STATEMENT OF
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SUBCOMMITTEE ON INCOME SECURITY & FAMILY SUPPORT

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Good morning Mr. Chairman, Ranking Member Linder, 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 early childhood home visitation.

I am Sharon Sprinkle and I work as a Nurse Consultant for the Nurse-Family Partnership. As a nurse consultant, I provide technical assistance and guidance to our programs in the Southeastern Region which includes Alabama, Arkansas, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. I have been fortunate to serve in many different capacities for Nurse-Family Partnership, including as a nurse home visitor, a nurse supervisor, and now a nurse consultant, using the knowledge and skills from my various roles to help guide and support our nurses, administrators and agencies successfully deliver program services. I am here in support of the Obama Administration's proposed initiative to create a new evidence-based home visitation program for low-income families. On behalf of the mothers, children and families served by Nurse-Family Partnership, I want to thank Chairman McDermott and Congressman Davis and the Members of this Subcommittee for their commitment to improving the health and well-being of children with dedicated funding for evidence-based home visitation. Your work is paving the way for a healthier, brighter future for at-risk children and families.

Every year, approximately 650,000 first time low-income mothers become pregnant with their first child. Nationwide, the Nurse-Family Partnership (NFP) model has served almost 100,000 families to date, and currently has over 18,000 first-time families enrolled in 28 States. National expansion of this program will dramatically improve the lives of at-risk families and yield returns to society in more stable and productive families. For every 100,000 families served by NFP, research demonstrates that 14,000 fewer children will be hospitalized for injuries in their first two years of life; 300 fewer infants will die in their first year of life; 11,000 fewer children will develop language delays by age two; 23,000 fewer children will suffer child abuse and neglect in their first 15 years of life; and 22,000 fewer children will be arrested and enter the criminal justice system through their first 15 years of life, among other outcomes.

NFP is a voluntary program that provides nurse home visitation services to low-income, first-time mothers by registered nurses beginning early in pregnancy and continuing through the child's second year of life. The children and families NFP serves are overwhelming young, poor, minority and at the highest risk of experiencing significant health, educational and employment disparities that have lasting negative impacts on their lives and communities. Nationally, 27 percent of families served by Nurse-Family Partnership are Hispanic; 22 percent are African-American; and 40 percent are Caucasian.

NFP nurses and their clients make a 2 ½ year commitment to one another, and develop a strong relationship over the course of 64 planned visits that focus on the strengths of the young mother and on her personal health, quality of care giving, and life course development. NFP nurses undergo more than 60 hours of training prior to receiving their caseload of no more than 25 families. Their partnership with families is designed to help them achieve three major goals: 1) improved pregnancy outcomes; 2) improved child health and development; and 3) improved parents' economic self-sufficiency. By

achieving these program objectives, many of the major risks for poor health and social outcomes can be significantly reduced.

When I was a nurse home visitor with the NFP program in Greensboro, North Carolina, I worked with a young client named Alice. Alice became pregnant at the age of 14 and was caring for her child while living in an apartment with her parents and 6 siblings. Alice needed someone to take her almost every time she had to transport her baby. She called me one morning as no one in her family could drive her to her appointment with her local Women, Infants, and Children (WIC) Program. During the car ride, I asked how things were going at home, expecting a simple "Fine" response. Instead, Alice informed me that her house hadn't had power for a week, but didn't seem too upset about this development.

I immediately had a multitude of questions such as "How have you been eating? How have you been doing your homework? When will the power go back on?" to which Alice's common reply was a simple shrug of the shoulders. After I dropped Alice off at her WIC appointment, I recognized that Alice and her family needed assistance identifying and connecting to community resources. After placing a call to the Department of Social Services without much response, I decided to contact a few local, community non-profits that assist low-income families who are unable to pay for food and vital services. Two organizations each agreed to cover half the electric bill, and when I drove Alice home, I informed her that she could tell her father that power would be restored the next day. Up until this point in my relationship with Alice and her family, Alice's father was not very engaged with my visits to the household. After electricity was restored to the house, this proud man said to me "A lot of people say they will help you, but you're the one who really did."

Another young mother, 18 year old Janice, enrolled in the Nurse-Family Partnership in Guilford County, NC early in her pregnancy. During the visit, it is my practice to review the signs and symptoms of preterm labor and also provide each participant with a binder that contains the NFP visit guidelines. At 6 ½ months pregnant, Janice began experiencing preterm labor. She went to the health department where she was receiving prenatal care and the provider assessed her and gave her instructions to go home, drink fluids and rest.

At home, Janice's preterm labor symptoms intensified. She was convinced that something was wrong but ambivalent because she had been to her healthcare provider earlier in the day. Janice decided to consult the Nurse-Family Partnership visit guidelines. After reading the visit guidelines she was certain that she needed to go to the emergency room. She went to the emergency room and was transported to a hospital that had a level three nursery and could manage babies with complex medical needs. Despite the efforts of the medical staff to halt labor, Janice gave birth to a 1 lb. 8 oz baby boy and he was admitted to the neonatal intensive care unit, where incubators, respirators, and other life-sustaining high tech equipment is the norm.

Baby boy Allen remained in the neonatal intensive care unit for approximately 2 ½ months. During his hospital term, I assisted Janice in finding transportation to the hospital to visit Allen; the hospital was some 30 miles from where she lived. During and after Allen's release from the hospital, I continued to support Janice by providing information, finding resources, facilitating her competence in parenting and offering reassurance. When the time was appropriate, Allen started Early Head Start at the suggestion of the NFP nurse and Janice returned to work and began contemplating going to college.

These two stories are just a glimpse into the impact that Nurse-Family Partnership has on first time, low-income families. NFP can help break the cycle of poverty by empowering young mothers to become knowledgeable parents who are able to care for their children and guide them along a healthy life course. NFP nurses use a client-centered approach, which means the nurse is constantly adapting to the needs of the family, ensuring that each visit is relevant and valued by the parent(s). 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 30 years through ongoing research, development, and evaluation activities conducted by Dr. David L. Olds, program founder 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
    - 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 self-sufficiency of the family

- 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 and program management system called the Clinical Information System (CIS) 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. The CIS was designed specifically to record family characteristics, needs, services provided, and progress towards accomplishing NFP program goals.

NFP's replication plan reflects a proactive, state-based growth strategy that maximizes fidelity to the program model and ensures consistent program outcomes. NFP urges Congress to support a wide range of home visitation models that meet the highest level of evidentiary standards in order to ensure the largest possible economic return on investment. NFP applauds President Obama for his Administration's commitment to funding programs proven to work through rigorous, scientific evidence and research.

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. The Pacific Institute released a report in March 2009 which found a 154% return on federal Medicaid investment (over 10 years) from the NFP model based on findings from the Memphis trial showing reduced enrollment in Medicaid and Food Stamps. Recent analyses indicate that the costs of NFP compared to other home visitation programs fluctuate by region, and even though the NFP model is more intensive than other programs, it is not always more expensive.

The Nurse-Family Partnership urges this Subcommittee to devote resources to assist States in implementing and expanding their home visitation programs to serve more families. We encourage the Committee to target taxpayer resources to the poorest communities that often lack critical maternal and child health and social resources to ensure the most at-risk families succeed. I would like to thank the Subcommittee for inviting me to testify, and I would also like to thank Chairman McDermott and Congressmen Davis and Platts for their leadership on behalf of the Early Support for Families Act. Thank you again, Chairman McDermott, Ranking Member Linder, and Members of the Committee, for the opportunity to testify before you today.