STATEMENT OF
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BEFORE THE
SENATE COMMITTEE ON FINANCE

MAY 10, 2016

Good morning Chairman Hatch, Ranking Member Wyden, and members of the committee. Thank you for the opportunity to testify on behalf of the Nurse-Family Partnership (NFP) program serving Essex and Morris Counties New Jersey in support of the life-changing potential of evidence-based programs like NFP. Additionally, on behalf of the mothers, children and families served by Nurse-Family Partnership, I want to thank Chairman Hatch and this Committee for their commitment to improving the health and well-being of at-risk families with dedicated funding for evidence-based home visiting programs. Your work is paving the way for a healthier, brighter future for at-risk children and families.

I am Tesha Bright and I have worked as an NFP Nurse Home Visitor for nearly eight years. As a nurse home visitor, I serve a regular caseload of 25 first-time, low income mothers and their families. In those eight years, I have experienced several meaningful examples of how this innovative program can empower young mothers to succeed.

Every year, approximately 800,000 first time, low-income mothers become pregnant with their first child. Nationwide, the NFP model has served over 239,000 families since replication began in 1996, and currently has over 31,000 first-time families enrolled in 43 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. For every 100,000 families served by NFP, research demonstrates that 14,000 fewer children will be hospitalized for injuries in their first two years of life; 300 fewer infants will die in their first year of life; 11,000 fewer children will develop language delays by age two; 23,000 fewer children will suffer child abuse and neglect in their first 15 years of life; and 22,000 fewer children will be arrested and enter the criminal justice system through their first 15 years of life, among other outcomes.

In New Jersey, NFP is part of the state's Home Visiting Initiative led by a joint effort of the Department of Health (DOH) and the Department of Children and Families (DCF). The first program was established in Trenton, NJ in 2002 and today, nine agencies have a capacity to serve approximately 1,500 families in all 21 counties across the state. My implementing agency, the Institute of Infant and Preschool Mental Health, serves Essex and Morris Counties, which includes the city of Newark. We currently serve about 187 moms, and were recently able to expand to serve an additional 50 moms with the help of federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding. 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. Still, we only reach about 3% of the population who could benefit from our services.

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. The program is free and voluntary to the women that enroll. The children and families NFP serves are young, living in poverty, and at the highest risk of experiencing significant health, educational and employment disparities that have a lasting impact on their lives, their families, and communities. Nationally, 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 ½ year commitment to one another, and develop a strong relationship over the course of 64 planned visits that focus on the strengths of the young mother and on her personal health, quality of care giving, and life course development. Their partnership with families is designed to help them achieve three major goals: 1) improve pregnancy outcomes; 2) improve child health and development; and 3) improve parents' economic self-sufficiency. By achieving these program objectives, many of the major risks for poor health and social outcomes can be significantly reduced.

In addition to our clinical training as registered nurses, NFP nurses are trained in a variety of developmental concepts and assessments. 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.

Over the past 8 years as a Nurse Home Visitor, I have worked with hundreds of young parents, many involved with the New Jersey Department of Child Protection and Permanency, formerly the division of Youth and Family Services (DYFS). I have worked as part of the treatment team providing a variety services for this population, but most importantly, my role is to provide consistency and structure as we plan and prepare for their first child. Working with this population is especially trying given the extensive mental health backgrounds, lack of trust, transient lifestyles, and histories of sexual and drug abuse. Throughout each client's involvement in NFP, she will experience many moments of success, but also many challenges. I am a constant partner through both of these periods.

I think of one of my 15-year old clients who, at the time, was living in a homeless shelter and was initially denied my services by shelter staff. They believed that this client would not be parenting her infant, and that the baby would be placed in a foster home upon discharge from the hospital until family could be located. Through persistence and a more flexible visitation schedule, I was able to not only begin seeing the client, but I was also able to deliver content in creative ways and encourage excitement about motherhood.

I received a 3am call when she went into labor. Upon reaching the hospital, I discovered she was being treated without compassion. This experience had the potential to be quite traumatic for this teen but by advocating for her and pulling staff aside, I ensured she was treated fairly. In the end, we delivered a healthy baby girl, and capturing those first photos of mom and baby were priceless. Breastfeeding was initiated at that time. Sadly, further arrangements were not made and mom went home without her baby, but I worked with the client to visit her infant. Over that time, this client continued to pump and provide breastmilk for the baby and our work encouraged a continued bond until both were united at a shelter/group home.

Another case involved pregnant sisters living in a foster home where lack of communication and cultural differences made the home a “silent battleground” fraught with passive-aggressive behavior and disrespect. This example shows how my job is so much more than “nursing” duties. My training in motivational interviewing and family communication was instrumental in encouraging open communication and understanding between all parties, which afforded the development of chore charts and house rules agreed upon by all.

I have learned many things over my years as a nurse home visitor that have helped me serve my clients better. I believe that the beauty of the model is meeting our clients where they are and building on their own desire to change their lives. When needed, flexibility of not only a visit schedule and location, but also the ability to check-in via text, encourages continuity of care during a very important time in a teen’s life. I also believe that sustained involvement of family members and fathers during visits is very important to the Nurse-Client relationship.

One of the biggest challenges I have identified when working with my teen population is maintaining participation when mom is not quite on board or feels that the program will be intrusive and/or has no value. By identifying this obstacle during intake, I try to defer to mom’s own role as parent -- emphasizing her strengths and encouraging her to share home remedies and beliefs. This type of conversation goes a long way in developing trust between the nurse and client. Additionally, spending time with the family doing creative activities (like making green smoothies or homemade baby food) helps to encourage participation in a more relaxed manner while also attempting to make small changes in the families food choices and health practices.

These stories are just a glimpse of the impact that Nurse-Family Partnership has on low-income, first time parents. NFP can help break the cycle of poverty by empowering young mothers to become knowledgeable parents who are able to 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 38 years through ongoing research, development, and evaluation activities conducted by Dr. David L. Olds, founder of the NFP model and Director of the Prevention Research Center for Family and Child Health (PRC) at the University of Colorado in Denver.

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

Improved pregnancy outcomes

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

Improved child health and development

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

Increased family self-sufficiency

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

- 83% increase in labor force participation of mothers at child age 4

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

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

In addition, NFP strongly supports Pay for Success as way to bring our program to more moms and babies. We recently launched our first Pay for Success project in South Carolina, which will expand NFP services to an additional 3,200 families statewide over the next four years. $13 million of the $30 million project is funded by a 1915(b) Medicaid waiver, which was awarded to South Carolina by the Centers for Medicare and Medicaid Services. The remaining $17 million is supported by philanthropic investors. South Carolina will make up to $7.5 million in success payments to sustain our services in South Carolina only if the independent evaluator, J-PAL of North America, finds positive results. The pilot for this project launched in January and we had a successful full launch last month.

We believe that Pay for Success represents an opportunity for smart policy to incentivize the growth of evidence-based programs. For that reason, we firmly support S. 1089, the Social Impact Partnerships Act (SIPA), sponsored by Mr. Chairman and Senator Bennet of Colorado, as well as its House companion, H.R. 1336. Amongst several provisions, this bill would create a new 10-year, $300 million fund to support state and local pay for success projects. Federal financial support for federal savings achieved through state PFS projects is critical, and these bills provide critical federal incentives to support smart state policies. For NFP, this part of SIPA is particularly important since Dr. Ted Miller's analysis of NFP outcomes across 39 evaluation reports project that 65% of NFP savings accrue to Medicaid (explained in further detail below). Without federal support for NFP PFS projects, states are required to pay back investors for all of the federal Medicaid and other savings achieved. Absent SIPA, South Carolina was able to build the PFS project on the foundation of the 1915(b) waiver, which made it possible to leverage federal financial support through that vehicle.

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 $1.4 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) and food stamps by $3 billion (present value in 2010 dollars). By comparison NFP costs $1.6 billion to serve those children and their families.

The Nurse-Family Partnership thanks the Committee for your continued interest in harnessing the ability of evidence-based programs to improve the daily lives of people who need it most. Programs like NFP improve a host of conditions that hinder children and families from becoming healthy, thriving in school and achieving economic success, and smart implementation and expansion can save scarce taxpayer resources and produce tangible results. I hope that the Committee will continue to support and expand funding streams that promote evidence-based social programs. Thank you again, Chairman Hatch, Ranking Member Wyden, and Members of the Committee, for the opportunity to testify today.