraprofessional Home-Visiting Intervention on American Indian Teen Mothers' and Infants' Behavioral Risks: A Randomized Controlled Trial. American Journal of Psychiatry 2013; 170:83–93.
4. Paraprofessional Delivered, Home-Visiting Intervention for American Indian Teen Mothers and Children: Three-Year Outcomes from a Randomized Controlled Trial. American Journal of Psychiatry. 2015; 172(2):154-162. doi: 10.1176/appi.ajp.2014.14030332.

METHODS

This paper describes the rationale, design, methods, and baseline results of the definitive randomized controlled trial of the Family Spirit Program.

5. The Family Spirit trial for American Indian teen mothers and their children: CBPR rationale, design, methods and baseline characteristics. Prev Sci. 2012; 13(5):504-518.

EXAMINING DRUG USE

This paper describes correlates of meth use in a sample of pregnant American Indian teens from a Family Spirit trial. It focuses on sociodemographic, familial, and cultural factors and use of other drugs.

6. Examining correlates of methamphetamine and other drug use in pregnant American Indian adolescents. American Indian and Alaska Native Mental Health Research.The Journal of the National Center. 2010; 17(1):1-24.

EDITORIALS

The first editorial was written in response to the 2009 Family Spirit outcomes paper. The author commends Family Spirit researchers for their creative, cost-effective way of addressing the mental health needs of American Indian children and their families. He further addresses the importance of participatory research.

7. Participatory Research Brings Knowledge and Hope to American Indian Communities.Journal of the American Academy of Child and Adolescent Psychiatry. 2009; 48(6):585-586.

The second editorial was published in the same American Journal of Psychiatry issue that the 2015 Family Spirit outcomes paper appears in as the cover story. The author acknowledges Family Spirit's major contribution to the science of early life intervention.

8. Getting to the Roots: Early Life Intervention and Adult Health. American Journal of Psychiatry. 2015; 172(2): 108-110.

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March 24, 2017

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives
1011 Longworth HOB
Washington D.C. 20515
Submitted online via: waysandmeans.submissions@mail.house.gov

RE: Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

Dear Chairman Brady:

On behalf of the National Nurse-Led Care Consortium (NNCC), I am submitting the following written comments regarding the reauthorization of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, which funds home visiting programs for low-income children and families.

MIECHV funds support evidence-based services that improve birth outcomes, early childhood health and development, school readiness, and economic self-sufficiency while reducing child abuse, neglect and injuries, cognitive disabilities, domestic violence, and juvenile delinquency. The MIECHV program helps states – including our home state of Pennsylvania – achieve these impressive outcomes while also producing a significant return on government investment.

NNCC's mission is to advance nurse-led health care through policy, consultation, and programs to reduce health disparities and meet people's primary care and wellness needs. NNCC's signature public health nursing programs are Philadelphia Nurse-Family Partnership (Philadelphia NFP) and the Mabel Morris Family Home Visit Program (MM-PAT), evidence-based early childhood initiatives that have served over 4,000 women and children to date.

Both Philadelphia NFP and MM-PAT are funded via MIECHV dollars administered by the Commonwealth of Pennsylvania's Office of Child Development and Early Learning. Philadelphia NFP and MM-PAT together comprise one of the largest countywide maternal-child home visiting programs in Pennsylvania. Our goals include: better pregnancy outcomes; improved child health and development; increased school readiness; and greater economic self-sufficiency for families. Philadelphia NFP and MM-PAT meet an important need by building the strength and capacity of especially vulnerable, hard-to-reach young mothers. By taking a

multi-generational approach, our programs invest in both the short-term and long-term well-being of families.

Program Overview

Philadelphia NFP implements the Nurse-Family Partnership model to serve low-income first-time mothers and their babies until age two. MM-PAT complements Philadelphia NFP by supporting families with young children from birth until age five, using the Parents as Teachers (PAT) model.

Research has demonstrated both the NFP and PAT program models' proven effectiveness in addressing a wide variety of challenges experienced by low-income families. The federal HomVEE project[1] notes that well-designed research has consistently demonstrated the following positive impacts associated with each model:

- **NFP:** Maternal health; Child health; Child development and school readiness; Reductions in child maltreatment; Reductions in juvenile delinquency, family violence, and crime; Positive parenting practices; Family economic self-sufficiency

- **PAT:** Child development and school readiness; Reductions in child maltreatment; Positive parenting practices; Family economic self-sufficiency

Research also shows a return on investment of between $3.29 to $5.70 for every $1.00 invested in the PAT and NFP programs.[2] **The exceptional outcomes achieved among both mothers and babies prove that participation in MIECHV-funded home visiting programs can change the entire trajectory of families' lives for the better.**

Both Philadelphia NFP and MM-PAT provide parental education and support through an established multi-year curriculum that focuses on topics such as child development, maternal-child health, and positive parenting practices. The total annual caseload for NNCC's home visiting programs is 700 unduplicated children. Each participating family receives multiple visits from their nurse home visitor, using a schedule linked to child development milestones and perinatal health needs.

Philadelphia NFP and MM-PAT provide home visiting services year-round on a full-time basis. Home visitors routinely make visits that are responsive to client needs, and that may include evenings and weekends to accommodate the client's school or work schedule. Home visitors

[1] The U.S. Department of Health and Human Services launched the Home Visiting Evidence of Effectiveness (HomVEE) project to assess the evidence underlying maternal-child home visiting program models, including NFP and PAT. For more information, see: http://homvee.acf.hhs.gov

[2] Nurse-Family Partnership (2016). Benefits and Costs Factsheet. For more information, see: http://www.nursefamilypartnership.org/getattachment/about/fact-sheets/NFP_Benefit_Cost_2016.pdf.aspx; Washington State Institute for Public Policy (2016). Parents as Teachers: Benefit-Cost Results. For more information, see: http://www.wsipp.wa.gov/BenefitCost/Program/118

are easily reachable by cell phone and text message, and communication with clients often takes place outside of regular business hours.

Participation in high-quality early learning programs provides children with a foundation for school success, and helps close the opportunity gap between children from low-income families and more advantaged children. Philadelphia city statistics show lower maternal education levels and higher rates of child abuse than statewide averages, indicating that many Philadelphia families stand to benefit from the child development, positive parenting and school readiness counseling provided through Philadelphia NFP and MM-PAT. The communities served by our early childhood home visiting programs have high rates of deep, intergenerational poverty, and social factors play an outsized role in the overall health status of women and children in these neighborhoods. **Working with their nurse, many young mothers break multi-generational patterns of abuse and neglect and set goals for themselves for the first time.**

As Philadelphia NFP Team Supervisor Breanne Ward, RN, MSN explains:

> "I think something that's really special is the intimacy of the nurse-client relationship. That is what I believe causes the positive changes to occur. There is a deep sense of trust that builds between the moms and nurses over time. ***The mom thinks to herself, 'There's a nurse coming into my home who really wants the best for me and my family. She believes in me. I can change my life, even if it's just one little step at a time.'"***

Client Testimonials

The following quotes shared by Philadelphia NFP and MM-PAT maternal clients exemplify how public health nurses and evidence-based MIECHV-supported programs contribute to family and societal well-being:

> **SABRINA:** "My nurse was very helpful and assisted in reassuring me that things would get better over time. ***There were many times [as a new mother] when I felt beyond stressed. I was always uplifted after speaking and meeting with my nurse."***

> **KALIA:** "The part I love most is that my nurse comes to my home and can see me at different days every week which is important because my work schedule is always changing. ***I want my kids to be their best and my nurse helps me know how to do that for them.*** I thought the hardest part of being a mom was having an infant, but talking to and being patient and fair with my four-year-old is a lot harder. My nurse lets me talk about this and points out the ways I am [patient and fair] and how I can parent the way I really try to."

STEPHANIE: "I have learned a lot from participating in NFP and ***I feel that it has improved my life, my health, and now my daughter has a better future because I can be the best mom to her***."

NINA: "***The consistency and commitment of the Nurse-Family Partnership is evident because [my nurse] Julie has been working with us for two years.*** We rarely experience this continuity of professional medical providers in the primary care and hospital settings."

DALIE: "***I love the program so much that I want all my friends with kids to be in it***."

KELECHI: "Nurse-Family Partnership is a phenomenal program. This program really helps the community. ***It is like that saying it takes a village to raise a child well. NFP is like my village in a sense.***"

Thank you for the opportunity to provide comments on the MIECHV program and its positive impact on families. If you or your colleagues would like additional information, or would like to visit our offices in Philadelphia, please feel free to contact me at kkinsey@nncc.us or 215-287-2114. We would welcome the opportunity to introduce you to the dedicated nurses on our staff, and the families we serve.

Sincerely,

Katherine K. Kinsey, PhD, RN, FAAN
Nurse Administrator and Principal Investigator
Philadelphia Nurse-Family Partnership
Mabel Morris Family Home Visit Program

NNCC Home Visiting Program Office:

1080 North Delaware Avenue, Suite 300 D
Philadelphia, PA 19125
E-mail: kkinsey@nncc.us
Phone: 215-287-2114

Nurse-Family Partnership
107 South Market Street, Suite 3
Berwick, PA 18603

March 21, 2017

We, the undersigned staff members of the Geisinger Clinic—Nurse-Family Partnership site covering Columbia, Montour, Northumberland, Snyder, Union and part of Luzerne Counties— are writing in support of the re-authorization of the Maternal Infant Early Childhood Home Visiting (MIECHV) Program. The Nurse-Family Partnership is an evidence-based community health program based on the work of Dr. David Olds that helps transform the lives of vulnerable mothers pregnant with their first child. Each mother we serve is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child's second birthday. Forty-five counties in Pennsylvania have Nurse-Family Partnership sites.

Significant outcomes from this program include:

- 48% reduction in child abuse and neglect
- 20% reduction in months on welfare
- 32% fewer subsequent pregnancies
- 35% fewer hypertensive disorders of pregnancy
- 56% reduction of emergency room visits for accidents and poisonings
- 72% fewer convictions of mothers by the time the children are at age 15 years
- 67% reduction in behavioral and intellectual problems in children at age 6 years
- 59% reduction in arrest of children at age 15 years.

Locally, the following outcomes have been replicated during the fiscal year 7/1/2015-6/30/2016:

- 98.1% of Geisinger Nurse-Family Partnership program babies were up-to-date with immunizations at 24 months as compared to 93% nationally.
- 23.5% of Geisinger Nurse-Family Partnership clients had a second pregnancy at 24 months as compared to 27.7% nationally.
- 68.5% of Geisinger Nurse-Family Partnership clients (18 plus years old at intake) were working when the baby turned 24 months as compared to 65.3% nationally.
- 9.6% of Geisinger Nurse-Family Partnership clients had low birth weight babies (infants born weighing < 2,500 grams or 5.5 lbs.) as compared to 10% nationally.
- 9.2% of Geisinger Nurse-Family Partnership clients had premature births (births which occurred at less than 37 week's gestation) as compared to 9.6% nationally.
- 52.2% of Geisinger Nurse-Family Partnership mothers were enrolled by the end of 16 weeks' gestation as compared to 45% nationally.

As Administrator of our site, when I think back over the past 16 years of families served, I remember:

- Women who lack self-esteem and allow themselves to be victims of abuse become confident enough to say no and leave so they and their babies are safe and have a chance of success.
- Women whose parent(s) have told them all their lives that they will never amount to anything have the courage to make changes to better their lives so their child can succeed. (Seek gainful employment, return to school, get a driver's license, sober up, enter drug treatment).
- One woman whose role model was her drug dealing step-father, found strength in the nurse home visitor's interventions, held a full-time job, moved into her own apartment and became one of our best mothers. A remarkable turnaround.

"From the site's Nurse Supervisor's perspective, "NFP is a proven prevention program which saves over $7 for every dollar spent. NFP provides the education and guidance needed to assist vulnerable first-time moms to become self-sufficient, contributing citizens. The lives of their children are forever positively impacted by the improved quality of parenting they receive". **Deb Forsythe**

I asked each nurse to give a short testimony. These will give you insights from the people who work side-by-side with the first-time mothers:

"The Nurse Family-Partnership program helps the nurse-mother relationship build strong and lasting family bonds". **Kara Ferro**

"The positive outcomes of the Nurse-Family Partnership program show that we are dedicated to helping some of the most vulnerable children in our communities have a healthier start and brighter future."
Lisa Foster

"Because NFP nurses follow a client for 2 1/2 years, the nurse forms a deep connection with that mother's needs and her heart's desire, facilitating real change in the life of the mother & child and extending to that mother's family and the broader community. The return on investment is evident by the data and statistics collected by the National Service Office which confirms the effectiveness of the program."
Christine Hayes

"The Nurse-Family Partnership works, because it is just that, a partnership with first-time parents that provides them with the tools they need for stellar parenting. This is done by meeting the parents at whatever place in their lives they are. Whatever the situation, the nurse provides mentoring, advocacy and guidance while allowing them to make their own choices and decisions. Excellent parenting equips their offspring to function as successful, productive members of society."
Donna Pauling

"Nurse-Family Partnership provides support to women during a critical time in their lives. Through education and establishing a trusting relationship, NFP positively impacts the health and overall well-being of both the mother and child." **Christine Resele**

"I am a nurse case manager for Nurse-Family Partnership. I have worked in this excellent home evidence based home care program for almost 9 years. I believe that continued funding would be necessary to help ensure continued interaction and education for some of the area's most at-risk clients. Through our program we have helped moms and babies flourish in areas of job readiness, education, parenting and prevention. Knowledge is key; most of these moms do not have that. Education is so imperative to excel and many have never had the support and education to go anywhere in life. If we can help these moms succeed, then the sky is the limit for their children so that they will not be left behind." **Anita Rose**

"NFP is the art of nursing at its best as the nurse home visitor partners with at risk families to engage them in becoming healthier and self-sufficient. My favorite part of the program is facilitating the mother-child bonding process, and seeing the excitement in the mom as the baby develops. As a home visitor, I'm encouraged by the statistics that prove the program is valuable not only for our families, but for our society as well." **Susan Roth**

There are countless other examples of success stories. When these moms/families succeed, you (as legislators) succeed too. Less money will be needed to support prisons, welfare programs, etc.

I am urging you to vote yes to re-authorization of the Maternal Infant Early Childhood Home Visitation (MIECHV) Program to support Nurse-Family Partnership. The future of our state and the nation depends on the children who are being born today. My staff and I ask that you vote to help us continue to help those who are down and out now, but who are motivated to change their circumstances so their child will have opportunities they never had. We in the Nurse-Family Partnership are working to make a difference for a lifetime—breaking the cycle of poverty by utilizing proven methods. **The outcomes speak for themselves. Independent research proves that communities benefit from this relationship—every dollar invested in Nurse-Family Partnership can yield more than five dollars and seventy cents in return.**

Sincerely,

Loreen Comstock, MSN, RN, GCNS-BC
Administrator

Deborah Forsythe, BS, RN
Supervisor

Kara Ferro, BSN, RN
Nurse Home Visitor

Lisa Foster, BSN, RN
Nurse Home Visitor

Christine Hayes, BSN, RN
Nurse Home Visitor

Donna Pauling, MSN, RN
Nurse Home Visitor

Christine Resele, BSN, RN
Nurse Home Visitor

Anita Rose, BSN, RN
Nurse Home Visitor

Susan Roth, BSN, RN
Nurse Home Visitor

SUPPLEMENTAL TESTIMONY
BETH RUSSELL
NURSE HOME VISITOR, NURSE-FAMILY PARTNERSHIP
LANCASTER GENERAL HEATH/PENN MEDICINE
LANCASTER, PENNSYLVANIA

Involvement of Fathers

NFP engages fathers in our home visits as well. That person may not be the father of the baby – maybe it's the mother's new boyfriend. But we try to engage with anybody that is in the home and present in the mother's life, or whom the mother would like us to engage with. We have NFP specific facilitators for fathers and other males that will serve as role models for the child. Additionally, our PIPE (Partners in Parenting Education) activities are geared to caregivers that may not be the mother.

Challenges in Implementation

The committee should be aware that while I have not encountered issues where MIECHV prevents me from meeting my client's needs, one broad challenge that prevents us from delivering the program to the population that could benefit is that we don't have enough nurses to serve all of the mothers in need. We regularly get referrals for NFP that we are not able to enroll due to our nurses not having any open slots in their caseload. Additional funding would help alleviate this challenge, of course. Another challenge is locating the client for the first time. We have to get creative and meet them at doctor appointments, school or WIC if we are unable to reach them by phone, because either they don't have one, or they don't respond to our messages because they don't really know who we are yet.

Sent on behalf of MIECHV Nurse-Family Partnership of Monroe County, PA.

Virginia Sosnowski, RN, BSN – Nurse-Family Partnership Supervisor/Administrator

Sent from my iPhone

Begin forwarded message:

From: Date: December 5, 2016 at 11:18:52 PM EST
To: Subject: Thank you

When I started Nurse Family Partnership I was 19, 20 something weeks pregnant, living on my own, and working 3 jobs to make ends meet. I came from a functional/dysfunctional home. My parents were a mess but also kinda had it together so it made it confusing when I thought about how I would raise my own child. I knew that I wanted to instill some of the same values but also knew that I wanted to do a lot better. My now husband (boyfriend at the time) was still living with his mom and hadn't even held a permanent job. I was so worried about how we would take care of this baby. Then at the doctor's office I saw a sign for nurse family partnership and figured why not.

Jan was my nurse and I'm so grateful for her every day. She did more than prepare us to take care of a baby. She instilled goals in us, she forced us to really think about what we wanted and to write them down on paper. At every meeting she checked in on our goals and how we were working towards them. She educated me on the importance of early literacy, attachment, and nursing. I knew I wanted to nurse and Jan stuck by me the whole time to help me accomplish that. When Logan was born she checked in frequently and reminded me to keep going and that I was doing a great job. Her love and kindness helped make me the mom I am today.

Today, my husband and I have surpassed our goals. Just a few months after having my son I achieved my goal of finishing cosmetology and about a year later my husband joined the military. Fast forward to today (5 years later) and I'm almost done with my bachelors in early childhood and my husband is now a Sergeant in the Marine Corp. We worked so hard to get here and I don't know about my husband but for me, a lot of my accomplishments stem from her support, education, and guidance. I encourage every new mom I meet to participate in this program. I just hope all of the nurses are as awesome as mine.

PARENT-CHILD HOME PROGRAM
50 YEARS OF PROVEN SUCCESS

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Sarah E. Walzer, CEO

March 28, 2017

House Ways and Means Human Resources Subcommittee
United States House of Representatives

RE: March 15, 2017 Maternal Infant Early Childhood Home Visiting Hearing

Dear Subcommittee,

The Parent-Child Home Program (PCHP) would like to take this opportunity to thank you for holding the March 15, 2017 hearing highlighting the critical role home visiting programs play in supporting parents with limited access to other supports and services to nurture healthy babies, prepare school ready children, and strengthen their families.

For over 50 years, PCHP has been helping families prepare their children for school success through intensive home visiting. This evidence-based early literacy, parenting, and school readiness model addresses the achievement gap head-on by working with underserved, under-resourced families when their children are between 16 and 48 months to provide them with the knowledge, skills, and tools they need to build school readiness where it begins, the home.

PCHP's target population is well-defined - low-income families (80% of PCHP families have annual incomes of $25,000 or less), challenged by significant obstacles to school readiness including poverty, low literacy, limited English, under-educated parents, single and teen parents, geographic isolation, cultural barriers, and/or homelessness, enter the Program when their children are approximately age two. They participate in the Program for two program cycles, and then with the support of Program staff transition to the next educational step in their community, most often Head Start or pre-kindergarten. Our goal is that those children most at risk of entering school not ready to be successful students, receive two cycles of parent-child visits and then a year of quality preschool and enter kindergarten ready to succeed in the classroom. Currently, the Program is working in 14 states (including Washington, California, Florida, Pennsylvania, Massachusetts, and New York) and in over 400 local communities.

PCHP is unique in employing Early Learning Specialists who are bilingual in the home languages of the families with whom they work (over 30 different languages), share their ethnic/cultural background, and live and/or have worked in the community where the families live. Twenty-five percent of PCHP's home visiting staff are former parents in the Program who are trained and hired to visit with other families in their communities. By building its own cost-effective, community-based workforce, PCHP not only strengthens families, it strengthens communities.

The Early Learning Specialists work one-on-one with families, providing 92, twice-weekly, 30-minute home visits over a two-year period. Each week, they bring a gift of a

book or educational toy, often the first in the home; and use the book or toy to model for the parent (grandparent/foster parent/primary caregiver) and child, reading, conversation, and play activities designed to stimulate parent-child interaction, develop language, literacy, numeracy, and social-emotional skills, and prepare children for school success.

This seemingly simple model has been proven to have profound outcomes. Over five decades, PCHP has built a record of replicating a model supported by rigorous evidence and consistently achieving its predicted outcomes for low-income families. Extensive evaluations have resulted in a large body of scientific literature (over 50 studies) published in juried journals and validated by the federal Joint Dissemination Review Panel. In the past two years, PCHP has received significant positive results from two new independent studies conducted by New York University and ORS Impact in the state of Washington. For decades, PCHP's research results have consistently supported the value of the Program for strengthening positive parent-child interaction and reducing risk factors for child abuse and neglect. Parents learn how to embrace their role as their children's first teachers and become ongoing academic advocates for their children. In turn, outcomes for child participants are astounding. PCHP graduates:

- Are 50% more likely to measure ready for kindergarten compared to their socio-economic peers
- Outperform the statewide average on third grade state math achievement tests.
- Score two and a half times higher on social-emotional assessments than control groups.
- Have a 30% higher high school graduation rate than their socio-economic peers.
- Enter school performing 10 months above their chronological age.
- Are 50% less likely to be referred to special education services by the third grade.

While the Parent-Child Home Program's research base proves the strength of the model and its effective replication in diverse communities, the successes of the children and families who participate in the Program provide invaluable insight into the impact of the Program — helping parents discover their role as their children's first and most important teachers, assisting them in building brighter futures for their family, and preparing children to be successful students. Evidence of the Program's success is seen each day in children discovering the joy of reading and learning, and in parents beaming with pride over their children's accomplishments. Below is a story that exemplifies the impact of the Parent-Child Home Program.

> It's summertime and Wesley, a single father, and his three-year-old daughter Heaven work on a puzzle together. Wesley asks his daughter lots of questions, stimulating interaction and conversation with her, something he learned by participating in Parent-Child Home Program funded through the United Way of King County in Washington.
>
> Many young learners take a break from books and educational toys during the school break, and experience summer learning loss, but not Haven. She'll continue developing her cognitive skills because her father continues to do what his home visitor modeled, playing, talking, reading, supporting and sustaining Heaven's learning all year long.
>
> Veronica Williams, an Early Learning Specialist with Parent-Child Home Program, emphasizes that the child is not the only one learning during the home visits. "I model for the parents what to do. It's a guideline and not a must-do. After a while, a lot of

parents take the lead, hand the child a book or a toy. The child will take it and the parent then takes charge and I think to myself, 'That's exactly what we want to happen.'"

Wesley says that when Veronica modeled educational play for him, a light bulb went off; the home visits were more than mere child's play. "It opened up a lot of learning for both of us, not just for her but for me, especially on how I need to teach her and the things I need to develop with her. She's coloring, tracing, all of the things that we worked on. She's phenomenal in puzzles and shapes. It was a big help for me because now I know what areas to really work on with her."

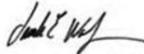
The odds are often stacked against low-income children like Heaven. Low-income children are behind their peers when they start kindergarten. The Parent-Child Home Program eliminates that preparation gap by supporting parents during the crucial early years of their child's development. Nationwide, more than 84% of children who complete the Parent-Child Home program graduate from high school, compared to just 54% of their socioeconomic peers.

Wesley said, "The Program taught me things that I need to teach my child." Helping Heaven succeed is no longer a dream for Wesley. The Parent-Child Home Program has equipped him and thousands of other parents who have participated in the Program, with the tools they need to make that happen.

The Parent-Child Home Program national center joins its home visiting and early childhood education partners nationwide in its support of reauthorizing MIECHV with a five-year extension including incremental funding increases up to **$800 million per year.**

Thank you for bringing attention to the critical work that home visiting does in communities across the country.

Sincerely,



Sarah E. Walzer
CEO

Parents as Teachers®

**STATEMENT OF CONSTANCE GULLY, PRESIDENT AND CEO
PRESENTED ON BEHALF OF THE
PARENTS AS TEACHERS NATIONAL CENTER
TO THE HOUSE COMMITTEE ON WAYS & MEANS
SUBCOMMITTEE ON HUMAN RESOURCES**

SUBMITTED MARCH 29, 2017

Chairman Smith, Ranking Member Davis, members of the subcommittee, thank you for the opportunity to submit written testimony following the March 15, 2017 hearing on the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. My name is Constance Gully and I am the President and CEO of Parents as Teachers National Center (PATNC). MIECHV helps meet a gaping need in our communities and for that, we are sincerely grateful.

Families in many of our communities are facing extreme stress. Last October, PATNC hosted our national conference in St. Louis. As a pre-conference session, we invited Parents as Teachers parent educators and program coordinators from across the country to meet and talk about the challenges their families face. The communities represented were quite diverse, from inner city, to suburban, to rural, to tribal. Despite the geographic distances and differences, the obstacles for families were very familiar:

- “We are a community serving rural, low income, low educational attainment, teen parents—an area that is saturated with chemical dependencies, single-parent households, and children with violent behavior concerns.”
- "I currently work with homeless mothers and their children...with families where one parent is incarcerated...with families that are involved with Child Protective Services."
- "We are located on a tribal reservation and very agricultural area with a large Hispanic population... lots of obstacles for families to overcome such as teen pregnancy, violence, substance abuse, etc."
- "In my two (housing) developments this year we have had 3 infant deaths...as a county we have been hit hard with the opiate epidemic with 247 overdoses in 20 days, 21 of which resulted in death."
- “We serve an urban community that has a history of drug and gang-related violence...Last summer we experienced an influx of murders. People were being murdered in front of their homes, at local parks, outside of car washes; many times the by-standers were family members and young children.”
- "One of my centers is in a neighborhood where there have been drive-by shooting deaths."

If we know nothing else, we know that learning begins before birth and that, with the rapid brain development that occurs, the first three years of life are absolutely critical to health, well-being, and success in school, life and work. Toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support[i]. In addition, we know that by age 3, there is already a 30-million word gap[ii] between children from the wealthiest and poorest families, and without intervention these children will find it harder, if not impossible, to ever catch up. These early years are not only a time of learning to read, count, and understand the world around them, these are the years when a strong foundation of executive function and self-regulation skills are built; that is, the mental processes that enable us to plan, focus attention, remember instructions, and juggle multiple tasks successfully.

Clearly, there is a critical need for MIECHV.

Through MIECHV, states and tribal communities have received financial and technical support to scale up existing home visiting systems and to support home visiting services to new populations in at-risk communities. With a focus on funding what works—evidence-based home visiting—as well as 'promising practices' that can bring new models to the field, this Federal funding has allowed states to present communities with a choice of models that best meet their needs. However, unmet need still far outweighs our collective capacity.

Parents as Teachers (PAT) is a nationally recognized evidenced-based, voluntary early childhood home visiting model that promotes the optimal early development, learning and health of children by supporting and engaging their parents and caregivers. Parents as Teachers has a core value of working with moms and dads, prenatally all the way through their children's first year of Kindergarten, not just first time moms, but also families with multiple children. PAT is the most widely replicated home visiting model in the country serving families in all 50 states, more than 100 tribal communities, and six other countries. In 2015/2016, PAT served 123,468 families with 148,659 children in the United States through 1.26 million personal visits and 45,500 group meetings. The model meets the evidence-based criteria of the federally funded Maternal, Infant, Early Childhood Home Visiting (MIECHV) program and has been selected by 35 states to be replicated through MIECHV and in 13 of the 25 tribal communities to be implemented through the 3% Tribal-MIECHV set aside.

Parents as Teachers has more than 30 years of implementation experience. In addition to the evidence-based model, PATNC has developed—and continuously updates—research-based, evidence-informed foundational curricula to serve families from pregnancy through kindergarten. Many Early Head Start home-based programs, Health Family America model affiliates, and other national and local organizations implementing locally designed, home-based programs deliver services using the PAT foundational curricula.

The delivery of Parents as Teachers is straightforward. Trained parent educators, who may be early childhood educators, social workers, nurses or other trained professionals recruited from the

communities they serve, work through local schools, hospitals, housing authorities, childcare centers, or other local implementing agencies to help strengthen and engage families. The model is designed to serve families through any agency that engages families with young children, including homeless, foster, and military families; families may enroll anywhere along the prenatal through Kindergarten continuum with maximum outcomes resulting from a partnership of at least two years.

The evidence-based model includes four components:

> ***Personal visits*** are individualized, strength-based visits where parent educators focus on child development and parent-child interaction, and empower parents to interact with their children in a way that facilitates healthy development. Visits may take place in the home—which removes the barrier of transportation—or in a community setting that is most comfortable to the family. Visits include the mother and child, however, fathers and other family members or caregivers involved in that child's life are encouraged to participate; in some cases, the primary parent served is the father. In families with multiple young children, the parent educator will screen and provide age-appropriate activities and guidance for those siblings as well. Visits cover issues such as sleep, discipline, good nutrition, health, routines, and child safety.
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> ***Child Screenings.*** At key intervals, parent educators screen the children for possible developmental delays, or any hearing, vision, or physical health problems. The goal is to identify any issues or delays early so that children can be referred to appropriate services and therapies. Early intervention is less costly and more effective at mitigating issues.
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> ***Community resource referrals.*** The parent educator, as part of the visit, helps bridge the gap between resources available and families' needs. Every personal visit includes a focus on family well-being. Parent educators help connect parents to agencies that can help in areas such as finding employment, finding health insurance, or getting a better education to help increase family self-sufficiency and independence. Parent educators also monitor parents for any signs of depression, medical issues, or intimate partner violence and offer community referrals.
>
> Finally, facilitated ***group connections*** allow parents to meet with other parents of young children as a support group, allowing them to practice parenting skills and build a strong family-community connection. Mothers of young children often experience social isolation and these connections serve as an additional, community support. Many programs offer group meetings for young fathers, helping provide positive social connections and opportunities for them to build healthy, ongoing relationships with other young fathers.

Researchers and experts have found that the social determinants of health—factors such as social support, parental stress, access to insurance, income and poverty status, and environmental conditions—affect families and their children. Home visiting programs are an essential intervention and prevention program to address these social determinants of health. Children need safe, stable, and nurturing relationships and environments to grow up healthy and ready for the world. Which is where Parents as Teachers can make a vital difference. PAT parent educators:

- Understand and respect that parents are their children's first and most influential teacher
- Work with families anywhere along the continuum from pregnancy through Kindergarten—the earlier the better
- Partner with parents to identify and build their parenting strengths
- Focus on family well-being and goal setting
- Identify health issues and developmental delays in children early and refer families to community resources that reduce the cost of later remediation
- Build healthy social networks for parents of young children
- Are a trusted, informed resource

As a result, parents enrolled in Parents as Teachers learn to be more self-sufficient and become advocates for their children, for life. Some examples include:

- At the age of 21, Sharon and her partner, Marcus, were first time parents of a 2-month-old daughter, Alanna. Sharon and her parent educator have met twice a month in Sharon's home for the past year. Marcus has also participated when his work schedule allowed. Sharon says, "In the past year I have learned so much about Alanna's development and the importance of each milestone. The hands on activities, working together one on one with my parent educator has helped me build my confidence as a mom. I share everything I've learned with Marcus, and I love it when he is able to sit in on the visits too." While in the PAT program, Sharon set personal goals to obtain her driver's license and purchase a car. She has achieved both goals. Sharon and Marcus both have jobs and use teamwork to split the workday so one parent can stay home with Alanna. They credit the PAT program for providing the focus and support they needed to be the best parents they can be.

- Amber is a single mom, a veteran who served in Iraq, and suffers from PTSD and depression. She was unemployed and fearful of leaving her daughter with anyone. She was very unsure about her parenting skills and reported that at times she felt overwhelmed by the constant fear of doing something wrong with her baby. She was somewhat cautious and reserved in the beginning but, with encouragement, she began to follow through with suggestions and activities between visits. Her daughter is now developing appropriately and her confidence as a parent and teacher to her child continues to flourish. Amber has returned to work. She continues to use what she learns from PAT to help her daughter prepare for preschool.

- Shelly and Justin enrolled after their son was born. As Shelly was adjusting to being a new mom, she was successfully treated for post-partum depression. When Jax was eight months old, the family moved to be closer to Shelly's family and left the program. They returned and re-enrolled when Jax was three. At that time, the program identified what appeared to be developmental regression and referred them to their pediatrician who suggested they wait until his next checkup and re-evaluate. Shelly did not feel comfortable waiting 6 months; as the program had educated her in advocating for her child, she sought a second opinion, which resulted in a diagnosis of autism. The program has continued to support and educate the family with the day-to-day obstacles of having a child with autism. Jax is making progress with therapy and services he receives at school.

- The youngest child in the P. family was identified as having a delay in his development of social and language skills, and autism spectrum disorder was suspected. Mother set goals to help her child improve his development, and she learned skills that helped him transition to preschool. During her

time in the program, mother became more confident, learned about the system of education, and began to advocate for her son.

- At enrollment, one mother had significant depression that affected her parenting. She used spanking as discipline, and screamed and criticized her children. Her parent educator supported mother's mental health needs and helped her connect to counseling services. She has developed coping skills that allow her to parent in a more positive manner.

Parents as Teachers is a proven and well-researched strategy for reducing the need for remedial education, increasing school readiness, reducing instances of child abuse and neglect, promoting family economic self-sufficiency, and parent involvement in their children's care and education. Outcomes include:

- improved language and literacy for young and school age children
- increased entire family engagement in children's learning and engagement with their schools
- increased school achievement for children
- identification and treatment of developmental delays well before the K-12 years
- improved parenting knowledge and skills
- decreased child maltreatment
    - one randomized trial of Parents a Teachers found that the use of harsh parenting was significantly lower in PAT families
    - In New York, a quasi-experimental evaluation showed PAT was associated with lower rates of suspected cases of abuse and neglect in a review of DSS and school based records.
    - A PAT program in Maine focusing on families with involvement with Child Protective Services, found that once entered into a PAT program 95% of families had no further substantiated reports or allegations of child abuse or neglect.
- increased family self-sufficiency
- child health outcomes, such as:
    - increased child immunization rates
    - lower body mass index rates
    - higher birth weights
    - improved family well-being
    - increased family health literacy

The Parents as Teachers National Center, which developed the evidence-based model, and the research-based curricula used by the models, provides training, technical assistance and quality assurance. The national center requires its affiliates maintain fidelity to the model and monitors performance.

Finally, and significantly, home visiting is cost-effective. One state institute for public policy issued to policymakers and budget writers a list of evidence-based programs that are well researched and that can with a high degree of certainty, lead to better statewide outcomes coupled with a more efficient use of taxpayer dollars. Those policy analysts found that Parents as Teachers has a cost benefit ratio of $3.29—it saves taxpayers money. [iii]

MIECHV is a success, but we need to reach more families in more communities. Parents as Teachers National Center respectfully asks that Congress reauthorize the Maternal, Infant, and Early Childhood Home Visiting program for five years, to increase to a year 5 annual level of $800 million.

Thank you.

For more information, or if you have questions about Parents as Teachers, please contact me at constance.gully@parentsasteachers.org or Alison Gee, VP Government and Community Engagement at alison.gee@parentsasteachers.org.

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[i] Toxic Stress - Center on the Developing Child - Harvard University developingchild.harvard.edu/science/key-concepts/toxic-stress/

[ii] https://www.aft.org/sites/default/files/periodicals/TheEarlyCatastrophe.pdf. 2003 summary article, University of Kansas researchers Betty Hart and Todd Risley

[iii] A Washington State Institute for Public Policy (WSIPP) report entitled "Return on Investment: Evidence-based Options to Improve Statewide Outcomes," found that Parents as Teachers has a benefit to cost ratio of $3.39. The Washington State legislature has directed WSIPP to identify "evidence-based" policies. The goal is to provide Washington policymakers and budget writers with a list of well-researched public policies that can, with a high degree of certainty, lead to better statewide outcomes coupled with a more efficient use of taxpayer dollars. The summary report information can be found here: http://www.wsipp.wa.gov/BenefitCost/Program/118 Programs are searchable by name.

March 28, 2017

Committee on Ways and Means
U.S. House of Representatives
1100 Longworth Office Building
Washington D.C. 20515

Re: Maternal, Infant, and Early Childhood Home Visiting program (MIECHV)

Dear Chairman Brady:

Home Visiting was established in West Virginia nearly 35 years ago. In West Virginia, the evidence-based models of Healthy Families America (HFA), Early Head Start (EHS) and Parents As Teachers (PAT) are used. The Maternal Infant Health Outreach Worker (MIHOW) model, a promising practice is also used.

In 1999, programs using three of these models agreed to collaborate and form an informal coalition which they named Partners in Community Outreach (PiCO). The term *In-Home Family Education* was coined around that time to accurately reflect the important support to families provided by these three models. The success accomplished by PiCO in promoting In-Home Family Education helped lay the collaborative groundwork for MIECHV funding to come to West Virginia in 2010. In fact, West Virginia is often held up as an example of successful collaboration for the nation. Our models collaborate well with each other as well as with other early childhood and prevention programs in West Virginia.

In 2016, Home Visiting/In-Home Family Education was provided to some families in all of the 55 counties in West Virginia with the help of state, federal, local foundation funding and in-kind resources. These services are provided by twenty-five agencies, employing over 150 staff and serving over 1800 families. The organizations on whose behalf I submit this statement are:

A.B.L.E. Families
Brooke Hancock Family Resource Network
Burlington United Methodist Family Services
CASE WV Early Head Start
Charleston Family Resource Center
Children's Home Society of West Virginia
Clarksburg Mission
The Community Crossing
Clay County Board of Education

Cornerstone Family Interventions
Doddridge County Starting Points
Lewis County Family Resource Network
Marshall County Family Resource Network
Monongalia County Starting Points Center
Monroe County Board of Education
New River Health Association
Nicholas County Empowerment Corporation
Northern Panhandle Head Start
Preston County Caring Council
Rainelle Medical Center
REACHH Family Resource Center
Regional Family Resource Network
TEAM for WV Children
Tucker County Family Resource Network
Wetzel County Center for Children and Families

Data collected by the West Virginia Home Visitation Program for the fiscal year ending September 30, 2016 reveals the following about families enrolled in the program:

Benchmark 1: Maternal & Newborn Health

- Over 93% of pregnant women began prenatal care within four weeks of enrolling in a home visitation program.
- 83% of women had a visit with their health provider within three months after delivery of their baby.
- 81% of women were screened for maternal depression.
- 93% of women reported using birth control to prevent unintended pregnancies.
- Over 95% of children received at least 50% of the American Academy of Pediatrics Bright Futures recommended standard well-child visits by six months of age.

Benchmark 2: Child Injuries, Abuse, etc.

- The percentage of families with substantiated child maltreatment cases dropped from 4.2% in Fiscal Year 2013 to 2.7%.
- The percentage of families with first time substantiated report for child maltreatment cases dropped from 4.2% in Fiscal Year 2013 to .62%.

Benchmark 3: School Readiness

- Over 99% of children showed developmental progress in communication.
- Over 98% of children showed developmental progress in problem solving cognitive skills.

Benchmark 4: Domestic Violence

- 93% of pregnant women and mothers were screened for domestic violence.

In addition to these impressive data, some of the programs listed on pages one and two shared the following stories about and quotes from the families they serve.

From Rainelle Medical Center, which provides Parents As Teachers to families in Greenbrier & Pocahontas Counties:

> Julie*, is a single mom raising her daughter without receiving any child support from the father. Relocating to Pocahontas County, West Virginia, she told her PAT Parent Educator Rachel that she wanted to get a job, car and work on getting her GED. Julie has had difficulty holding down a job due to debilitating anxiety and limited work experience. Despite this, she was able to get a car through the DHHR and complete SPOKE classes. Through the support of her Parent Educator Rachel, Julie continues to work on her GED in between jobs and doesn't let her difficulties keep her from working toward her goals. *not her real name

The Early Head Start program at CASE WV in Mercer County shared this story:

> A seventeen-year-old mother of a new born child, who is also a former special education student and former resident of a group home, transitioned to her sister's home and enrolled in the program. Before the first home visit could be made the young mother was asked to leave her sister's home and ultimately became homeless. An uncle allowed her to move into his residence which was isolated and physically inaccessible to home visitors. Telephone contact was maintained with the mother for the next few weeks to offer support through discussions regarding the care, safety and nurturing of the infant. The Home Visitor provided guidance regarding developmental milestones, nutrition, well child visits, immunizations, strategies for dealing with depression and questions to ask the infant's doctor during visits as well as questions for her doctor regarding birth control information. A crisis erupted with the uncle and the mother became homeless again. With encouragement and support from the Home Visitor, the mother asked her mother to keep the child and the mother contacted the homeless shelter in Beckley, WV. She was accepted into the facility and during her stay at the shelter she completed applications for housing in Bluefield. She is currently living at Tiffany Manor, has her child with her, has begun studies to take her GED exam and has moved from the waiting list for home visits to scheduled home visits and participation in the program.

From Cornerstone Family Interventions, which provides Parents As Teachers to families in Boone & Lincoln Counties:

> In Early November 2016, a Lincoln County, West Virginia mother named Cassie expressed concern about her nine-month old son Ely's gross motor development. Cassie stated that Ely had not started to crawl and did not move around much. As a result of these concerns, PAT Parent Educator Christopher completed the Aces & Stages Questionnaire and found that Ely did have a slight delay in his gross motor ability. So Cassie and Christopher developed a plan of action to improve Ely's gross motor ability. Just two months into the plan, Ely made tremendous strides. Cassie stated that Ely was not only crawling forward and backwards all around the house, but was now pulling himself up and has

> been able to stand while holding on to things. Cassie stated that Ely had also started to hold his grandparents' hands and walk a little. In late January 2017 Ely started walking on his own, and during the last developmental screen in February, he was right on target with his development.

Our Maternal Infant Health Outreach Worker program in Ohio County, through Northern Panhandle Head Start, sends us this quote from Patty:

> "[My home visitor] gives me confidence as a mom. When the whole world beats me down and tells me I can't, she reminds me I can, and already have. Learning things about what is healthy for my children helps me feel like I can make a positive difference in their lives. Every mom needs to feel like that."

Nicole, a grandmother in Barbour County, states this about the Allegheny Highlands Parents As Teachers program at the Tucker County Family Resource Network:

> "My daughter Sara and 11 month old grandson are participants in Barbour County Parents as Teachers. [Parent Educator] Teresa has worked diligently with Sara to help her learn parenting skills which include developmentally appropriate activities, nutrition, health care, and ways to keep Lennox occupied and engaged. This program reaches out to many young parents, helping them to bond and interact with their children through learning activities and community outreach.
>
> I myself have participated with Lennox and Teresa, when Sara was unavailable. Parents as Teachers workers take their time individualizing their programs to each child, so that they can succeed and thrive on their own developmental level. Lennox has finger-painted, worked with object permanence, texture activities, and material manipulation among many other activities. All these skills will help Lennox in the future when he attends school. We have learned different ways to interact with Lennox that stimulate his mind and help him learn. Parents as Teachers also help parents keep track of their children's growth and developmental milestones, and since they are engaged with the families more often, they are able to assist in early identification of any concerns.
>
> Parents as Teachers also has community events, so that young parents can socialize and participate in fun, age-appropriate activities with other families. Many young parents feel isolated and depressed, and these events allow them to meet other families with kids the same age.
>
> Parents as Teachers and Teresa have played a vital role in helping Lennox become the bright, happy, and adventurous little boy he is. This program has played an important role in our family and our community. "

As you can see, MIECHV funding has made a difference in the lives of families of young children in West Virginia.

We are confident that future screenings, data and referrals to services will reveal even more improvements in the health, safety, educational readiness and well-being of West Virginia's youngest children and their families.

Thank you for the opportunity to share this information with you.

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Overview of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Award in Pennsylvania

The Pennsylvania, Department of Human Services, Office of Child Development and Early Learning (OCDEL) is writing in support of the re-authorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.

The MIECHV program, along with Pennsylvania's early childhood programs, are administered by OCDEL, an office that joins together programs from both the Pennsylvania Department of Human Services and the Pennsylvania Department of Education. Well-positioned to implement services through a systems approach, OCDEL administers child care subsidy and licensing; Early Intervention; birth to five; and infant-toddler, and pre-kindergarten programs, in addition to family support programs such as evidenced-based home visiting. These services, when managed under one umbrella agency, implement MIECHV at the state level and serve Pennsylvania in the effort to enhance and expand the early childhood infrastructure, ultimately supporting families' positive outcomes. OCDEL assists families and their children, from prenatal through school age, by using data, research, and stakeholder guidance to assure high quality services.

The main goals of OCDEL are to:

- Work effectively, collaboratively, creatively, and successfully to ensure that all families have access to high-quality early care and education programs for their children.
- Engage stakeholders in actionable ways that provide guidance on programs and policies.
- Identify and use key data and research to improve policies and practices.

Through the MIECHV award, Pennsylvania received $11,798,665 in formula funding for the 2016 federal fiscal year. This provided the following evidenced-based home visiting services to:

- Fund 31 Local Implementing Agencies (LIA's)
- Provide home visiting services in 46 out of 67 counties
- Fund four evidenced based models across the state:
    - Early Head Start – Home Based (EHS)
    - Health Families America (HFA)
    - Nurse-Family Partnership (NFP)
    - Parents as Teachers (PAT)

In federal fiscal year 2015, home visitors in Pennsylvania:

- Made 39,027 home visits to 6,208 parents and children in 3,169 families;
- Enrolled 2,105 new parents and children to the program; and
- Served families living in communities in 46 counties across the state, of which 21 counties are rural.

Through MIECHV, OCDEL established the following requirements of our LIAs:

Enrollment: LIAs are required to report their enrollment on a monthly basis to their designated infant toddler specialist and are required to maintain 95 percent enrollment.

Continuous Quality Improvement: LIAs are required to participate in Continuous Quality Improvement (CQI). All LIAs submitted their initial plans for review in April 2016, working on a CQI topic that fell within one of the eight topic areas below:

- Breastfeeding
- Community collaboration
- Data
- Enrollment/recruitment
- Family engagement and retention
- Subsequent pregnancy
- Screenings
- Staffing and professional development

Throughout the work of the CQI team, LIAs successfully made enhancements to programs and services. The following are examples of agency CQI achievements:

- ARIN Intermediate Unit 28 identified implementation of the State Home Visitor Competencies as their CQI topic. They have successfully created and implemented a system of tracking that both identifies the early childhood domains that are in highest need of further professional development, and also the trainings that staff are participating in that meet that need. The information ensures that staff are getting training that is relevant, data-based, and meeting the requirements outlined by OCDEL.

- Cameron County Family Center wanted to increase family engagement and chose to create an updated family survey as their CQI topic. This provided insight into what the families hoped to gain from participation in the program. As a result, the center offered several new family engagement opportunities, such as a father/daughter dance and mother/son game night. These activities were well-received and highly attended, bringing family strengthening activities to the community that were reflective of client goals.

- Community Services of Venango County chose lead screenings as their CQI focus. By detecting high lead levels early in children, the potential for developmental delays and other complications can be decreased. There is a significant need for screenings in the communities of Venango County because few children are screened. At the beginning of

the CQI work, 36 percent of children were receiving lead screenings. Establishing a goal to increase the amount to 50 percent of all children by December 2016. As of December 2016, 69 percent of the children enrolled had received a lead screening.

Coordination with Early Intervention (EI): All LIAs are required to coordinate services with EI agencies to ensure support to those children receiving services or children identified after enrollment as needing services. Coordination between home visiting and EI is documented in a memorandum of agreement (MOA). LIA staff noted that receiving and providing referrals for EI, having more information about the child (e.g. Individual Family Service Plans (ISFP)), and working with children on the same goals are all benefits to having a relationship with EI.

As part of home visiting coordination with EI, all home visiting programs within OCDEL were moved from the Bureau of Early Learning Services into the Bureau of Early Intervention to better coordinate between the two programs. This administrative arrangement is intended to create smoother transitions for children and families between and among services.

Community Collaboration: All LIAs must comply with the following community collaboration requirements:

a) Participate in existing local collaborative groups to coordinate home visiting and other early childhood initiatives if available;
b) Work to develop shared resources and referral strategies between local home visiting agencies and other community service providers to allow for early access to services by families;
c) Actively work with other local community agencies and refer those needing services, if at capacity, to other agencies that will meet their needs;
d) Establish a point of contact from each agency for follow up conversations and planning as needed;
e) Outline protocols to share information and coordinate services as appropriate;
f) Determine a frequency for the MOA to be reviewed and revised;
g) Determine other topics as relevant to local programs; and
h) Obtain signatures on the MOA.

Program Review: All agencies during the 2015-2016 reporting period received two site visits from their designated infant toddler specialist. This is beyond the home visiting models monitoring requirement. The infant toddler specialists are professional staff who complete the agencies' review annually to ensure they are meeting all program requirements beyond the home visiting models requirements. During this review, a Program Review Instrument (PRI) is completed. The PRI assesses the programs in the following areas: reporting requirements, enrollment, confidentiality, home visit completion, staff qualifications, professional development, curriculum, use of screenings, coordination with EI agencies, transitions, community collaboration, and a CQI plan. The highest score that the implementing agency can receive on a PRI is 140. The scores are broken down into three areas: exemplary- 95-100 percent, compliant- 86- 94.9 percent, and deficient- 0- 85.9 percent. Of the 32 MIECHV sites, 25 received exemplary scores; those who did not score in the exemplary range were placed on corrective action plans.

Home Visiting Steering Team: The steering team is a group of individuals that meet to discuss various topics that affect MIECHV LIAs. Enrollment reports are reviewed monthly. Challenges that LIAs are experiencing are considered and supports are provided as needed. The team approves and provides feedback regarding policies and procedures, announcements, and data collection. All program requests are considered and approved by the team. Additionally, after all program reviews are completed, the team evaluates the results and uses the collected information to make informed decisions.

Home Visitation Stakeholders Committee: The committee continues to meet on a quarterly basis, either in person or via phone. In 2016, the group has expanded to over 100 representatives from across various state agencies, local home visitation service providers, technical assistance agencies, and advocacy groups. During the meetings, updates are shared from collaborating agencies, as well as successes from the home visiting field, allowing for local innovation and collaboration among programs to be fostered. In addition, workgroups are assembled to gather feedback on current policies for home visitation, defining the priorities in the home visiting field, and identifying needed professional development opportunities.

2011-2014 MIECHV Statistics

The following clients received services under Pennsylvania MIECHV awards from 2011 through 2014:

Under 18 years of age	17%
Race Ethnicity	**Percentage Served**
White	47%
Black	21%
Hispanic	28%
Other	3%
Unmarried	84%
Less Than High School	19%
TANF Recipient	44%
Food Stamp Recipient	53%

Clients receiving home visiting services were typically low-income, young, unmarried, and possessed less than a high school education. Through these funds, 54 percent of MIECHV families received all of their recommended well-child visits in the first year of life and 30 percent of clients who enrolled prenatally were 30 percent more likely to quit smoking in their third trimester.

How Do Clients Benefit from Home Visiting services offered through MIECHV funding?

1. Positive Health Outcomes – Clients received valuable information about how to have a healthy pregnancy and support their child's health needs.

2. Better School Readiness – Clients felt their children were better prepared for entering the classroom.

3. Social Supports – Programs enabled clients to leverage resources and meet personal goals such as obtaining jobs, locating housing, accessing education, and connecting to community resources.

How do Programs Benefit from Receiving the MIECHV award?

Through Collaboration with their local communities:

Columbia County Family Center (PAT): The Family Center began to collaborate with another local agency, The Jaycees. The organization has a newly renovated building with a kitchen, updated technology, and plenty of space for classes and group connections to be held. It is located a block away from the current Family Center site. Starting in March 2017, all group events will be held at this location. The Jaycees also agreed to provide snacks for each event. They will also have boxes of food on hand so that if any family is struggling financially and could benefit from receiving food assistance, Family Center staff can provide it to them on the spot.

Family First Health (NFP): Family First Health have been able to build on an initial referral relationship with the York County Women, Infants, and Children (WIC) office. They have revised the referral forms specifically to meet the needs of WIC and created a drop-box for referrals to be submitted. The forms are sent out with the intake packets for any WIC applicants who are pregnant, the client completes the packets, and staff is responsible for picking up the forms on a weekly basis. This has resulted in more than double the number of monthly referrals from this source in the first month.

Guthrie, Towanda Memorial Hospital (NFP): In November, the hospital hosted a spa day open to all current NFP mothers in collaboration with Firefly Massage Seminars, local massage therapists. Licensed massage therapists are required to complete continuing education credits, and Firefly Massage Seminars can provide those credits. Firefly Massage Seminars has a six-hour CEU course which includes three hours of instruction (teaching new techniques), followed by three hours of actual practice on volunteers. This is where NFP comes in – providing the volunteers. This event serves as a teaching tool for the program as well as for the licensed massage therapists. Clients learn many lessons, including that self-care can aid in attentiveness and happiness as a mother. Not only does this event help mothers learn new techniques in self-care, but they also learn life skills including how to plan, arrange for child care and transportation, and how to make appointments.

Through Family Successes:

ARIN IU 28 (PAT/EHS): ARIN offers multiple client examples of family success -- a young single mom rented a home on her own for the first time with the help of St. Vincent de Paul; a young mom completed her first semester at Indiana University of Pennsylvania; and a mom recently paid off all her debts and is now debt free. A new staff member was able to increase her case load and new families greatly welcomed her expanded presence. A single mom

completed job training and is now an LPN. Several new babies were born into the program. With assistance, one child was finally accepted into the Head Start program in their community.

Cameron County Family Center (PAT): A local family was struggling to find out what was causing the delays in their child's development. As a direct result of the developmental screening done by their PAT Parent Educator (home visitor), they were able to make a quick referral to EI services which lead to medical appointments with specialists. The family has since learned that their child has a rare genetic disorder. In many cases, families may become disheartened to hear such news; however this family believes that early detection and the ongoing support of both PAT and EI will be assets to their overcoming many of the obstacles they face in the future.

Columbia County Family Center (PAT): In December, a single mom enrolled in PAT program graduated from college with a Bachelor's Degree. This mom is one of the original MIECHV funded families enrolled when the award was received. She has been very consistent with the programs. This mom has a medically needy child who requires a Bayada nurse. She still managed to plug along and finish her education despite this.

Community Prevention Partnership of Berks County (NFP): The program has at least eight clients who graduated from NFP who either are studying to become a nurse or who have obtained a degree in nursing.

Maternity Care Coalition: During an early fall home visit, Karl, a client, expressed his goals and dreams for himself and his family. It was during that home visit, for the first time, Karl reported feeling inspired to challenge himself to get his GED. At that time, he also expressed life fears, being afraid of the unknown and failure. During home visits, Karl's advocate (home visitor) provided him with words of encouragement and support to create a goal plan with attainable action steps. Together they addressed barriers, concerns, and identified tasks. One of the first steps was to find a GED program. Karl searched for schools by area, availability, and additional trade options. He took the initiative to find a GED program that was prefect for him. Maternity Care Coalition is proud to say that Karl enrolled in a GED program and started classes in December 2016. He reported that he is forever grateful for his advocate and happy to be making steps to better himself and his family.

By Providing Services to their communities which can have long term effects:

Susquehanna Home Care and Hospice: In the summer of 2015, the NFP program of Susquehanna Home Care and Hospice was featured in the Nurse Family Partnership NewsLink published by the national service office. The article "Not looking back, but always looking forward," captured the impact of a nurse home visitor in the life of a young mother. The mother was 19 years old and uncertain about what the future held when she was enrolled in NFP. Today she is a graduate of Dickinson Law School, a wife, and a mother of three. She credits much of her success to her nurse home visitor, who was in attendance on her graduation day.

Central Susquehanna Community Foundation: This program was highly regarded in an article featured in their local newspaper. It was quoted by a local pediatrician that "Nurse Family Partnership is effective and important." The article goes on to interview a currently

enrolled mother and her nurse. The mother praising the nurse and the program for providing her with education and support and the nurse describing her devotion to the families that she serves. It goes on to state that the relationship between mother and nurse is why the program works. "Sometimes this is the first trusting relationship that a young mom has," was quoted by the nurse. This relationship can make all the difference.

Allegheny County Health Department: Allegheny County has created a community resource titled the Allegheny Link. The mission of the Allegheny Link is to simplify and streamline access to services and supports in an effort to help individuals and families maintain their independence, dignity and quality of life. Families and providers can visit the website or call and be linked to services that fit the unique needs of the individual family. http://alleghenylink.org/

Notice:
This report was developed using reports collected from the agencies listed on pages nine and ten. Information located within this report was collected as a requirement of the MIECHV award within Pennsylvania. They did not have any direct input into the report.

Questions regarding this report can be directed to
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Attn: Andrew M. Dietz, Family Support Program Manager
333 Market Street
6th Floor
Harrisburg, PA 17126

Questions can also be directed via email to anddietz@pa.gov

Through this report, we have shared a brief summary of all that home visiting can do to bolster family resiliency, improve child outcomes, and facilitate positive familial relationships. We ask you to strongly consider the re-authorization of the Maternal Infant Early Childhood Home Visitation (MIECHV) Program. The future of our commonwealth and the nation depends on the success of children who are born today. We, at the state office, along with all of our LIAs, ask that you consider the long-ranging, positive effects home visiting has on families and communities, and reference the success stories mentioned above, as well as the success of the MIECHV program in general.

We are motivated to help change families' circumstances so that the caregivers and their children will have opportunities to move beyond poverty, obtain meaningful employment, gain an education, learn the value of giving back to their communities, and become model citizens.

In addition to Pennsylvania's MIECHV award, Governor Tom Wolf has proposed $9 million in additional state funding to support evidenced-based home visiting models within the commonwealth. The success of MIECHV evidenced-based home visiting programs shine a spotlight on what these programs can do for both individual families and communities.

We thank you for your consideration in this matter.

Sincerely,

Suzann Morris
Deputy Secretary
Office of Child Development and Early Learning
Departments of Education and Human Services

MIECHV Local Implementing Agencies	Phone #	Fax #	Address	City	State	Zip
Allegheny County Health Department	412-247-7954	412-578-8325	807 Wallace Ave, 4th Floor, Suite 407	Pittsburg	PA	15219
ARIN Intermediate Unit 28	724-463-5300	724-463-5315	2895 W. Pike Rd.	Indiana	PA	15701
Cameron County Commissioners	814-486-1810	N/A	20 West Fifth Street	Emporium	PA	15834
Capital Area Head Start	717-541-1795	717-232-4597	3705 Elmwood Drive	Harrisburg	PA	17110
Central Susquehanna Community Foundation	570-784-1723	570-752-7435	410 Glenn Avenue, Suite 200	Bloomsburg	PA	17815
Chester County Health Department	610-334-6459	N/A	601 Westtown Rd., Ste. 290	West Chester	PA	19382
Children's Advocacy Center of Lawrence County	724-658-4688	724-658-8810	1000 S. Mercer St.	New Castle	PA	19601
Columbia County Family Center	570-387-9086	570-389-5703	11 W. Main Street, PO Box 380	Bloomsburg	PA	17815
Community Prevention Partnership of Berks County, Inc.	610-376-6988	610- 376-6944	227 North Fifth Street	Reading	PA	19601
Community Services of Venango County	814-678-7766	N/A	206 Seneca St.	Oil City	PA	16301
Crozer-Keystone Health System	610-497-7344	N/A	CK NFP, Community Hospital, 2600 W. 9th Street	Chester	PA	19013
Erie Family Center	814-874-6995	814-874-6994	913 Payne Ave	Erie	PA	16503
Family First Health	717-846-6776	N/A	116 South George Street	York	PA	17401
Fayette County Community Action Agency	724-437-6050	724-437-4418	108 N. Beeson Blvd.	Uniontown	PA	15401
Guthrie, Towanda Memorial Hospital	570-268-2518	N/A	91 Hospital Drive	Towanda	PA	18848
Home Nursing Agency Community Service	814-942-1903	888-277-8190	500 E. Chestnut Ave	Altoona	PA	16601
Infant Development Program, Inc.	570-748-3928	570-748-3610	980 East Water Street	Lock Haven	PA	17745

Jefferson-Clarion Head Start	814-849-3660	814-849-0128	18 Western Ave., Suite C	Brookville	PA	15825
Lancaster General Health	717-824-8124	717-544-5914	527 North Lime Street	Lancaster	PA	17601
Maternity Care Coalition	610-278-5117	215-989-3584	2000 Hamilton Street, Suite 205	Philadelphia	PA	19130
Montgomery County Health Department	610-278-5117	610-278-5167	1430 DeKalb St., PO Box 311	Norristown	PA	19404
National Nurse-led Care Consortium	267-765-2322	215-731-2400	1080 N. Delaware Ave Suite 300 D	Philadelphia	PA	19125
Perry County Family Center	717-582-3656	717-582-4949	8391-R Spring Road	New Bloomfield	PA	17068
Pinnacle Health Hospitals	717-231-8010	717- 782-5507	2645 N. 3rd St.	Harrisburg	PA	17110
Pocono Medical Center	570-426-1688	570-422-8249	206 East Brown Street	East Stroudsburg	PA	18301
Pottstown Family Center	610-630-2111	610-326-3104	3125 Ridge Pike	Norristown	PA	19403
Sadler Health Center Corporation	717-960-4321	717- 218-6671	100 N. Hanover Street	Carlisle	PA	17013
STEP (Lycoming Clinton)	570-601-9689	800-206-3006	2138 Lincoln Street	Williamsport	PA	17701
SUM Child Development	570-966-2845	570-966-9693	14 South 11 Street	Mifflinburg	PA	17844
Susquehanna Home Care and Hospice (Divine Providence)	570-326-8912	N/A	1100 Grampian Blvd, Fl. 4	Williamsport	PA	17701
The Guidance Center	814-731-0613	N/A	110 Campus Drive	Bradford	PA	16701

PEOPLE'S EMERGENCY CENTER

Nurturing Families, Strengthening Neighborhoods, Driving Change.

United States House of Representatives
Subcommittee House Ways and Means Human Resources

Testimony of Kathy Desmond, CEO of People's Emergency Center in Philadelphia, PA

March 23, 2017

I am Kathy Desmond, CEO of the People's Emergency Center (PEC) in Philadelphia (PA). PEC provides emergency, transitional, and permanent supportive housing to more than 160 families on any given day. In an average year, we serve over 100 families with more than 250 children in our Emergency Housing Program.

Overall, the City of Philadelphia annually serves 1,400 families in emergency housing, and more than 5,000 children and youth.

I urge the Committee to **extend** the Maternal, Infant, Early Childhood Home Visiting (MIECHV) program and urge for the greater use of MIECHV programs to serve children and families who experience homelessness.

As you are aware, MIECHV supports home visiting programs that minimize potential health risks of children and improves school readiness and achievement. These are services that homeless families and children need prior to and after they exist emergency or transitional housing. MIECHV can offer homeless families the stabilizing force that is needed to keep them in their communities and not re-enter the homeless system, services for which the homeless housing system provides in little abundance.

The federal departments of Health and Human Services, Housing and Urban Development, and Education released an interagency policy statement on meeting the needs of families with young children who are at risk of or experiencing homelessness. The policy statement recommends MIECHV as a key resource.

In Philadelphia, the Children's Work Group Early Childhood Committee (CWGEC) has brought together housing providers, home visiting program providers, public health experts and academics so that there is a space to talk to one another, follow-up, and learn about developing issues and strategies to combat family homelessness and barriers to early childhood development. Together, we are working to identify how home visiting programs can serve our families and children, and reauthorization of MIECHV would help Philadelphia reach this goal.

PEC and the CWGEC is working to understand the utilization of home visiting programs by families residing in Emergency and Transitional Housing Service providers. The results of a recent survey of providers showed that out of eight responders to our survey, seven of them referred families to Early Head Start (EHS) in the past year, but only half refer to other home visiting programs. In other words, EHS is a consistent referral but providers do not make regular referrals to **other home visiting programs**. In addition, EHS serves 3-years old. This fact suggests to us that the home visiting programs serving infants and toddlers are not a primary connection for families by the emergency housing system.

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PEC then followed-up with intensive interviews with specific home visiting programs in Philadelphia. These interviews revealed that these programs work with very traumatized, stressed-out families who are still housing insecure. Erin, a Nurse Home Visitor with the Nurse Family Partnership (NFP), reported that "***lead poisoning, asthma, eczema, and developmental delay are common issues for our homeless children. If they are in really unsafe condition, they are not physically allowed to get down and develop motor skills***."

Staying in contact with homeless families is a **common barrier** represented among the interviews. Joy from NFP reports that ***"I have a difficult time keeping hold of people who are homeless and couch surfing. They usually have a very low income and their phone numbers are changing all the time."*** Homelessness makes it challenging to retain families in care and continue to provide the services that they desperately need.

These are just two examples. There are many more showing the needs that our families have after they leave an emergency or transitional housing program.

Overall, our two surveys show that some homeless children and families are benefiting from home visiting programs, but certainly not the majority, and yet these families are suffering

In summary, some families are assisted by MIECHV programs, but not all, even though these families are highly traumatized and in need of stabilizing services after they exit from shelter.

PEC advocates for the continuation of funding for MIECHV and for MIECHV to expand its work with families and young children who experience homelessness.

Thank you for consideration of my comments.

References:

Fantuzzo, J., LeBoeuf, W., Brumley, B., & Perlman, S. (2013). A population-based inquiry of homeless episode characteristics and early educational well-being. Children and Youth Services Review, 35, 966-972. doi:http://dx.doi.org/10.1016/j.childyouth.2013.02.016

Solari, C.D., Althoff, S., Bishop, K., Epstein, Z., Morris, S., & Shivji, A. (2015). 2014 Annual homeless assessment report. U.S. Department of Housing and Urban Development.

Masten, A. S., Cutuli, J. J., Herbers, J. E., Hinz, E., Obradović, J., & Wenzel, A. J. (2014). Academic risk and resilience in the context of homelessness. Child Development Perspectives, 8(4), 201-206.

Office of Supportive Housing, 2016.

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Testimony for

The United States House of Representatives Committee on Ways and Means
Subcommittee on Human Resources

Hearing on the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

March 15, 2017

Submitted by:
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Chicago, IL 60604

Contact: Dan Duffy, President and CEO
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Prevent Child Abuse America and its network of 50 state chapters and 588 Healthy Families America program sites thanks the Chairman and the other distinguished members of the U.S. House Committee on Ways and Means Subcommittee on Human Resources for their hearing on the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program on Wednesday, March 15.

The testimony below will add detail and nuance to the testimony that the committee has already heard and will help illustrate not only the impact of home visiting, but also how investing in programs like MIECHV helps both the families served by the program, but also the taxpayers in communities where home visiting is making a difference.

About Prevent Child Abuse America

Founded in 1972, Prevent Child Abuse America is a national organization with chapters in all 50 states and nearly 600 Healthy Families America home visitation sites. We lay the groundwork to deliver the great childhoods that all children deserve and we promote services that improve child well-being and develop programs that help to prevent all types of abuse and neglect.
We work towards our mission by advocating for a variety of evidence based services that promote healthy child development and create the context for healthy families in thriving communities. As an organization, we believe that it is everyone's responsibility to be good stewards of children, not just the federal government. Our signature prevention program is the Healthy Families America home visiting model.

About Healthy Families America

Developed in 1992, Healthy Families America (HFA) is Prevent Child Abuse America's nationally-recognized, signature home visiting program. Rooted in the science of attachment and infant mental health, HFA is designed to work with families who have histories of trauma, intimate partner violence, and mental health and/or substance abuse issues. HFA services begin prenatally or immediately after the birth of a baby and are offered voluntarily, intensively and over the long-term depending on the needs and wishes of the family (3 to 5 years after the birth of the baby).

Healthy Families America has a strong research base which includes randomized control trials and well-designed quasi-experimental research. The model is based on a set of 12 research-based elements providing benchmarks to measure quality derived from more than 30 years of research. These Critical Elements are operationalized through a series of best practice standards, requiring a comprehensive and rigorous accreditation process to ensure model fidelity.

To date, research and evaluation indicates impressive outcomes. Reviews of 15 evaluation studies of HFA programs in 7 states produced the following outcomes:

- Reduced child maltreatment;
- Decreased low weight babies;
- Improved parent-child interaction;
- Improved success in school measured at age 7;
- Increased parent educational attainment;
- Increased access to primary care medical services; and,
- Increased well-baby visits.

Why Home Visiting?

> **"MIECHV is evidence-based policy that works; to empower families, to coordinate services, and to unify systems."** - *Eric Bellamy, Home Visiting Manager, Remarks at the Subcommittee Hearing on MIECHV, 3.15.17*

All parents want what is best for their children. At the same time, not all parents have the same knowledge, skills, or resources to understand child development or their role as a parent. Early childhood home visiting provides a voluntary and direct service in which home visitors can help equip parents with the tools they need to be the best parent possible.

Evidence-based services such as parent education, parent support programs, and early home visiting are effective strategies leading to positive outcomes for children and families. Home visitors help parents understand, recognize and promote age appropriate developmental activities for children; meet the emotional and practical needs of families; and improve the manner in which parents achieve better outcomes for their children. Research has shown that voluntary home visiting is an effective and cost-efficient strategy for supporting new parents

and connecting them to helpful community resources, helping these new parents give their baby the great childhood they deserve.

Who Participates?

> **"It's important to keep home visiting because there are young women out there like myself that have been through a ton, who have battled though struggles, and who need to learn more about their pregnancy, the rights and wrongs, as well as to have someone there that understands them and doesn't judge and is there through every step of the way."** - *Rachel, Healthy Families America participant*

According to data from the Human Resources Service Administration, Maternal and Child Health Bureau, participants in the federal MIECHV program tend to be living in or at risk of poverty, in addition to other risk factors. According to the data:

- **77%** of families who receive home visiting services had household incomes at or below 100 percent of the federal poverty guidelines ($24, 250 for a family of four)
- **46%** of families were at or below 50% of the federal poverty guidelines
- **31%** of participants had less than a high school education
- **35%** of participants had only a high school diploma
- **22%** of newly-enrolled households included pregnant teenagers
- **12%** of newly-enrolled households reported substance abuse problems, and
- **15%** of newly-enrolled households reported a history of child abuse and maltreatment

Simply put, the families and children served by federally-funded home visiting programs are among the most vulnerable populations in the country.

The Problem of Child Abuse and Neglect

> **"Infants are more likely to enter foster care than any other age group - twice as likely as one-year olds and more than five times as likely as 11-year-olds. Several home visiting models, including Healthy Families America, have proven that home visiting is a tool that can keep these children safe at home."** - *Rep. Danny Davis, Remarks at the Subcommittee Hearing on MIECHV, 3.15.17*

Abusive or neglectful experiences in early childhood can have long-lasting effects that increase the probability of poor developmental outcomes, such as learning, personal behavior, as well as physical and mental health problems for children. These negative outcomes manifest later in life as increased likelihood of both physical and mental health problems as well as decreased work efficiency.

These effects can be broken down into real-world costs. Research has shown that **child abuse and neglect affects over one million children every year and its effects cost our nation $220 million every day.**[1]

Fortunately, prevention solutions such as home visiting offer hope. A U.S. Government Accountability Office (GAO) study finds that total federal costs of providing initial prevention program funding for low-income populations were offset over four years. [2] Another study found longer term savings based on the cost reduction of social problems related to abuse.[3] Abused children have higher rates of juvenile delinquency and special health care needs than those who have not been abused.[4] Ultimately, increased early funding surrounding child abuse prevention will save taxpayers over the long-term while protecting those children most at risk.

Research has shown that our country and our families see the greatest benefit when we choose to invest in programs that prioritize prevention, such as MIECHV.

Investing in prevention is less costly to society and individuals than attempting to treat problems later. Prevent Child Abuse America estimates that implementing effective policies and strategies to prevent child abuse and neglect can save taxpayers **$80 billion per year**.[5] Further, the Centers for Disease Control and Prevention determined that the average lifetime cost of nonfatal child abuse per victim was over $210,012 in 2010 dollars, including $32,648 in childhood health care costs; $10,530 in adult medical costs; $144,360 in productivity losses; $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs.[6] In 2008, the total lifetime economic burden from new cases of fatal and nonfatal child maltreatment in the United States was approximately $124 billion. In sensitivity analysis, the total burden was estimated to be as large as $585 billion.[7]

The cost of the status quo includes direct costs for foster care services, hospitalization, mental health treatment, and law enforcement. Indirect costs include loss of productivity, as well as expenditures related to chronic health problems, special education, juvenile delinquency and the adult criminal justice system.[8] An international study by the United Nations Children's Fund (UNICEF) placed the United States **next to last** on child well-being, among the 21 wealthiest

[1] Gelles, Richard J., & Perlman, Staci (2012). Estimated Annual Cost of Child Abuse and Neglect. Chicago IL: Prevent Child Abuse America.
[2] U.S. General Accountability Office. (1992). *Prevention Programs Need Greater Emphasis. Report to the Chairman, Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, U.S. Senate.* (GAO Publication No. GAO/HRD-92-99).
[3] Ibid., 25.
[4] Ibid., 27.
[5] Gelles, Richard J., & Perlman, Staci (2012). Estimated Annual Cost of Child Abuse and Neglect. Chicago IL: Prevent Child Abuse America.
http://www.preventchildabuse.org/images/research/pcaa_cost_report_2012_gelles_perlman.pdf
[6] Fang, X., et al. (2012). The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse & Neglect, Volume 36, Issue 2, pages 156–165.
[7] Ibid., 157.
[8] Gelles, R., & Perlman, S. (2012)

nations in the world.[9] Although only one indicator of child well-being, rates of child abuse and neglect are ultimately tied to a nation's investment in its children.

Home Visiting: A Positive ROI for Families and for the Nation

> **"Dawn, one participant I met with on Monday, shared her experience of working with a home visitor who helped her find a stable home and steady income in order to provide for her growing family. These are the types of outcomes we should be expecting and receiving from the limited use of taxpayer resources."** *- Rep. Adrian Smith, Remarks at the Subcommittee Hearing on MIECHV, 3.15.17*

Home visiting programs that receive federal funding through MIECHV are held to rigorous standards for effectiveness and must demonstrate a positive impact in order to continue receiving funds. This approach both supports families while protecting taxpayers by ensuring that at-risk families receive the support they need in a way that is both cost-effective and solutions-focused.

Since its inception, there have been over 185 studies on Healthy Families America. The most rigorous evidence of the program's efficacy comes from 15 publications of multiple randomized control trials, or RCTs. Those trials have consistently demonstrated positive impacts in all six domains required by the MIECHV *program (improvements in maternal, newborn, and child health; prevention of child injuries, child abuse, neglect or maltreatment and reductions of emergency room visits; improvements in school readiness and child academic achievement; reductions in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports).*

The majority of these findings were replicated and sustained over time. Some of the most compelling recent findings from HFA research include reduction in low birth weight rates by nearly half[10], reduction in rapid repeat birth rates by nearly half overall and by two-thirds for teen mothers[11], and improved parenting attitudes and behaviors demonstrated by numerous studies in more than 17 states[12]. [13]

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[9] UNICEF, Child poverty in perspective: An overview of child well-being in rich countries, *Innocenti Report Card* 7, 2007. UNICEF Innocenti Research Centre, Florence.

[10] Lee, E., et al., (2009). Reducing low birth weight through home visitation: A randomized controlled trial. American Journal of Preventive Medicine, 36(2), 154–160.

[11] Ownbey, M., et al., (2011). The effects of a healthy families home visitation program on rapid and teen repeat births. Child & Adolescent Social Work Journal, 28(6), 439-458.

[12] HFA Impacts on Parents & Families (n.d.) Chicago: Prevent Child Abuse America. http://www.preventchildabuse.org/index.php/research/research-reports

[13] Avellar, Sarah, et al., Home Visiting Evidence of Effectiveness Review: Executive Summary, Washington, D.C. U.S. Department of Health and Human Services, Office of Policy, Research and Evaluation, September 2013, http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf#exec_summary.

In addition to the research from individual models, federal evaluations of home visiting models have shown similar, positive results. In 2015, research from HRSA showed impressive outcomes attributable to MIECHV models. According to their research, of all home visiting models:

- **83%** demonstrated overall improvement in MIECHV benchmark areas,
- **81%** demonstrated improvement in maternal and newborn health,
- **85%** reported improvements in school readiness and achievement,
- **85%** resulted in improvements in family economic self-sufficiency, and
- Screenings for developmental delays in young children are **double that of the national average** in the 18 states with MIECHV programs.

Results like these indicate that not only do MIECHV funded programs have a positive effect on the families who participate, but that these positive outcomes can reverberate across the community. With more parents gainfully employed and more children born healthy and into families that understand child development, entire communities will see more children excelling in school, fewer parents reliant on social safety net programs, and more families set to succeed.

Conclusion: Home Visiting Works

The data provided here, whether told from the tables within a randomized control trial or from the mouth of a young mother who has a different future thanks to MIECHV, proves that home visiting works. Home visiting is an effective, evidence-based, and cost-efficient solution to the problems faced by many new families across the country. In implementing this solution, MIECHV provides an example of the kind of federal/state partnership that demonstrates positive outcomes for both the families who participate in it and the taxpayers who help fund it.

If we truly want to make a difference for young parents like Rachel and babies like Angelica, federally funded home visiting programs must become more widely available in communities across our country. To that end, Prevent Child Abuse America and Healthy Families America encourage an expansion of MIECHV funding and a long-term reauthorization that will provide stability to the programs that have been providing stability to at-risk families across the United States. While no one program can end child abuse and neglect or break the cycle of poverty, home visiting is an example of how one program can interface with other community programs and resources to provide a positive return on investment and to create a holistic system of support around at-risk families.

House Ways and Means Subcommittee on Human Services

Hearing on Maternal, Infant, and Early Childhood (MIECHV)

Home Visiting Reauthorization Hearing

March 15, 2017

Statement for the Record Submitted by:

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Distinguished Members of the Human Resources Subcommittee:

"Parenting Our Children: In the Best Interest of the Nation" is an axiom that I believe all of us can firmly support and agree upon. And it is in this spirit that I encourage you to give serious consideration to including language in the MIECHV reauthorization that would expand services and/or provide incentives and resources for Home Visiting Programs to serve fathers as well as mothers.

"Parenting Our Children..." is also the title of a 1996 report to Congress and the President that emanated from the bi-partisan U.S. Commission on Child and Family Welfare of which I served as its Associate Director. In 1990, approximately 28% of all lives births nationwide were to unmarried mothers.

The Commission was created as part of the Child Support Recovery Act of 1992 (P.L. 102-521) to study and to advise Congress and the President on issues relating to child custody, parental access and visitation, abuse, 'services for children and families, family and juvenile courts and the child welfare system. The focus of the Commission's attention was based, in large part, on the growing concern and consequences of father absence in the lives of children. As a result, the Commission held hearings around the country to solicit recommendations for changes in public policies that held the promise of increased father involvement--and responsibility (both financially and emotionally) – in the lives of their children.

Today, the changes in family formation and structure are even more pronounced given the continued increased in nonmarital child bearing. In **2014**, **40%** (1.7 million est.) of all live births (3.9 million est.) nationwide were to unmarried parents.

And this percentage is exponentially higher among various racial groups, specifically: 71.5% to unmarried births to African-American mothers, 53.2% to Hispanic Mothers; and 29.3% to White

mothers. While there have been improvements in reducing teen pregnancies, over 65% of mothers between the age of 20-24 years had children outside of marriage.

And to draw this changing demographic closer to home, I have included the nonmarital births percentages and numbers for the members of the Human Resources Subcommittee based on their respective states:

2014	Percent and Number of Nonmarital Births *
Nebraska (Adam Smith)	33% or 8,840
Indiana (Jackie Walerski)	43% or 36,409
Minnesota (Mike Bishop)	32% or 22,610
New York (Tom Reed)	40% or 94,658
Missouri (Jason Smith)	40% or 30,292
Florida (Carlos Curbelo)	48% or 105,422
Washington (Dave Reichert)	32% or 28,450
Illinois (Danny Davis)	40% or 63,555
Texas (Lloyd Doggett)	42% or 166,754
Alabama (Terri Sewell)	43% or 25,721
California (Judy Chu)	39% or 194,960

* An analysis of 1990-2014 Natality MicroData files from Centers for Disease Control and Prevention, National Center for Health Statistics

One of many consequences of these changing demographic trends is that as of 23.6% of children (17.4 million) lived in father-absent homes and the poverty rate for these households is 48% -- over four times the rate for children living in married couple families.

Father absence also has unintended consequences for a child's emotional and social well-being. According to Child Trends,

> *Children born to unmarried mothers are more likely to grow up in a single-parent household, experience instable living arrangements, live in poverty, and have socio-emotional problems.*

As these children reach adolescence, they are more likely to have low educational attainment, engage in sex at a younger age, and have a birth outside of marriage as young adults, children born outside of marriage are more likely to be idle (neither in school nor employed), have lower occupational status and income, and have more troubled marriages and more divorces than those born to married parents

Our country's social policies have failed to respond to the changes in family formation. It has also failed to incorporate a "father factor" into mainstream child and family support programs that would create on-ramps to services for fathers who live apart from their children.

Changes in the MIECHV reauthorization that offer fathers home visiting services similar to those provided to mothers could have many positive impacts on family and child well-being. It holds the promise of providing an incentive for both mothers and fathers to establish a co-parenting partnership, thereby enabling fathers (since mothers are often the "gate keepers") to maintain a parenting relationship with their children.

In a study entitled Promoting Father Involvement in Home Visiting Services for Vulnerable Families: Finds from a Pilot Study of Dads Matter by Guterman, N.B., J.L., & Banman, A. (under review – 2017), researchers posited the following:

Perhaps most fundamentally, the field of home visitation as a whole has largely overlooked the key role that fathers play in young children's developmental outcomes and in configuring home visiting services to address their role. It is rather startling to note, for example, that none of the home visitation models that have been rigorously evaluated have been designed to target fathers as primary service recipients, none were designed to address the array of father-related influences on children's well-being, and none have yet included fathers as subjects of study, leaving a scant evidence base from which to understand how home visiting programs can best address fathers' roles in promoting positive child and family outcomes.

This is an especially significant oversight: A growing body of evidence has indicated that fathers play a central role in the development of young children, influencing a variety of critical outcomes for later life.

Indeed, a growing evidence base has documented a wide variety of fathering roles and an array of important developmental outcomes linked with these roles. In addition to discernable benefits accruing to children from fathers' economic contributions to the family, evidence indicates that greater positive father involvement in early childhood, regardless of whether fathers live with mothers, has been linked with improved mother-infant attachment quality, greater academic achievement, lower aggression, lower delinquency, lower depression, and lower anxiety in children

Furthermore, father-inclusive services have proven to contribute to positive outcomes in the areas of:

Paternal Involvement During Pregnancy

Paternal involvement during pregnancy was shown to positively influence health outcomes for the mother, child, and father. However, the father's role and level of involvement during the pregnancy may be limited by the focus on the mother during the prenatal period. New parents described how attending ultra-sound appointments together strengthened their relationship. Mothers found the father's presence soothing and reassuring during the pregnancy. Mothers also cited the father as the best source of support during the nine months.

Source: Widarsson, M., Engstrom, G., Tyden, T., Lundberg, P., & Hammar, L. (2015). 'Paddling upstream': Fathers' involvement during pregnancy as described by expectant fathers and mothers. Journal of Clinical Nursing, 27, 1059-1068.

Paternal Engagement in Child and Family Services

Research on the engagement of fathers in a variety of child and family interventions and programs suggests that fathers' participation in services boost mothers' engagement in the intervention and improve service outcomes.

Sources: Fals-Steward, W., Fincham, F.D., & Kelley, M.L. (2004). Substance-abusing parents' attitudes toward allowing their custodial children to participate in treatment: a comparison of mothers versus fathers. Journal of Family Psychology, 18(4), 666.

Bagner, D.M., & Eyberg, S.M. (2003). Father involvement in parent training: When does it matter? Journal of Clinical Child and Adolescent Psychology, 32(4), 599-605.

Gevan, S., Granic, I., Solomon, T., Blokland, K., & Ferguson, B. (2012). Paternal involvement in Multisystemic Therapy: Effects on adolescent outcomes and maternal depression. Journal of Adolescence, 35(3), 743-751

Paternal Engagement in the Perinatal Period

Involving fathers in the perinatal period, as is targeted by home visiting programs, is linked to continued involvement over time. Father involvement among young unmarried parents, on average, often declines over the first 2 years of their children's lives, but when fathers participated in the birth they were more likely to be positively involved 2 years later across multiple measures, including contact, direct caregiving, financial contribution, decision making, and contact with extended family.

Source: Bellamy, J.L., Thullen, M.J. & Hans, S.L. (2015). The effect of fathers' presence at birth on involvement over time. Journal of Marriage and Family, 77(3), 647-661.

In closing, I sincerely hope you will give serious consideration to making father-inclusive services an important hallmark of the MIECHV Reauthorization.

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March 29, 2017
Subcommittee on Human Resources
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Chairman Smith, Ranking Member Davis, and Members of the Subcommittee on Human Resources:

We appreciate the opportunity to submit testimony in support of reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. The mission of the Sargent Shriver National Center on Poverty Law is to provide national leadership in advancing laws and policies that secure justice to improve the lives and opportunities of people living in poverty. The Shriver Center develops and advances policies that respond directly to the needs of people in poverty, including in the areas of health care, education, housing, civil rights, and employment.

A large body of research links poverty in childhood to poor adult outcomes such as lower educational attainment and earnings and higher incarceration rates. Over the last decade, researchers have examined the effect of poverty at different stages of childhood. What they found is that living in poverty during early childhood is far more damaging to a child's long-term prospects than is living in poverty at later ages. The negative effects of early childhood poverty can last a lifetime, at significant cost to society as a whole. Nationally, 43% of all young children live in low income families with incomes below 200% of the federal poverty threshold in the crucial early years of life. Roughly one in every ten children under age five live in deep poverty, or below 50% of the federal poverty level. The sheer number of children living in poverty in our nation gives urgency to stemming the harm at an early age.

The federal MIECHV program provides a promising means to ameliorate the harsh effects of early poverty, building upon decades of scientific research showing that home visits by a nurse, social worker, or early childhood professional during pregnancy and in the first years of life improve the lives of young children and families. The federal MIECHV program serves many of the most vulnerable families by promoting key elements necessary to improve lifetime outcomes for children born into families living in poverty: universal developmental screening and early intervention services to support children's healthy development; parenting education and support services; and connecting families to medical care, including behavioral health care and infant mental health support. In FY 2015, MIECHV reported serving approximately 145,500 young children and families. According to the Administration for Children and Families (ACF), 77% of MIECHV participating families had a household income at or below 100% of the federal poverty level ($24,350 for a family four), while 46% were living in deep poverty, with income at or below 50% of those guidelines.

Illinois has long valued evidence-based home visiting programs as an effective strategy for strengthening expectant and new families. By developing a cross-sector statewide home visiting system, Illinois has provided essential services to over 17,000 families, making it a nationally-recognized model of a state system supporting a variety of evidence-based models and innovative practices. National and Illinois-specific research studies show that high-quality evidence-based home visiting programs result in numerous positive outcomes for children and their families, including:

- Increasing rates of breastfeeding, immunization, well-child visit, and developmental screenings;
- Promoting language development and school readiness;
- Improving rates of high school graduation; and
- Increased rates of talking, reading and positive interactions between parent and child.

In addition to the positive short-term benefits of home visiting programs, there is a host of positive longer term outcomes associated with these services, including reduced risk of chronic health behaviors and outcomes (such as obesity, diabetes, heart disease, alcohol consumption, and smoking. Recent economic literature also demonstrates that

public investments in high-quality programs for disadvantaged children from birth to age five can result in an estimated 13% annual rate of return.

Among MIECHV-funded programs in 2016, 100% of families were screened for needed services, 93% of children received recommended well-child visits, and 93% of children were screened for developmental delay before age one. These accomplishments have critical implications for the healthy long-term trajectory of low income children and families. And yet home visiting programs reach only a small fraction of the children and families who would benefit from them.

In closing , we would like to reiterate our strong support for the reauthorization of the MIECHV program. Extending the MIECHV program for an additional five years, and doubling the expenditure, would allow many more children and families to overcome the ill effects of poverty, and strengthen our nation's promise.

Respectfully submitted,

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Sources:

Duncan, Greg J. and Magnuson, Katherine (2011). The Long Reach of Early Childhood Poverty. Pathways Magazine. The Stanford Center on Poverty and Inequality.
http://www.stanford.edu/group/scspi/_media/pdf/pathways/winter_2011/PathwaysWinter11_Duncan.

Garcia, J; Heckman JJ; Leaf DM; Prados MJ. The Life Cycle Benefits of Influential Early Childhood Program (2016). Retrieved from: http://heckmanequation.org/content/resource/lifecycle-benefits-influential-early-childhood-program.

House Ways and Means Subcommittee on Human Resources

Hearing on Maternal, Infant, and Early Childhood (MIECHV)
Home Visiting Reauthorization Hearing
March 15, 2017

Statement for the Record Submitted by:

Jennifer Bellamy, Neil Guterman, Aaron Banman, Sandra Morales-Mirque, Justin Harty

The *Dads Matter* Research Team,

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March 28, 2017

We are pleased to provide our statement in support of reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Reauthorization, and wish to urge language in that reauthorization that provides incentives and resources for home visiting programs to more fully consider and include fathers in the design and delivery of home visiting services to families in need.

The scientific evidence supporting the benefits of early home visiting for children's development is now clear, and MIECHV is thoughtfully designed so that ongoing quality improvements and scientifically guided innovation can be achieved that can magnify the positive impact of such services to our most vulnerable young children and their families. The *Dads Matter* research team at the University of Chicago and the University of Denver have been designing and testing one such innovation that more fully incorporates fathers into the delivery of home visiting services. Why?

Simply stated, because the successful inclusion of fathers in such services holds significant potential to substantially boost the benefits of such services for the developing child, which were originally designed to be mother and baby focused. Studies show that although fathers may less commonly play the primary caregiver role in very early childhood, they are increasingly playing a direct caregiving role, and their positive involvement during the phase in which home visitation services are provided can improve mother-infant attachment, lower child abuse and neglect risk, and later lead to improved academic achievement, lower aggression, lower delinquency, lower depression, and lower anxiety in children. Moreover, studies conducted in other child and family services suggest that the inclusion of fathers can also increase mothers' engagement in those services and both boost and extend outcomes so that the impact of programs is maintained over time.

A recent survey of home visitors in the state of Illinois conducted by one of our team members finds that almost all workers have access to fathers (98% know they have a father in a caregiving role within their caseload); and yet, many fathers are not actively included in services by home visitors, and thus often miss a key opportunity to improve outcomes for children and families.

Our research team has been designing and testing a program enhancement to evidence-based home visitation program models supported under MIECHV, called *Dads Matter*, and our pilot findings suggest that fathers can be well engaged by such services, and that this enhancement can increase fathers' productive involvement with their children, strengthen the quality of the mother-father relationship, reduce parental stress for both parents, and lower risk of both physical child abuse and neglect. While these findings are preliminary, they are highly promising, and we are presently subjecting the *Dads Matter* enhancement to a randomized controlled trial study design with over 200 families to evaluate its overall effectiveness under "gold standard" scientific conditions. Such an enhancement adds nominal financial costs to existing home visiting services.

Given that fathers have traditionally not formed the focus of early home visitation services, and that their productive engagement and involvement can promote even greater outcomes for children and families, we recommend that the reauthorization of MIECHV include language that provides incentives and resources

for home visiting programs to more fully include fathers in the design and delivery of evidence-based home visitation programs.

March 21, 2017

The Honorable Adrian Smith
Chair, House Ways & Means
Human Resources Subcommittee
&
The Honorable Jason Smith, Jackie Walorski, Carlos Curbelo, Mike Bishop, Dave Reichert, Tom Reed, Danny Davis, Lloyd Doggett, Terri Sewell and Judy Chu
Subcommittee Members

The Florida Association of Healthy Start Coalitions, Inc. (FAHSC) is pleased to share our experience implementing the Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative and its impact on families who seek services.

In Florida, MIECHV is implemented through a public-private partnership. FAHSC is one of three non-profit organizations in the country that serve as the state lead. We coordinate our activities with key state agencies, as well as other state and local partners working to improve outcomes for expectant and new families. FAHSC represents a statewide network of community-based maternal and child health coalitions established in 1991 to reduce infant mortality and promote healthy child development. The coalitions are community-driven and governed by volunteers who live in the service area and are knowledgeable about local resources and needs. We work to ensure families are successful and have the information, care and support they need to raise children who are healthy, safe and enter school ready to learn.

Our work in maternal and child health over the last 25 years led us to embrace the opportunity offered by MIECHV. Home visiting, particularly in pregnancy and the first two years after birth, is an effective and proven strategy for changing the trajectory of parents and the lives of their children. It provides education, encouragement, linkage to health care and other resources, and personal support to vulnerable families during a critical period of rapid brain development. It levels the playing field for low-income families in high-need communities and contributes to their social and economic success, as well as the success of their children.

Florida currently receives $10.9 million annually in MIECHV funding and implements three evidence-based home visiting models – Nurse Family Partnership, Parents as Teachers and Healthy Families Florida – in 28 high-need communities. Programs were selected by the communities based on local needs and gaps in services. The models are implemented by local Healthy Start Coalitions, hospitals, federally-qualified health centers, early learning coalitions, and other community-based organizations. MIECHV resources leverage public and private funding that support a continuum of

community programs, including Florida Healthy Start, Healthy Families Florida, HIPPY, Early Steps and Early Head Start.

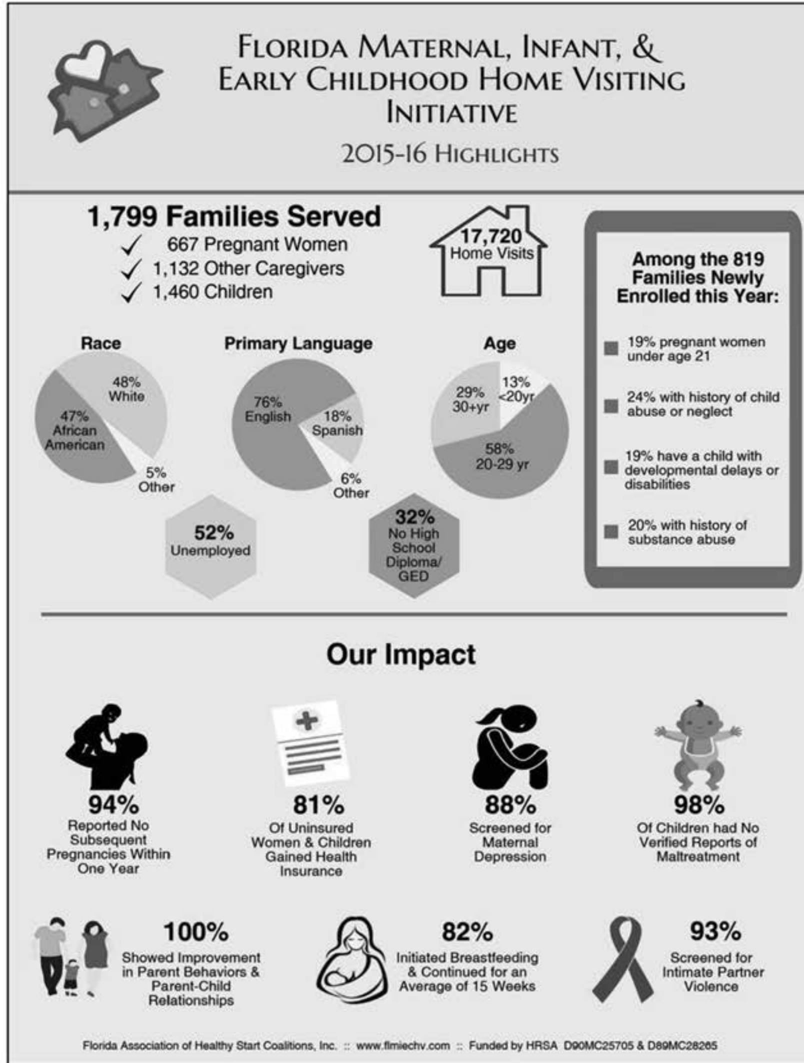
During 2015-16, local MIECHV sites in Florida served nearly 1,800 of the most at-risk families. Programs provided more than 17,700 home visits during the year. As shown in the following graphic, MIECHV provided our state and communities with the resources to implement evidence-based home visiting programs that had a direct and measurable impact on participating families. Noteworthy, nearly half of program participants took steps toward economic self-sufficiency by gaining employment or enrolling in school. Between 2013 and 2015, the Florida MIECHV initiative achieved required improvements in five of the six legislatively mandated benchmark areas (Maternal & Child Health; Child Safety; School Readiness; Reducing Violence, and Coordination & Referral).

Families are the faces behind the data and describe the real impact of home visiting on their lives and the future of their children. Below we share a few of the many stories we hear daily:

Hi my name is Denise M,

I was a participant in the Nurse Family Partnership (NFP) program in Jacksonville. NFP is a program for first time parents where a nurse comes to visit you in your home. This home visitor helps you get prepared to be a parent. Your home visitor nurse stays with you until your child is 2 years old.

While I was a participant in the NFP program I made a choice to breastfeed my son. My nurse home visitor Janet McDonald gave me information one visit about breastfeeding and I knew that I had to try it. I breastfed my son for 12 months and I have to say I truly loved it. Although it wasn't easy in the beginning I knew that I was giving my son the best gift I could ever give him. After my experience with breastfeeding I told anyone I could about it. I was so thankful to the NFP program and the Coalition that they truly became part of my life. I never wanted to leave this program but knew one day that day would come and another mom would learn everything that I did.



FLORIDA MATERNAL, INFANT, & EARLY CHILDHOOD HOME VISITING INITIATIVE
2015-16 HIGHLIGHTS
1,799 Families Served
667 Pregnant Women
1,132 Other Caregivers
1,460 Children
17,720 Home Visits
Among the 819 Families Newly Enrolled this Year:
19% pregnant women under age 21
24% with history of child abuse or neglect
19% have a child with developmental delays or disabilities
20% with history of substance abuse
Race
48% White
47% African American
5% Other
Primary Language
76% English
18% Spanish
6% Other
Age
13% <20yr
29% 30+yr
58% 20-29 yr
52% Unemployed
32% No High School Diploma/ GED
Our Impact
94% Reported No Subsequent Pregnancies Within One Year
81% Of Uninsured Women & Children Gained Health Insurance
88% Screened for Maternal Depression
98% Of Children had No Verified Reports of Maltreatment
100% Showed Improvement in Parent Behaviors & Parent-Child Relationships
82% Initiated Breastfeeding & Continued for an Average of 15 Weeks
93% Screened for Intimate Partner Violence
Florida Association of Healthy Start Coalitions, Inc. :: www.flmiechv.com :: Funded by HRSA D90MC25705 & D89MC28265

I was very pleased one day to know that I wasn't the only mom that wished the NFP program last longer. The Coalition and the Jacksonville NFP program granted our wish. They allowed us to put together a NFP support group. In this group we give all NFP participants (graduates and current) a chance to get together and get to know each other. This group is still fairly new but we are growing and we hope to have all participants come to the once a month meetings. We have moms days out and play dates with the kids. We are trying to get a daddy's group together where the graduated dads will mentor the new dads in the group. I am very thankful to the Northeast Florida Healthy Coalition for this platform that they have allowed us to have.

Recently The Northeast Florida Healthy Start Coalition has given me another amazing opportunity. I am now working with the Coalition on a grant to increase breastfeeding initiation and duration through a grant with the National Association of City and County Health Officials (NACCHO) as a peer breastfeeding counselor. I have been trained as a peer breast feeding counselor and now I have breastfeeding support groups for pregnant and breastfeeding moms. This program works hand in hand with our NFP program by referring NFP clients at 33 weeks that show interest in Breastfeeding to me for breastfeeding support. We are also working on putting pumping stations in two local high schools. I get to share my story to so many now and I just hope that I can make a difference in one person's life. NOTE: Denise continued to pursue her training and recently passed an exam to receive her certification as a Lactation Counselor.

My PAT+ mentor Alyssa asked me if I wanted to share my story and I was absolutely thrilled to if it meant I could somehow inspire one other person…I had my son Lucas on May 31st last year and it was the best day of my life. Just being able to hold this little bundle of love after carrying him for 10 months, worrying about if I had stocked up enough diapers and if he had enough clothes. It had all melted away. When I brought him home I was so scared. Here I was a 23 year old single mother of a beautiful baby boy. The first few weeks were very stressful between trying to breast feed getting up at night every 2 hours…running on 0 energy, worried if I was changing his diaper right. Now Lucas is 10 months old. I am enrolled in school full time. I would never have thought I'd be going to school with an infant while being a single parent but I wouldn't change a thing. Lucas is the world to me. I don't know what I would do if I didn't have Alyssa to listen to me when no one else would. Or bounce ideas off of. Or even email her in the middle of the night when things are bothering me. I am so thankful I have someone like her in my life. She has helped me through so much. I have a happy healthy little boy that keeps me motivated. I would

really suggest this program to anyone like myself or even to a woman that has a happy home life because having a child is never easy. And it's always nice to have someone to talk to reassure you that you are doing a great job.

"I don't know what I would have done without you." Those words were spoken by Oneida, a 17 year old, first-time parent who enrolled in the home visiting program at age 16 when she was eight weeks pregnant. During eight months of home visits, she was an active and interested participant. Her primary goal was to finish her education. During her pregnancy, Oneida and her nurse home visitor worked on strategies to keep herself healthy and relaxed by learning more about the pregnancy process and ways to reduce stress. In later visits, Oneida learned about developmental milestones and ways to calm a baby. At each visit, the nurse assessed her for any physical concerns, discomforts, changes in her environment, or coping with the pregnancy. In turn, Oneida followed through on guidance and referrals. On October 31, Oneida delivered a healthy, 9 lb., 2 oz. baby boy. Since then, she and the nurse have discussed the importance of proper nutrition, sleep position, well-baby visits, immunization schedule and family planning. Oneida kept her postpartum appointment and has chosen a method of family planning after reviewing several options with the nurse. While on maternity leave with no income, Oneida started experiencing some financial difficulties. She shared her financial difficulties with her nurse home visitor, who referred her to local financial assistance office. Oneida was planning to return to work but was informed that the company that employed her was closing. Oneida wanted to start looking for job and she requested the assistance of the nurse in putting together a resume. The nurse discussed all the information needed for a resume and provided guidance and assistance. Oneida utilized the resume and successfully found new employment. Oneida is grateful for the opportunity to participate in the home visiting program and also for having a nurse home visitor who has always been very helpful.

One of the mothers we are working with is 18 years old who has recently received her high school diploma. Her child is a one-year-old little girl who is healthy, happy, and active little girl who is full of joy.

When we first met she was very sad after becoming isolated because she was in high school and had a baby. She stated that many of her friends abandoned her when she needed their support the most. She felt that she did not have a friend in the world. Her family and the baby's dad was supportive, but

they were not with her during the day at school. She wanted to graduate and show the girls that she could have a baby and succeed.

As a Parent Educator, I focused on family well-being and her education, letting her know that we as an agency see her self-worth. Her first goal was to graduate. Once she completed her first goal we celebrated her success and talked about how she can do anything that she puts her mind to.

Since meeting her first goal of graduating, she has set new goals and is reaching them one by one. One of her goals was to get her driver's license so that she could take her daughter to her appointments all by herself. She was recently successful at getting her license. She is now spending time with other moms and no longer feels lonely.

She in now babysitting to bring in income and has taken the TABE test as her first step toward enrollment into college. She now has confidence in herself and the decisions that she is making for her family.

On July 24, a Family Support Worker Supervisor (FSWS) met with a determined young lady who was unemployed, faced homelessness, had little support, and was 21 weeks pregnant with her second child. The FSWS soon learned that the expectant mother had suffered from mental health complications; recently had her first child removed from her care, and had a history of using substances. The father of the baby was incarcerated.

After learning about the benefits of Healthy Families, she signed into the program with her assigned Family Support Worker (FSW). The FSW began to educate her on maternal health and the implications of using tobacco, drugs, and alcohol while pregnant. The participant vowed not to use substances such as tobacco, alcohol, and illicit drugs, because she wanted her baby to be healthy. She realized that she had to make some serious changes in her life. She learned the importance of living in a stable in environment when her baby is born; therefore she decided to move into the paternal grandparents' home. As the time got closer to the her baby's due date, the FSW educated the participant on the benefits of breastfeeding, providing a safe place for her baby to sleep, and how to cope with her baby's crying. The FSW also went down a checklist to ensure the she had all the necessities for a sweet, newborn baby.

The participant gave birth in December, and began to breastfeed her baby right away. Beneficially, she continues to breastfed the child who is now five months old. Both mom and baby continue to live in a stable, nurturing home with the paternal grandparents. The participant has secured

child care for her daughter, while she works part-time. Proudly, this mother is able to say that she has not used any substances such as alcohol or illicit drugs, and does not smoke or use tobacco.

We celebrate all the accomplishments she has made towards self-sufficiency, using activities that promote positive parent/child interaction, and ensuring that her baby is up-to-date with immunizations and well-baby checks.

MIECHV not only supports families, but is also raising the bar for all home visiting programs in Florida by creating core competencies, managing statewide training, promoting accountability and continuous quality improvement, and contributing to systems development at both the state and local level.

Systems development, in particular, is critical for coordinating multiple evidence-based home visiting programs and related services, ensuring families get the services that best meet their needs and preferences. Florida has invested MIECHV funds in piloting Coordinated Intake & Referral (CI&R) in 10 communities. Multi-agency teams, led by the local Healthy Start Coalition, worked together over a two-year period to craft strategies for making home visiting a "hub" of local place-based early childhood systems. The goal of CI&R is for families to receive the most appropriate services as well as to minimize duplication, ensure effective use of local resources, and collectively track what happens to each family. Using Florida's universal prenatal and infant screening, the teams developed service inventories and agreements, decision trees to aid in linking eligible families to home visiting and other programs, awareness & education material for families, referral tracking systems, and related processes.

CI&R and other systems work supported by MIECHV further impacts families and communities:

"Bringing the agencies together while avoiding duplication of services through the CI&R project guarantees the best utilization of funds received for direct services. Follow-up with the family is a key component through the CI&R process in that it ensures the family receives services that best address their individual needs. The BFG Coalition encountered several families that would have gone without much needed services, had they not received a follow-up call through the CI&R program." - Sharon Owens, Executive Director of the Bay, Franklin, Gulf Healthy Start Coalition.

"The Coordinated Intake and Referral Learning Collaborative has provided an excellent opportunity to improve our systems for linking families in our community to the most appropriate and preferred community services. The learning collaborative provided both an opportunity for communities

to learn from each other and the time and resources to improve the intake and referral system to needed community resources. Through this project, our team has had the ability to develop a mobile app that will be used by both parents and social service providers in our area." Brenda Breslow, Director of Programs, Hillsborough Healthy Start Coalition.

Based on the success of the pilots, the Florida Department of Health, the state's Title V agency, is providing funding to replicate CI&R in other communities through Healthy Start.

The Florida Association of Healthy Start Coalitions, Inc. strongly believes MIECHV is a wise and sound investment of tax dollars. Evidence-based home visiting supported by MIECHV sets the standard for all early childhood services provided in a state. MIECHV leads the way in demonstrating programmatic accountability.

MIECHV impacts families. It impacts services. It impacts state and local systems of care.

Thank you for the opportunity to share our experience in implementing the MIECHV program in Florida.

March 27, 2017

The Honorable Adrian Smith
Chair, House Ways & Means, Human Resources Subcommittee

The Honorable Carlos Curbelo
House Ways & Means Committee, Human Resources Subcommittee

Dear Mr. Smith and Mr. Curbelo,

On behalf of the United Way of Miami-Dade, I am pleased to provide this statement of support for the Reauthorization of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. This program aligns with two key United Way priorities – strengthening investment in early childhood and supporting economic self-sufficiency for working families.

Our organization is committed to implementing evidence-based strategies that contribute to healthy child development and ensure all children enter school ready to learn. We are impressed with the track record of MIECHV and the home visiting programs it funds in Florida in achieving measureable results in improving outcomes for vulnerable families and their children. This program supports evidence-based home visiting programs that provide education, coaching and support to families who ask for help during a critical period of early brain development. Experts, including economist and Novel laureate James Heckman, have underscored the importance and wisdom of investing in families during this period. Home visiting offers proven prevention and early intervention that avoids the need for costly remedial services in the future. Evidenced-based home visiting models implemented in Miami-Dade through MIECHV and other funders complement and enhance our efforts and investment in quality early learning.

United Way is also leading efforts in Florida to address the financial challenges faced by low-income, working families. With state and local support, we provide tax filing assistance to ensure these families take advantage of the federal Earned Income Tax Credit (EITC) and other programs that contribute to their economic self-sufficiency. We have worked with MIECHV in Florida to assist home visitors with linking the families they serve to these and other resources. Our collaboration with MIECHV has allowed us to reach families who could benefit the most from this assistance.

Home visiting works. MIECHV is a critical funding source for leveraging both public and private resources in Florida. We urge you to support the reauthorization and continued funding of this effective program. Thank you.

Sincerely,

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House Ways and Means Human Resources Subcommittee

March 15, 2017

Hearing on the Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

Written Comments and Statement for the Record of Voices for Ohio's Children

Voices for Ohio's Children
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March 15, 2017

Ways and Means Committee Office
1102 Longworth HOB
Washington, D.C. 20515

Re: Hearing on the Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

Voices for Ohio's Children is pleased to provide a written statement regarding reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. We hope our comments will prove helpful to the House Ways and Means Human Resources Subcommittee as it considers support for this important program.

Organizational Background

Voices for Ohio's Children is a nonprofit, nonpartisan advocacy organization dedicated to keeping Ohio children safe and healthy; educated in quality programs from preschool through high school; connected to their families, friends, and communities; and employable by ensuring their access to afterschool programming and work opportunities.

Voices does exactly what it sounds like—we give Ohio kids a voice in the public policy process. We do this by providing proactive leadership on our policy priorities—which are based on need, trends, and community feedback—and by partnering with national and state advocates, service providers, and government offices. Voices is also an experienced convener and facilitator of diverse stakeholder groups.

Voices offers regular public education opportunities on a variety of children's issues. Join our Policy Team each month for our Public Policy Partner webinar series. You can also get involved in Voices' work by becoming a Public Policy Partner. Visit our website at RaiseYourVoiceForKids.org to learn more and to sign up for our weekly e-newsletter and upcoming events.

Home Visiting Matters

Home visiting is a powerful tool for families. Research shows that home visits by a nurse, social worker, early childhood educator or other trained professional during pregnancy and in the first years of life improve maternal and child health, prevent child abuse and neglect, increase positive parenting and enhance child development and school readiness.[i]

Long-term developmental well-being, safety and early school success of children are important public policy and social objectives. These goals are not achieved through a single effort, but through many small, consistent efforts that improve a parent's ability to care for a child and themselves. According to the PEW Charitable Trusts, "Home visiting is proved to be an excellent spark for initiating such change and for placing young families on the right track."[ii]

Home visiting delivers early education and support to families on their terms and in their own homes, which eliminates environmental constraints such as transportation and structured hours of operation.[iii] This allows home visitors to observe family processes in their natural environments.[iv] Through stand-

alone programs, or in partnership with center-based services, voluntary home visiting educates families, provides resources for health, child development and school readiness. .[v] Families who participated in home visiting services were half as likely to be involved with Child Protective Services.[vi] Home visiting bridges community resources for participating families in order to build a better future for themselves.

Home visiting is a tool for reducing Ohio's abysmal infant mortality rate. Ohio's 2015 infant mortality rate was 7.2 infant deaths per 1,000 live births, a rate 21 percent higher than the most recently reported national rate. The white infant mortality rate was 5.5 and the black infant mortality rate was 15.1, with black babies dying at nearly three times the rate as white babies.[vii] Studies have found that high-quality home visiting programs yielded better birth outcomes. Children whose parents participated in home visiting programs are born with fewer instances of low birthweight and are more likely to be breastfed.[viii] An Ohio study found infants whose families did not receive home visiting were 2.5 times more likely to die in infancy compared to those infants whose families received home visiting services.[ix]

What is home visiting?
Home visiting is an in-person, evidence-based service that provides pregnant women and families—particularly those considered at-risk—the necessary resources and skills to raise children who are physically, socially and emotionally healthy and ready to learn.

Evidence-based
In order to receive state funds through Help Me Grow or federal funds through MIECHV, the home visiting model must be designated as evidence-based by the U.S. Department of Health and Human Services (DHHS). The Department of Health and Human Services launched the Home Visiting Evidence of Effectiveness (HomVEE) review to conduct a thorough and transparent review of the home visiting research literature. HomVEE provides an assessment of the evidence of effectiveness for home visiting program models that target families with pregnant women and children from birth through age five.

According to the PEW Charitable Trusts, "Decades of research show that these family support programs are effective and ultimately save money for taxpayers. When quality programs, carried out in local communities, are properly implemented, they lead to increased family self-sufficiency, lower health care costs, and reduced need for remedial education."[x]

Home visiting programs must be shown to be effective and consistently improve measurable outcomes for Ohio's children and families. Success is measured by demonstrating improvement in six benchmarks:

1. Improvement in maternal and newborn health;
2. Reduction in child injuries, abuse, and neglect;
3. Improved school readiness and achievement;
4. Reduction in crime or domestic violence;
5. Improved family economic self-sufficiency; and
6. Improved coordination and referral for other community resources and supports.[xi]

Maternal, Infant, and Early Childhood Home Visiting in Ohio
The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is a federal/state partnership active in all 50 states that funds home visiting models for states, territories and tribal entities. MIECHV is not a home visiting model or direct service provider, but a name given to the federal program that funds federally recognized evidence-based home visiting services across the nation.

Jointly administered by the U.S. Department of Health and Human Services' Health Resource Administration and the Administration for Children and Families, the Affordable Care Act appropriated five years of funding for the program in 2010 and the funding was extended to March 2017 by the passage of the Medicare Access and CHIP Reauthorization Act of 2015. In Federal Fiscal Year 2016 (FFY16) Ohio received $5,819,100 MIECHV funding resulting in a total program capacity to serve 1,687 families[xii]. The number of home visits provided will be determined at the end of the FFY closing September 30, 2017.

The U.S. Department of Health and Human Services requires 75 percent of granted MIECHV funds be used to implement approved evidence-based home visiting models and up to 25 percent may be used on promising approaches rather than approved models. Ohio's MIECHV funds support expanded access to home visiting by broadening the eligibility base to encompass additional families who previously could not participate in HMG home visiting services funded by the state, as well as systems-building initiatives, quality improvement processes, partnership development, targeted outreach and public education.[xiii]

The Ohio Department of Health is the MIECHV lead agency and is charged with the execution of the statutory purposes of the program which include: strengthen and improve the programs and activities carried out under Title V of the Social Security Act; improve coordination of services for at-risk communities; and identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.[xiv]

The MIECHV program targets pregnant women under age 21 and families who are: low income; live in at-risk communities, have a history of child abuse; potential substance abuse; smokers in the home; children demonstrating low achievement; children who have developmental delays; and mothers who have served or serve in the armed forces.

Priority for MIECHV funding is given to families living in at-risk communities as identified by a statewide needs assessment.[xv] Thirty one counties were identified by the Ohio Department of Health as being at-risk for poor birth or family developmental outcomes in a 2010 needs assessment. Within these counties there are communities, neighborhoods, and/or census tracts with individual and clustered risk indicators that rate even higher than the county or state averages identified as the most at-risk communities to be served with the MIECHV program.[xvi]

In FFY16 there were 27 unique Local Implementing Communities receiving MIECHV funding to provide services in Ohio. MIECHV was expanded to Cuyahoga County on October 1, 2016. Counties served include Adams, Allen, Ashtabula, Clark, Clinton, Columbiana, Coshocton, Crawford, Fayette, Franklin, Gallia, Hamilton, Harrison, Jefferson, Lucas, Mahoning, Marion, Meigs, Montgomery, Pike, Ross, Scioto, Stark, Summit, Trumbull and Vinton.

Similar to Help Me Grow, the program gives states flexibility to identify the issues most pressing to their communities and select their programs which are locally implemented where the participating families live.[xvii] Currently Ohio's MIECHV funds support implementation of the Nurse Family Partnership® (Cuyahoga, Franklin and Montgomery) and Healthy Families America® models.

The goals of MIECHV are:

- Improve maternal and child health;
- Prevention of child injuries, child abuse, neglect or maltreatment and reduction of emergency department visits;
- Improvement of school readiness and achievement;
- Reduction in crime or domestic violence;
- Improvements in family economic self-sufficiency; and
- Improvements in the coordination and referrals for other community resources and supports.[xviii]

Home Visiting Outcomes in Ohio

Data on Ohio's state-funded home visiting program, Help Me Grown, and MIECHV programs are collected by the Ohio Department of Health.

In SFY16, highlights of the outcomes achieved by Ohio's HMG and MIECHV programs were as follows:

The average length of stay for a child in a home visiting program was 414 days. Forty-two percent of families were enrolled in home visiting prenatally and 38.6 percent of those mothers started receiving services in her first trimester. Nearly all (99.45 percent) of the mothers who received services in their first trimester had one or more pregnancy risks. Seventy one percent of mothers enrolled prenatally reported accessing prenatal care.

Of the moms who enrolled in home visiting in their first trimester and reported smoking, 50 percent of those moms quit smoking. The statewide average of pregnant women who quit smoking was only 17.76 percent.

Mothers in home visiting programs determined by screening to be at high risk for maternal depression was 22.3 percent and 47.2 percent of those moms received a community referral for treatment.

Child developmental screenings of children in home visiting programs resulted in 13.92 percent identified as having a potential developmental delay, 5.09 percent identified as at-risk for social emotional delays and 9.32 percent needed connected to Early Intervention services.

Reauthorize MIECHV before September 2017 for a five-year term, increasing funding from $400 million to $800 million annually.

Home visiting programs strengthen child and families today and strengthen our economy tomorrow, but they continue to be underfunded and largely unknown across the country. Implementation of evidence-based home visiting programs is made more difficult by short-term funding extensions, as many programs are designed to serve families for multiple years. In addition, programs can be reluctant to expand their services and challenged to retain trained staff without consistent, stable funding.

Policymakers should enact a five-year extension of MIECHV and double its funding from $400 million to $800 million annually before it expires in September 2017. The reauthorization over five years with double funding will enable MIECHV: to serve more children and families in the hardest to reach communities, providing them with improved health, educational and workforce outcomes that provide greater opportunities to succeed; enable states and the federal government to realize cost-savings in reduced expenditures on health conditions, remedial educational costs and costs associated with child

abuse and neglect; and promote state innovations in their programs that make state systems and services more efficient.

Thank you for your consideration. By working together, we can ensure a positive future for our families and our nation.

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[i] Health Resources & Services Administration. (2016, February). *Ohio*. Retrieved from Federal Home Visiting Program: https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/oh.pdf

[ii]

The Pew Charitable Trusts. (2015, May 7). *Using Data to Measure Home Visiting Performance*. Retrieved from Home Visiting Project: http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2015/05/using-data-to-measure-home-visiting-performance

[iii] Gill, S. G. (2007). Home Visitor Competence, Burnout, Support, and Client Engagement. *Journal of Human Behavior in The Social Environment*.

[iv] Krugman, R. D. (1993). Universal Home Visiting: A Recommendation from the U.S. Advisory Board on Child Abuse and Neglect. *The Future of Children*, 185-191.

[v] Lee, E. M.-H. (2009). Reducing low birth weight through home visitation: A randomized controlled trial. *American Journal of Preventive Medicine*, 36(2):154-160.

[vi] Lowell, D. C.-G. (2011). A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice. *Childhood Development*, 82(1):193-208.

[vii] Ohio Department of Health. (2016, November 16). Number of Ohio Infant Deaths Rise in 2015; State Surging New Resources to Support Local Initiatives. Columbus, Ohio.

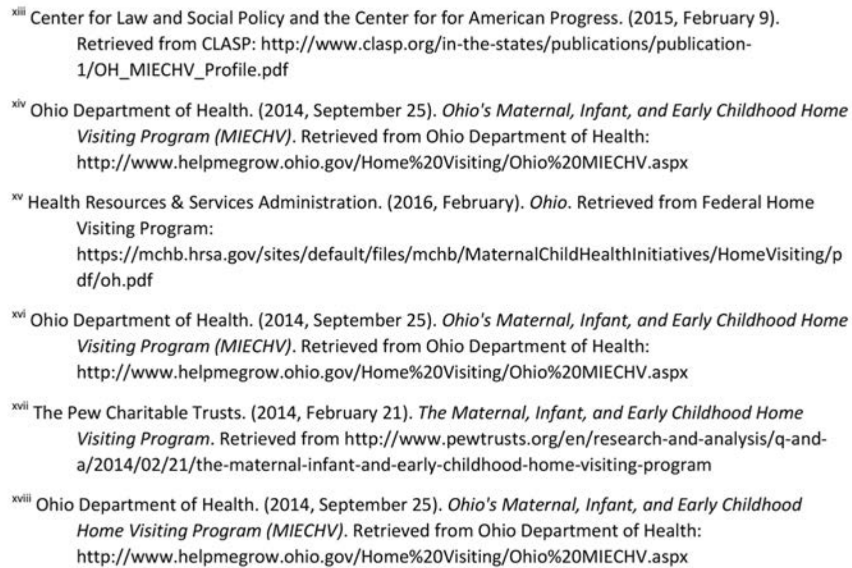
[viii] U.S. Department of Health & Human Services Administration for Children & Families. (n.d.). *Reduction in Child Maltreatment*. Retrieved from Home Visiting Evidence of Effectiveness: http://homvee.acf.hhs.gov/Outcome/2/Reductions-in-Child-Maltreatment/4/1

[ix] Edward F. Donovan, R. T. (2007, June). Intensive Home Visiting Is Associated With Decreased Risk of Infant Death. *Pediatrics, 119*(6), 1145-51.

[x] The PEW Charitable Trusts. (2014, January). *Benefits of the Maternal, Infant, and Early Childhood Home Visiting Program.* Retrieved from Home Visiting Family Support Programs: http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2014/home20visiting20factsheet20january202014pdf.pdf?la=en

[xi] Ohio Department of Health. (n.d.). *For Help Me Grow Professionals*. Retrieved from Help Me Grow: http://www.helpmegrow.ohio.gov/Professionals/For%20Professionals.aspx

[xii] Ohio Department of Health. (2016, September 28). Early Childhood Home Visiting Regional Meeting. Columbus, Ohio.



[xiii] Center for Law and Social Policy and the Center for for American Progress. (2015, February 9). Retrieved from CLASP: http://www.clasp.org/in-the-states/publications/publication-1/OH_MIECHV_Profile.pdf

[xiv] Ohio Department of Health. (2014, September 25). *Ohio's Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)*. Retrieved from Ohio Department of Health: http://www.helpmegrow.ohio.gov/Home%20Visiting/Ohio%20MIECHV.aspx

[xv] Health Resources & Services Administration. (2016, February). *Ohio*. Retrieved from Federal Home Visiting Program: https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/oh.pdf

[xvi] Ohio Department of Health. (2014, September 25). *Ohio's Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)*. Retrieved from Ohio Department of Health: http://www.helpmegrow.ohio.gov/Home%20Visiting/Ohio%20MIECHV.aspx

[xvii] The Pew Charitable Trusts. (2014, February 21). *The Maternal, Infant, and Early Childhood Home Visiting Program*. Retrieved from http://www.pewtrusts.org/en/research-and-analysis/q-and-a/2014/02/21/the-maternal-infant-and-early-childhood-home-visiting-program

[xviii] Ohio Department of Health. (2014, September 25). *Ohio's Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)*. Retrieved from Ohio Department of Health: http://www.helpmegrow.ohio.gov/Home%20Visiting/Ohio%20MIECHV.aspx

WASHINGTON STATE HOME VISITING COALITION

March 22, 2017

The Honorable Adrian Smith
Chair, House Ways and Means Human Resources Subcommittee
United States House of Representatives

RE: March 15, 2017 Maternal Infant Early Childhood Home Visiting (MIECHV) Hearing

Dear Congressman Smith,

The members of the Washington State Home Visiting Coalition thank you for holding a hearing on the Maternal Infant Early Childhood Home Visiting (MIECHV) Program in your House Ways and Means Subcommittee on Human Resources on March 15, 2017. This hearing provided a unique opportunity for subcommittee members to hear firsthand about the transformative power of evidence-based home visiting.

MIECHV has greatly accelerated the expansion of evidence-based home visiting in Washington state. Since 2010, $32.4 million in MIECHV funds has supported home visiting in 15 of Washington's 39 counties. In our state, MIECHV helps support a portfolio of home visiting programs, including evidence-based programs such as Nurse Family Partnership and Parents as Teachers.

Rigorous research has tested and proven the benefits of evidence-based home visiting programs. While outcomes vary depending upon which home visiting model is used, programs may result in:

- Reduced child abuse and neglect and need for child welfare services
- Healthier births
- Increased preschool and kindergarten readiness
- Reduced crime or domestic violence
- Improved family economic self-sufficiency
- Improved coordination and referral for other community resources

The Washington State Home Visiting Coalition joins its colleagues nationwide in its support of reauthorizing MIECHV with a 5-year extension including incremental funding increases up to **$800 million per year.** This action would:

For more info, please contact:

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Coalition Members: American Indian Health Commission for Washington State • Children's Alliance • Children's Home Society of Washington • Fight Crime: Invest in Kids Washington • Mission: Readiness • Nurse-Family Partnership • Parent-Child Home Program • Parent Trust for Washington Children • Parents as Teachers • Partners for Our Children • Patrick Dunn & Associates • Ready Nation • United Way of King County • Washington Chapter America Academy of Pediatrics • Washington State Association of Head Start and ECEAP

- Expand and improve existing evidence-based home visiting services
- Enhance our state's ability to reach more vulnerable children and families
- Provide stability for families and administrators by assuring continuity of funding for effective programming
- Build infrastructure that benefits not only MIECHV programs but all community resources and program coordination
- Improve implementation and evaluation of evidence-based policy that can be replicated in future public policy programs
- Create cost-savings for communities and government

Despite significant federal, state and local investments in home visiting, Washington state serves only twenty-five percent of eligible families (8,200 families). More than 28,800 of eligible families could be served should additional funds be made available.

Thank you for bringing attention to this evidence-based program that provides multiple benefits to participating families.

Sincerely,

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