PERSPECTIVES ON EARLY CHILDHOOD HOME VISITATION PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON EDUCATION REFORM

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

September 27, 2006

Serial No. 109–59

Printed for the use of the Committee on Education and the Workforce

Available via the World Wide Web: http://www.access.gpo.gov/congress/house
or
Committee address: http://edworkforce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

30–056 PDF WASHINGTON : 2006

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PERSPECTIVES ON EARLY CHILDHOOD HOME VISITATION PROGRAMS

Wednesday, September 27, 2006
U.S. House of Representatives
Subcommittee on Education Reform
Committee on Education and the Workforce
Washington, DC

The subcommittee met, pursuant to call, at 10:30 a.m., in room 2175, Rayburn House Office Building, Hon. Tom Osborne [vice chairman of the subcommittee] presiding.

Present: Representatives Osborne, Biggert, Platts, Wilson, Musgrave, Kuhl, McKeon, Woolsey, Davis of Illinois, Scott, Kucinich, and Davis of California.

Staff present: Jessica Gross, Press Assistant; Cameron Hays, Legislative Assistant; Richard Hoar, Professional Staff Member; Kate Houston, Professional Staff Member; Lindsey Mask, Press Secretary; Chad Miller, Coalitions Director for Education Policy; Deborah L. Emerson Samantar, Committee Clerk/Intern Coordinator; Rich Stombres, Deputy Director of Education and Human Resources Policy; Toyin Alli, Staff Assistant; Ruth Friedman, Legislative Associate/Education; Lloyd Horwich, Legislative Associate/Education; and Joe Novotny, Legislative Assistant/Education.

Mr. OSBORNE [presiding]. Good morning. A quorum being present, the Subcommittee on Education Reform will come to order.

We are meeting today to hear testimony and perspective on early childhood home visitation programs.

Under Committee Rule 12(b), opening statements are limited to the chairman and the ranking minority member of the subcommittee. Therefore, if other members have statements, they may be included in the hearing record.

With that, I ask unanimous consent for the hearing record to remain open 14 days to allow members' statements and other extraneous material referenced during the hearing to be submitted.

Without objection, so ordered.

Good morning. I am pleased to convene this hearing to examine early childhood home visitation programs. The purpose of today's proceedings is not necessarily to demonstrate support for any one program or any one piece of legislation. Rather, we are here to listen and to learn and we have assembled a strong panel of witnesses to guide us through this examination.

I would like to thank the panel for assembling today.

Few would argue that parent-child relationships in the home environment are not critical elements of child development and early childhood home visitation programs aim to bolster those relationships and improve the environment at home.

The home visitation programs that we will focus on today seek to deliver parent education and family support services directly to parents with young children and aim to offer guidance to parents on how to support their children's development from birth through their enrollment in kindergarten.

Advocates of these home visitation programs argue that the services they offer comprise an effective research-based and cost-efficient strategy to bring families and resources together to ensure that children grow up healthy and ready to learn.

I look forward to hearing the perspectives of our witnesses on these assertions.

And I might just add parenthetically that in the state of Nebraska, we have a very high ratio of out-of-home placements for foster care and we have found that home visitations early on are very effective in preventing some of the tragedies that happen, family split-ups, so on.

Some research into home visitation programs indicates that combining these in-home programs with out-of-home center-based programs may be more effective in producing positive outcomes for the child, including cognitively, than programs using either approach alone.

Again, I look forward to hearing perspectives from our witnesses on this, as well.

Home visitation programs are not a new topic for Congress. Legislation that has been referred to this subcommittee, H.R. 3628, The "Education Begins at Home Act," would authorize $400 million in state grants over 3 years to establish or expand early childhood home visitation programs.

I would like to add that I am proud to be a cosponsor of this legislation, which was introduced by my colleagues, Danny Davis and Todd Platts.

Sometimes in Congress, we do things that aren't very cost-effective and we spend huge amounts of money on substance abuse, dropouts, incarceration, and not enough on the prevention side. So I think this will be money very well spent.

The secretary of health and human services, in consultation with the secretary of education, would award these funds competitively and the grants may be used to support parent education and family support services provided in home settings, much like the programs we are here to discuss today.

Within this program, assistance would be targeted to English language learners and military families, with more than $50 million over 3 years directed toward programs serving these populations specifically.

Once again, we are not here to vote on, endorse, or even consider this legislation today. Rather, we are here simply to listen and learn. I look forward to our discussion.

With that being said, we have a very impressive group of witnesses this morning. I thank them for joining us today as we learn

more about home visitation programs. I look forward to hearing from them, as well as my colleagues.

And with that, I yield to Ms. Woolsey for any opening statements that she may have.

Ms. WOOLSEY. Thank you, Mr. Chairman. Thank you for holding today's hearing.

Before I talk about today's topic, I want to express my best wishes to our chairman, Mr. Castle. He and I have been working together since we were both elected in 1992 and sworn in in 1993, and we have been working together on education and children's issues.

He is the chair of this subcommittee and my ranking member position. We can't go on without him and we will have him back and he will be whole and strong. But we just now want him to take care of himself so that he will be back. So that is what I wanted to say about Mr. Castle.

We know that every child needs the opportunity to reach his or her full potential in this country in order for us to reach our full potential as a nation. That is why today's hearing is so very, very important.

I look forward to hearing from witnesses about the successes of early childhood visitation programs and the challenges that you face, that have been faced, and the solutions that you see.

In particular, I look forward to hearing about the specific services that these programs offer parents and children and the outcomes they have achieved in improving school readiness.

We know the difference between a young child that is ready to start school and a young child that is starting school needing to get ready, what a disadvantage it is to that child.

And we need to know about the parents' ability to support their children through their social, emotional, cognitive, language, and physical development. I is a learning experience, particularly with the first one.

What do they talk about, the first waffle? We call our trial and experimenting is on the first waffle and look what we do with that one.

But I look forward to discussing these programs to ensure that families receive the training that they need.

One of our greatest challenges will be that the program needs a dedicated source of funding. We have no certainty about the level and quality of services unless we are able to promise year to year funding.

So that is why I so honor Congressman Danny Davis and Congressman Todd Platts and Congressman Osborne, who introduced The "Education Begins at Home Act," and I thank them for doing this.

I thank you for being here and sharing with us.

But we have to remember the context that we are working in. And I am not going to lash out. I am going to only say one little short thought.

We have had 6 years of gross under-funding for early childhood development programs under the Bush administration. This has to turn around or wonderful, wonderful programs like yours will not have any way of being funded. So know that we all understand

that and we are going to be working to that end. So I look forward to hearing from you.

And could I yield to Danny? Do I have a little bit of time?

Do you have any opening statements? Then your time will be—I guess you will be the first to speak.

Mr. OSBORNE. I think we are going to have Danny introduce one of our guests, and anything he wants to say at that time he certainly can. We never muzzle Danny.

I might just add to Ms. Woolsey's comments on Chairman Castle. He seems to be doing well, expected to have a full recovery, and I am sure he will return here after the election.

We have a very distinguished group of witnesses today, and I will begin by introducing three of them, and Danny will introduce one.

Mrs. Michele Ridge is a former first lady of Pennsylvania, an advocate for children and families. She is chair of the Children's Partnership and a member of the board of Nurse Family Partnerships.

And we are delighted to have you here this morning.

And I believe that Dr. Daro is a constituent or an acquaintance of Mr. Davis. So he can introduce her at this time.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman. And I, too, want to thank you, Chairman Castle and Ms. Woolsey for holding this hearing.

And it is my distinct pleasure to introduce an expert in this field of work, one who was born and grew up in my congressional district in Oak Park, Illinois, but then lives in Representative Judy Biggert's district, and then works in Representative Bobby Rush's district.

Dr. Deborah Daro is a research fellow at the Chapin Hall Center for Children at the University of Chicago. Her 20 years of experience in evaluating prevention and child abuse treatment programs clearly reflect her expertise in child well-being.

Dr. Daro has a long history with home visiting. Growing on her work in child abuse prevention, she developed and put in motion Healthy Families America, one of the largest home visiting programs in the nation.

She has been involved in comprehensive research efforts to understand the contributions of home visiting, providing a balanced perspective on its successes and areas for improvement.

In addition, Dr. Daro has the unique ability among researchers to understand how research can inform and aid policy. I think her comments will do much to help us understand how policymakers can best support child development to prepare children for school, and we are indeed delighted that she is with us this morning.

Thank you, Mr. Chairman.

Mr. OSBORNE. Thank you, Mr. Davis.

We are a little bit out of order here. Ms Scovell, I don't want you to think we are going to leave you out.

Ms. Scovell is the state Parents as Teachers supervision coordinator at the Lake Forest School District in Delaware Early Childhood Center, and Ms. Scovell is a certified Parents as Teachers parent educator and supervisor.

Glad to have you here this morning.

And the last panelist we have is Chief James Burack, serves in Milliken, Colorado, and interim co-administrator. Chief Burack also serves as a current member of the Weld County Community Corrections Board.

And I would like to yield to Marilyn Musgrave at this time. I believe that the chief is from your district, and she wanted to make a comment on the chief, hopefully favorable.

So, Ms. Musgrave?

Mrs. MUSGRAVE. Well, thank you, Mr. Chairman. And, indeed, my comments are favorable.

Milliken is a wonderful, small community in the northern part of my district. I would just like to tell the chief, as we had visited on another occasion, that I have a son-in-law in law enforcement and I have the highest regard for what you do.

And I want to tell you that your influence on the lives of children and the redirection that you would have them take is most admirable.

So I am just happy and proud to have you here before the committee today and I just want to thank you for the good work that you do.

Thank you, Mr. Chairman.

Mr. OSBORNE. Thank you, Ms. Musgrave.

I think you are all familiar with the lights. You have a green light for 5 minutes, and then you see the red light come on and that is when you are supposed to wrap up your remarks. And so, we would like to adhere to that schedule as best we can.

And so we will begin with the witnesses. Ms. Ridge, we will start with you. And thank you for being here this morning.

STATEMENT OF MICHELE RIDGE, FORMER FIRST LADY OF THE COMMONWEALTH OF PENNSYLVANIA, MEMBER OF BOARD OF DIRECTORS OF NURSE FAMILY PARTNERSHIP

Mrs. RIDGE. Thank you, Mr. Chairman, and thank you to all the committee for the opportunity to testify on behalf of the Nurse Family Partnership and the "Education Begins at Home Act."

I am Michele Ridge, a member of the national board of directors of the Nurse Family Partnership, a national nonprofit organization dedicated to producing long-term improvements in the health and well-being of low-income first-time mothers and their children.

Research has proven that the Nurse Family Partnership program can break the cycle of poverty, abuse, crime, poor health, and government dependence. At the same time, this program increases labor force participation, improves school readiness, saves substantial resources, and changes the course of life for mothers, children and future generations.

Nurse Family Partnership is an evidence-based nurse home visitation program, with proven clinical multigenerational outcomes. This voluntary intervention and prevention program model is delivered by highly trained registered nurses and beginning early in pregnancy and continuing until a child is 2.

The program's founder, Dr. David Olds, has conducted, during the past 25 years, three randomized control trials across three diverse populations. This research shows numerous significant and positive outcomes, including a 48 percent reduction in child abuse

and neglect, improvements in elementary school readiness, including a 50 percent reduction in language delays for a child at age 21 months, and a 67 percent reduction in behavioral and intellectual problems for a child at the age of 6.

Reduction in high risk pregnancies include 32 percent fewer subsequent pregnancies, a 31 percent reduction in closely spaced subsequent pregnancies, a 46 percent increase in father presence in the household, and a 59 percent reduction in arrests of juveniles, and a 61 percent reduction in the arrests of mothers.

In Pennsylvania, Governor Ridge and I worked to implement the Nurse Family Partnership model as a proven youth violence prevention program. Several local Pennsylvania communities went through a rigorous strategic planning process under an initiative called Communities that Care, which has now been adopted by the Substance and Mental Health Administration.

Communities voluntarily selected Nurse Family Partnership because evidence showed this model could deliver hard to achieve outcomes. NFC emerged as the most strongly endorsed violence prevention model in Pennsylvania.

Today, the Nurse Family Partnership national service office supports programs in 270 counties and 22 states, serving 20,000 families a year, including 2,280 families in 36 counties across Pennsylvania.

In addition to Pennsylvania, NFC is statewide in California, Colorado, Louisiana, Ohio and Oklahoma. Many other states are seeking to expand local Nurse Family Partnership program.

Its replication plan reflects a proactive, state-based growth strategy that maximizes fidelity to the program model and ensures consistent program outcomes. In other words, it gets results.

As NFC's program model has moved from science to practice, great emphasis has been placed on building the necessary infrastructure to ensure quality during replication.

Nurse Family Partnership provides intensive and ongoing education and training for nurses and we maintain a unique data collection and program management system, called clinical information system, which helps Nurse Family Partnership to monitor program implementation and outcomes in a real time day-to-day basis.

A more thorough description of this quality assurance tool is provided in my written statement.

Nurse Family Partnership's success and cost-effectiveness and been proven through four independent evaluations, each of which are cited in my written statement.

A Department of Justice evaluation identified Nurse Family Partnership as one of 11 prevention and intervention programs nationwide out of a pool of 650 programs that met the highest standard of program effectiveness in reducing adolescent violent crime, aggression, delinquency and substance abuse.

RAND Corporation and the Washington State report weighted the costs and benefits of Nurse Family Partnership and concluded that the program returns approximately $3 for every $1 invested. These reports identify Nurse Family Partnership as having the highest cost-benefit ratio of any home visit program studied.

The Nurse Family Partnership supports the "Education Begins at Home Act," as introduced in the House of Representatives. This

bill provides consolidated funding to support the important work of home visitation programs, including Nurse Family Partnership.

Nurse Family Partnership urges Congress to direct funds toward home visit models that maintain the highest level of evidentiary standards in order to ensure the largest possible return on the Federal investment.

On behalf of the Nurse Family Partnership staff and volunteer leadership, I would like to thank Congressman Davis, Congressman Platts, and Congressman Osborne for their leadership on behalf of this legislation.

I would share with you that I have visited a nurse home visitation program in Congressman Platts' district in York several years ago and enjoyed that visit and the results of that home visitation program are outstanding.

I would like to particularly thank Congressman Davis for his willingness to include in the legislation language encouraging high standards of quality assurance and evaluation. In this era of limited Federal funding, we must invest Federal resources in programs that have proven outcomes and that really work on behalf of our nation's mothers and children.

So thank you again for the opportunity to appear before you and testify on behalf of Nurse Family Partnership.

[The prepared statement of Mrs. Ridge follows:]

Prepared Statement of Michele Ridge, National Board of Directors, Nurse-Family Partnership

Good morning Mr. Chairman and thank you for the opportunity to testify on behalf of the Nurse-Family Partnership and in support of the Education Begins at Home Act.

I am Michele Ridge, a Member of the National Board of Directors of the Nurse Family Partnership, a national non-profit organization dedicated to producing long-term improvements in the health and well-being of low-income, first-time parents and their children. One reason I chose to join this National Board is because Governor Ridge and I established this program throughout the state of Pennsylvania in 2000. The Pennsylvania NFP program remains strong and active today, serving approximately 2280 families in 36 counties in Pennsylvania, and nearly 8,000 Pennsylvania families since the program began. After describing the NFP program model, I will discuss the process by which Governor Ridge and I chose this program to serve first-time, low-income mothers and their families.

Nurse Family Partnership (NFP) is an evidence-based, nurse home visitation program with multi-generational, enduring outcomes that have been demonstrated in three randomized clinical trials, each conducted with a different population living in different social settings. A randomized trial is the most rigorous research method for measuring the effectiveness of an intervention.

NFP is a voluntary program that provides nurse home visitation services to low-income, first-time mothers by highly trained, registered nurses beginning early in pregnancy and continuing through the child's second year of life. NFP nurses and their clients make a 2 and 1/2 year commitment to one another, with 64 planned visits focusing on the mother's personal health, quality 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.

The NFP model is designed to help families achieve three major goals: improve pregnancy outcomes; improve child health and development; and 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.

Each day in America, 2,482 children are abused or neglected, 4 children are killed by abuse or neglect, 2,447 babies are born into poverty, 888 babies are born at low birthweight, 77 babies die before their first birthdays, and 4,356 children are arrested. Every second, a public school student is suspended, every 9 seconds a high school student drops out, every minute a baby is born to a teen mother, every 8 minutes a child is arrested for violent crimes, every 41 minutes a child or teen dies in

an accident, and every day a mother dies in childbirth. Today, more than 20% of U.S. workers are functionally illiterate and innumerate. The high school dropout rate is increasing. The U.S. has the highest child poverty rate of the 20 developed countries belonging to the Organization for Economic Cooperation and Development.

The Nurse-Family Partnership is successfully addressing these poor social and health outcomes. We know that investing in children during the earliest years of their lives holds promise for both improving long-term human functioning and improving the economic productivity of our society. Economists tell us that economic growth depends on human capital, the label they use to describe the resource represented by people and their productivity. The Nurse-Family Partnership is an opportunity to invest in human capital.

NFP is the only evidence-based prevention program of its kind to be subjected to over 30 years of rigorous research, development, and evaluation 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 has conducted three randomized, controlled trials with three diverse populations in Elmira, NY (1977), Memphis, TN (1987), and Denver, CO (1993). Evidence from the trials document powerful outcomes, including the following:

48% reduction in child abuse and neglect (Elmira, 15 year follow-up)
59% reduction in child arrests (Elmira, 15 year follow-up)
61% fewer arrests for the mother (Elmira, 15 year follow-up)
72% fewer convictions for the mother (Elmira, 15 year follow-up)
46% increase in father presence in the household (Memphis, year 5)
Reduction in high-risk pregnancies:
32% (Elmira, 15 year follow-up) and 23% (Memphis, year 2) fewer subsequent pregnancies
31% fewer closely spaced (<6 months) subsequent pregnancies (Memphis, year 5)
Improvement in elementary school readiness:
50% reduction in language delays at child age 21 months (Denver)
67% reduction in behavioral/intellectual problems at child age 6 (Memphis)
Improvements in cognitive development at child age 6 (Memphis)
Improvements in language development at child age 4 and 6 (Memphis)
Improvements in child executive functioning at age 4 (Denver)

Each study has been reevaluated to find out if the program effects seen while families were receiving home visits faded out once the program ended, or were sustained over time. The results of each study have been positive, and provide the evidence necessary to justify offering the program for public investment.

As NFP's program 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 for nurses, NFP has a unique data collection and program management system, called the Clinical Information System (CIS), which helps NFP monitor program implementation. CIS was designed specifically to record family characteristics, need, services provided, and progress towards accomplishing NFP program goals. Program quality and outcomes can be measured and/or monitored in real time as every home visit is reported by the respective NFP nurse.

In Pennsylvania, the Nurse-Family Partnership model was identified as an evidence-based program for youth violence prevention and reduction. As a result, Governor Ridge directed juvenile justice funds to establish and support NFP in Pennsylvania. Juvenile justice and TANF funds have been used to maintain the program in 36 counties across Pennsylvania. Other states have used a variety of funding sources to establish and sustain NFP program sites, including Medicaid, TANF, Tobacco settlement, Title V Maternal & Child Health Block grant, Healthy Start, and private funds.

Today, the Nurse-Family Partnership National Service Office supports programs in 270 counties and 22 states serving 20,000 families a year. In addition to Pennsylvania, NFP has statewide implementations in states including California, Colorado, Louisiana, Ohio, and Oklahoma, and many other states are seeking to expand local NFP programs into statewide initiatives. 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 direct funds toward home visit models that maintain the highest level of evidentiary standards in order to ensure the largest possible return on the federal investment.

NFP's success and cost-effectiveness has been proven through four independent evaluations (Washington State Institute for Public Policy, 2004; 2 RAND Corporation studies 1998 and 2005; Blueprints for Violence Prevention, Office of Juvenile Justice and Delinquency Prevention). Blueprints identified NFP as 1 of 11 prevention and intervention programs nationwide that met the highest standard of pro-

gram effectiveness in reducing adolescent violent crime, aggression, delinquency, and substance abuse, out of a total of 650 programs reviewed to date.. 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 over time will return a minimum of $2.88 for every dollar invested, with a return of $5.70 for higher risk populations. Savings accrue to government in lower costs for health care, child protection, education, criminal justice, mental health, and government assistance, and higher taxes paid by employed parents. The Washington State Report found a net return to government of $17,180 per family served by NFP, far higher than the return from all other social service programs measured in these studies. Although the costs for NFP in this study were higher than the costs for some other home visit programs, NFP had a higher cost-benefit ratio. More recent analyses indicate that the costs of NFP compared to other home visitation programs fluctuates by region, and even though the NFP model is more intensive than other programs, it is not always more expensive.

Among home visitation programs, NFP is unique in that the model focuses on a specific population of low-income, first-time mothers and the use of highly trained registered nurses. In the Denver clinical trial, NFP evaluated the impact of using registered nurses versus paraprofessionals when providing home visitation services to this select population of first-time low income mothers. Nurses were found to provide stronger outcomes for this population. During the program, paraprofessionals produced effects that were approximately half the size of those produced by nurses. Two years after the program ended, at the child's age four, paraprofessional-visited mothers began to experience some benefits, but their children did not. Nurse-visited mothers and children continued to benefit from the program two years after it ended, with the greatest impact on children born to mothers with low psychological resources. I'd like to note, however, that this evaluation has only been applied to the Nurse-Family Partnership and may or may not translate to other home visitation programs.

The Nurse-Family Partnership supports the Education Begins at Home Act as introduced by the House of Representatives. This Act proposes intelligent solutions to core problems facing new families nationwide. This bill provides consolidated funding to support the important work of home visitation programs including NFP. I'd like to thank Congressmen Davis, Platts, and Osborne for their leadership on behalf of this legislation and particularly Congressman Davis for his attention to quality assurance and evaluation criteria. In this era of limited federal funding, we must invest federal resources in programs that have proven outcomes.

Thank you again, Chairman Castle and Members of the Subcommittee, for the opportunity to testify before you today.

Mr. OSBORNE. Thank you, Ms. Ridge.

Ms. Scovell?

STATEMENT OF ANNA SCOVELL, PARENTS AS TEACHERS SUPERVISOR, SUSSEX COUNTY, DE, PARENTS AS TEACHERS

Ms. SCOVELL. Good morning, Mr. Chairman, distinguished members of the committee, fellow witnesses, and honored guests. My name is Anna Scovell, and I am here today to provide personal testimony on my experiences with home visitation services for families with young children.

I would like to take a moment to recognize my colleagues from Delaware.

Would you please take a moment and rise? Thank you.

I have had the privilege of being the Sussex County Parents as Teachers program supervisor for the last 4 years, and I am currently celebrating my 10th year as a certified Parents as Teachers parent educator.

In my testimony today, I will describe Parents as Teachers services in the state of Delaware, specific techniques used in delivering services to families, and the benefits of Parents as Teachers for parents and children.

Parents as Teachers is a proven parent education and family support program that provides home visiting services to families throughout pregnancy up until the child enters kindergarten.

In the state of Delaware, Parents as Teachers serves approximately 1,750 families per year. In Sussex County, we served 450 families during the last school year, including teen parents, rural families, military families, English language learners, parents who did not finish high school, as well as those with advanced degrees.

The one thing that all of these parents have in common is that they want to be the very best parents that they can possibly be. Home visitation services, such as Parents as Teachers, helps parents realize this goal.

I want to share with you a story about one of my families, because I think it is really special.

I worked with a married couple some years ago who had a young son. Mom was a high-strung, excitable person, and dad was just the opposite. He was pretty laid back and calm.

Living in low-income housing at the time, they were doing their very best, trying to juggle their jobs, child care, transportation, and mounting bills. Through our routine screening process, I realized that their son had a possible language delay.

After referring the family for further evaluation, the little boy was able to receive speech therapy services. And before this little boy turned 3, the parents found out they were expecting twins.

After the twins were born, the parents discovered that one of the babies had Down's syndrome. Mom wasn't very sure that she could handle these three children under the age of 3, much less cope with two children who had special needs. She was overwhelmed and in need of additional support.

The family and I searched for community resources for their special needs children, which proved to be particularly difficult in this rural community. While the family faced many struggles in their day-to-day life, they were committed to Parents as Teachers and rarely missed our scheduled visits.

Dad participated in as many of the home visits as he could and the entire family attended evening parent-child special events.

I worked with this family for almost 6 years, sharing their joys and working through their concerns and fears. They still stay in touch with me and send me pictures and family updates at Christmas.

Sussex Parents as Teachers is funded by the Delaware Department of Education and sponsored by the Lake Forest school district and is free to participating families. Enrollment is on a voluntary basis.

While we give priority to parents with identified risk factors, we strive to serve all families.

There are four major components of the Parents as Teachers program: personal visits, parent group meetings, developmental screenings, and resource networking.

Personal visits in the home or child care facility are typically scheduled on a monthly basis. Using a strength-based model, parent educators share child development observations and discuss upcoming milestones.

We reinforce positive parenting skills, address their questions and concerns, explain the importance of brain development during the first 3 years of life, and share parent-child activities.

Our parents participate in group meetings, which we offer 3 days a week. During these meetings, parents learn from and support each other. They observe their child with other children and practice parenting skills.

We conduct annual developmental screenings to identify strengths and delays and make follow-up referrals, when appropriate. In addition, we connect parents to community resources for financial, medical and educational assistance.

Families who participate in Parents as Teachers have an increased knowledge of child development, improved parenting practices, early detection of developmental delays and health issues, prevention of child abuse and neglect, and increased school readiness, which leads to school success.

Because our program is affiliated with the school district, there is a continuum of services for families with children, prenatally through school age. Evaluation results show that Parents as Teachers children are more likely to be on tract developmentally and to have developmental delays identified early and remediated, when possible.

Parents as Teachers children, at age 3, are significantly more advanced in language, social development, and problem-solving and other cognitive abilities than comparison children.

The "Education Begins at Home Act" would provide critical Federal funding to support home visitation services, such as Parents as Teachers, not only in Sussex County, Delaware, but across the country.

All parents deserve parenting information and family support so they can help their child reach their full potential and the "Education Begins at Home Act" will help this become a reality.

Thank you, Mr. Chairman and distinguished members of the committee, for allowing me this opportunity to share with you today.

[The prepared statement of Ms. Scovell follows:]

Prepared Statement of Anna M. Scovell, Sussex County Parents as Teachers Program Supervisor

Good morning Mr. Chairman, distinguished members of the committee, fellow witnesses, and honored guests. I am here today to provide personal testimony on my experiences with home visitation services in Delaware and to emphasize the need for federal governmental support for such services for families with young children. I have had the privilege of being the Sussex County Parents as Teachers program supervisor for the last four years and I am currently celebrating my tenth year as a certified Parents as Teachers parent educator providing direct services to families and childcare providers. In this testimony, I will describe my experience with home visitation activities, specific techniques used in delivering services to families, how our program collaborates with existing community supports and resources, and the benefits of the Parents as Teachers program for families.

In the state of Delaware, Parents as Teachers serves approximately 1,750 families and 1,850 children per year through 4 programs based in the following Delaware cities: Georgetown, Bear, Newark, and Woodside. In Sussex County, we served 451 families during the last school year. Of those enrolled families, over three quarters of the families were of low income; nearly three quarters were single parent households; one third of the families had parents having less than a high school diploma or GED; over one third were teen parents; one third were speakers of other languages, mostly Spanish; one quarter of the children did not have health insurance;

and almost one quarter of the children were identified with disabilities. As you can tell from the percentages, many of our families have multiple risk factors. Other families enrolled were involved in chemical dependency, mental health, the corrections systems, homeless shelters, relative care, and foster care. I personally have served families ranging from teen mothers, to rural families, to dual income middle class families, to single parent families receiving public assistance. The one thing that all these parents have in common is that they want to be the very best parents they can possibly be. Home visitation services such as the Sussex Parents as Teachers program helps parents realize this goal.

Sussex Parents as Teachers is funded by the Delaware Department of Education and is sponsored by the Lake Forest School District. The program is free to families who enroll. Enrollment is on a voluntary basis and families may exit the program at any time. While we give priority to parents with identified risk factors, we strive to serve all families regardless of the age of the parents or the number of children in their family because we believe that all families can benefit from our services. Parents may be enrolled during the prenatal period or after their child is born. Our program makes long term parenting education and family support available to families during those critical first three years of their child's life. Providing this parenting education and family support in the home is critically important because it strengthens the individual relationship with the family, increases the parent's ability to utilize the services, and encourages parents to incorporate the parenting information and strategies in their day-to-day home life.

Each year there are more than 50 identified families on a waiting list to be served. There is a great need for home visitation that spans across all socio-economic and educational levels. In Delaware, we have an initiative called "Ready Families, Ready Children, Ready Schools, and Ready Communities". This campaign is a solid first step in providing parenting education and family support for the education of our youngest children. The federal legislation that you are considering takes this concept and propels it into the national spotlight. ALL parents deserve parenting information and family support and the Education Begins at Home Act will provide a reliable funding source for home visitation programs that will meet this tremendous need not only in Sussex County, Delaware, but across the country.

There are four components of the Parents as Teachers home visitation activities in Sussex County. Personal visits in the home or child care facility are scheduled on a regular basis. Parent educators visit prenatal childbirth classes and share prenatal developmental information to new parents. We visit high schools and facilitate teen parenting groups. Weekly parent group meetings with parent-child activities are conducted in local libraries, churches, community centers, or with other partnering agencies. Developmental screenings and health questionnaires for children are conducted on an annual basis. Referrals are made to Child Development Watch for further evaluations if needed. Parents and children are connected with local resources for financial, medical and educational assistance. Families are connected to resources for children and family enrichment such as infant massage, gymnastics, music for tots, family fun events at the zoo and local museums.

In each of the components, fathers are encouraged to become involved in the activities, including our weekly play groups. During a recent group meeting, I was able to videotape a father and son sitting on the floor playing blocks. The father was helping his son build an airplane hanger and dramatically provided the sound affects of the airplane landing. This parent-child interaction was facilitated by the parent educator and may not have occurred without this intervention.

The Sussex Parents as Teachers home visitation services uses a strength based model for parenting education and family support. A strength based model builds upon parenting assets so parents can help their children learn, grow and develop to reach their fullest potential. Educators are encouraged to build rapport with parents, share child developmental observations and discuss what is coming next in a child's development. During personal visits, the parent educator reinforces positive parenting skills, shares parent-child activities, provides resources for parents, administers developmental screenings and connects parents to resources. The Parents as Teachers Born to Learn curriculum that we use provides research-based information about early childhood development in all domains: language development, cognitive development, social-emotional development, and motor development. We emphasize the critical role that parents play in their children's growth and development and the importance of the first three years for brain development.

Parent educators in the Sussex Parents as Teachers home visitation program use specific techniques such as goal setting, active listening, affirming parental knowledge, skills and behaviors. They help parents through developmentally appropriate and/or challenging parent-child experiences. Routines and activities important to the parents are discussed with parent educators to help parents address specific issues.

Parent educators share written material that is available on two different readability levels in both English and Spanish which covers an array of child development and parenting topics. Community resources are also included in the material and discussed with the parents. Videos or DVDs are utilized during home visits. Parent educators receive feedback on a routine basis by supervisors trained in reflective supervision. Parent educators meet on a monthly basis to discuss individual case management, identify professional development needs and share resources.

Benefits to families enrolled in the Sussex Parents as Teachers program include increased parent knowledge of childhood development, improved parenting practices, early detection of developmental delays and health issues, prevention of child abuse and neglect, and increased school readiness and school success. Because our program is affiliated with a school district, there is a continuum of services for families with children, beginning with pregnancy and extending through school-age. Evaluation results show that Parents as Teachers prepares children to enter kindergarten ready to succeed. Parents as Teachers children are more likely to be on-track developmentally and to have developmental delays identified early and remediated. Parents as Teachers children at age three are significantly more advanced in language, social development, and problem solving and other cognitive abilities than comparison children. The positive impact on Parents as Teachers children carries over into the elementary school years. Parents as Teachers children score higher on kindergarten readiness tests and on standardized measures of reading, math and language in first through fourth grades.

Community supports and collaborations include parents themselves, family members, friends, neighbors, parent educators, faith based organizations, or local agencies. Sussex Parents as Teachers has developed collaborative relationships with local hospitals, public health clinics, Nemours Health and Prevention Services, the Pregnancy Care Center, Division of Family Services, Delaware First Home Visiting Program, Delaware Adolescent Pregnancy Program (DAPI), Children and Families First; public school wellness centers; Early Head Start; Head Start; Even Start; Parent Information Center; childcare centers; and the United Way. During the 2005-2006 school year, more than 200 families were referred to our program by these and other agencies.

Sussex Parents as Teachers employs sixteen part-time parent educators and one full-time family consultant. Our parent educators have backgrounds in early childhood education, special education, elementary education, social work, counseling, and nursing. Educators are available to make home visits during the day, evenings and Saturdays, depending on individual family's schedules. Each visit is usually 45-60 minutes in length and visits typically are offered once a month. However, individual family needs are assessed during regularly scheduled supervision meetings and families may be visited more than once each month if there is an identified need. A variety of Parents as Teachers curricula are used during home visits. They include: Born to Learn—Prenatal to Three; three Years to Kindergarten Entry; Working with Teen Parents; and Supporting Families of Children with Special Needs. Our Early Intervention, Part C program educators who work with families who have children under the age of three with an identified developmental delay or special need visit families once each week to work on Individualized Family Service Plans. These plans have specific goals and objectives for the child and family to work on. A variety of supports are offered between visits such as weekly parent-child activities at our Stay and Play centers and parent groups meetings on specific topics. Families often email or phone their parent educators with questions or concerns that arise between visits.

Some families referred to our program have many issues and over the course of time things change in their lives, sometimes dramatically. This was the case with a married couple I worked with a several years ago. Mom was a high strung, excitable person and dad was just the opposite. He was laid back and calm. Living in low-income housing at the time, they were already doing their best trying to manage time, living expenses, jobs, childcare, and transportation. A possible language delay was detected during a home visit when I administered a Denver II screening to their son and a referral was made for further evaluation. Subsequently, their son qualified for and received speech therapy. Before the child was three, the parents found out they were expecting twins. After the twins were born the parents discovered one of them had Down Syndrome. Mom was not sure she could handle three children under the age three or cope with two children having special needs. She was overwhelmed and in need of more support. I was able to enroll the twins in Parents as Teachers and continue visiting the family. The family and I searched for community resources for their special needs children. It was difficult at times because resources in a rural community are limited and we did not know whether or not the family qualified for different services. Through it all, the parents always

made time for my visits and calls. Dad participated in some of the home visits and the entire family attended some evening parent-child special events. I worked with this family for almost 6 years sharing their joys and working through their concerns and fears. They still stay in contact with me and send pictures and family updates every Christmas.

I was first introduced to Sussex Parents as Teachers home visitation program in 1992. I had just left my job as a public school special education pre-kindergarten and kindergarten teacher to stay at home to raise my two sons, ages 2 and 4. My extended family lived far away, my husband worked full-time and was involved in local activities in the evenings and on weekends, and my close friends were working parents or parents of adult children. I had a master's degree in education and thought I knew how to be a great parent. It was not long before I started to experience feelings of isolation, depression, lack of patience, and total exhaustion on some days. We tend to parent the way we were parented and although my parents did their best, I did not necessarily want to use the same parenting style and techniques my parents used with my siblings and me. It was by working part-time with Sussex Parents as Teachers that I learned to be the best parent I could be.

The Parents as Teachers Born to Learn training to become a certified parent educator was unlike anything that I had experienced in college. The Born to Learn Prenatal to Three Years training is intense and comprehensive. The training provides the educator with information and learning opportunities to share with parents, family members and providers on how to promote healthy child development and how to be the best possible teacher in a young child's life. This was such a wonderful new program that allowed me to stay with families for three years and meet with them on a monthly basis. As I grew more confident as a parenting educator, I become more competent and confident as a parent. Thanks to the new knowledge gained from Parents as Teachers, I felt equipped to give my boys the best possible early education and I knew that I was truly contributing to the well being of other families.

A year after my initial Parents as Teachers training, I was facilitating a parent-child play group in my community, making regular home visits with a diverse group of parents, recruiting new families, administering developmental screenings, and linking families to community resources. I loved my job, however there were a few drawbacks. A lack of supervision, a sense of professional isolation in the field and a change in my family's financial situation prompted me to return to full-time work.

In 1995 I helped open a new state of the art child care facility and was able to continue with Parents as Teachers at the center by initiating the newly developed Parents as Teachers Supporting Care Providers through Personal Visits program. I coordinated the program for several years before I left to teach child development at a local university. Those personal visits with child care providers, parents and children were magical. Trusting and respectful relationships developed between parents and providers. Parental and provider resilience was built. Concrete support during times of need was provided. Knowledge of parenting and child development was increased.

I taught at the university for several years when my friend Cris, one the three women who pioneered Sussex Parents as Teachers, encouraged me to apply for the newly formed full-time coordinator position. I accepted the position with the hope that I could give to my staff of parent educators what they give to parents and children—new knowledge and skills, recognition, validation and affirmation. I believe I do this on a regular basis. I have completed my doctoral coursework, successfully passed my comprehensive exams and drafted my dissertation proposal. Friends and family ask what I want to do when I finish my Ph.D. in organizational leadership and I tell them that I want to continue in the home visitation field because we have much more work to do with families in this 21st century. Parents as Teachers has afforded me the knowledge, skills and confidence to be a better parent, skilled teacher and successful administrator. All families with young children, and their providers, deserve to have access to the best parent educators, current child development information, and family supports so that children will learn, grow and develop to reach their fullest potential.

Thank you, Mr. Chairman and distinguished members of the committee, for allowing me the opportunity to share this testimony with you today.

Mr. OSBORNE. Thank you very much.

And, Dr. Daro?

STATEMENT OF DEBORAH DARO, RESEARCH FELLOW, RESEARCH ASSOCIATE (ASSOCIATE PROFESSOR), CHAPIN HALL CENTER FOR CHILDREN, UNIVERSITY OF CHICAGO

Ms. DARO. Thank you very much.

I want to begin with thanking Congressman Davis for that wonderful, kind introduction, and to thank him and Mr. Osborne and Mr. Platts for your support of this legislation that most certainly is designed to improve outcomes from children.

There is uniform agreement, I think, around the country about the importance of early learning. Learning begins at birth, not when a child enrolls in kindergarten.

Within this early learning context, voluntary home visitation programs have surfaced as a promising vehicle for providing support to new parents in how to nurture and promote their child's healthy development.

The "Education Begins at Home Act" is an important milestone in fostering more comprehensive systems of early learning. It has two key characteristics. First, it vests decisionmaking authority in the states in terms of selecting a given intervention. This is in keeping with the historical preference for state and local interest in public education.

At present, about 37 states are involved in trying to develop early learning systems for their communities and their constituents and our review find that state leaders do understand the importance of quality, careful documentation and implementation and impacts, and sustaining their programs through a system of public and private partnerships.

Federal legislation that can promote this good behavior on the part of states is certainly something to be applauded.

Second, I think the bill requires the collection and use of information to improve practice. As such, the legislation goes a long way toward creating the type of learning environment we know are needed to improve social service delivery quality and outcomes.

We often in our lives move forward without perfect knowledge, but we should never move forward without having a community of learning to guide our decisionmaking.

So what constitutes best practice in home visitation? There is a difference, in my mind, between looking at empirically based programs and empirically based practice. Most of the research that I do and spend time examining really looks at the characteristics of service delivery that makes for strong outcome.

This body of knowledge suggests that there are certain characteristics of home visitation that increase the odds of them achieving positive outcomes. By positive outcomes, I think one of the most important is building a strong parent-child relationship, building a strong sense of attachment between that child and their primary caretaker.

If we know nothing else about education in this country, we know that children that show up at school socially and emotionally healthy are ready to learn.

And what does that mean? These are children that can establish relationships and keep them, these are children that can manage their emotions, and these are children that, most importantly, can

see a goal for themselves and then motivate themselves to get there.

That is the kind of outcome quality home visitation can produce.

But it is not just any home visitation program. What are some of the characteristics that make a difference? Certainly, solid internal consistency. A program says what it is going to do and then sets up a method to get there.

Forming an established relationship with the family, so that it extends for a sufficient period of time to accomplish the goals of the program, to increase knowledge, to build skills, to help that parent form and sustain a relationship with their child.

It requires competent, well trained staff, staff that not only have the book knowledge of how to do this work, but the relationship knowledge on how to do this work.

It requires high quality supervision, so that workers are constantly supported in the work they need to do.

It requires solid organizational capacity. To deliver these programs, organizations themselves need to be robust and able to weather the comings and goings of various funding streams.

And then, finally, this program needs to be able to link to other community resources and services. No one program can do it all. The only strength that we have is when we collectively work together for the well-being of children.

Even when home visitation programs embrace these characteristics, I would love to tell you they are a 100 percent successful, but they are not. They are not for a host of reasons, partly because families are difficult, families are challenging, and partly because we just don't know all the answers we need to know.

We know more today than we knew 10 or 15 years ago. We have a greater understanding of what it takes to enroll and engage these families in the service delivery process. We have stronger service protocols. We have better staff training and methods of supervision, a greater understanding of how to link families with services.

We don't, however, have all the answers, and that brings me to my last point.

I think the importance of this legislation is it does not require a single model. It doesn't tell people, "Here is the program that will work." It requires more of states.

First, it requires that they go through a planning process, a discernment process to discover what strengths they have, what limitations they have, and how can they build best on their existing services in order to launch an effective system of early intervention.

For some states, that will be their healthcare system. For other states, it may be their education system.

In Illinois, we have a strong early learning coalition, where advocates have come together and are really building a collective response to the problem.

Second, no one program works for all families. A program that enrolls families prenatally can't service families if they are not getting prenatal services.

For some families, the link and attraction will be an education program. For other families, it is going to be healthcare program.

For home visitation to be successful, it needs to have the ability to meet parents where they are and engage them appropriately.

And, finally, this field is in desperate need of new learning. By allowing states the opportunity to select and then test the utility of different models, both in terms of outcomes and implementation and the scale-up potential they may have for advancing learning.

Such learning is essential if we are to identify and resolve the adaptive challenges we face in ensuring that children born today are ready for school tomorrow.

Thank you.

[The prepared statement of Ms. Daro follows:]

Prepared Statement of Deborah Daro, Ph.D., Chapin Hall Center for Children, University of Chicago

Background

Early intervention efforts to promote healthy child development have long been a central feature of social service and public health reforms. Today, prenatal care, well-baby visits, and assessments to detect possible developmental delays are commonplace in most communities. The concept that learning begins at birth, not when a child enrolls in kindergarten, has permeated efforts to improve school readiness and academic achievement (Kauffman Foundation, 2002). More recently, child abuse prevention advocates have applied a developmental perspective to the structure of prevention systems, placing particular emphasis on efforts to support parents at the time a woman becomes pregnant or when she gives birth (Daro & Cohn-Donnelly, 2002).

Although a plethora of options exist for providing assistance to parents around the time their child is born, home visitation is the flagship program through which many states and local communities are reaching out to new parents. Based on data from the large, national home visitation models (e.g., Parents as Teachers, Healthy Families America, Early Head Start, Parent Child Home Program, HIPPY, and the Nurse Family Partnership), it is estimated that somewhere between 400,000 and 500,000 young children and their families receive home visitation services each year (Gomby, 2005). In addition, 37 states have early intervention service systems that include home visitation services, which may include one or more of these national models or may be based on a locally developed model (Johnson, 2001). Although the majority of these programs target newborns, it is not uncommon for families to begin receiving home visitation services during pregnancy, to remain enrolled until their child is 3 to 5 years of age, or to begin home visits when their child is a toddler. Given that there are about 23 million children aged 0-5 in the U.S. (and about 4 million births every year), the proportion of children with access to these services is modest but growing.

The Education Begins at Home Act represents an important milestone in establishing an effective and more easily accessible system of support for all new borns and their parents. Among the bill's most important features are identifying the critical elements that constitute a quality home visitation program; allowing states to select a specific service model that reflects these quality elements and best complements its other early intervention efforts; and requiring the collection and use of information to enhance practice. Although no legislation comes with absolute guarantees, the Education Begins at Home Act builds on an impressive array of knowledge regarding the efficacy of home visitation programs and creates an implementation culture which emphasizes quality and continuous program improvement.

In my time this morning I want to briefly summarize the evidence supporting the expansion of home visitation programs for new borns, identify those program elements associated with more positive outcomes, and discuss the array of efforts underway by several of the national home visitation models both individually and collectively to sustain ongoing quality improvements.

The Broader Context of Early Learning

Before considering the specific outcomes of home visitation programs, it is important to reflect on the full body of research that initially supported the current policy emphasis on newborns and their parents. The rapid expansion of home visitation over the past 20 years has been fueled by a broad body of research that highlights the first 3 years of life as an important intervention period for influencing a child's trajectory and the nature of the parent-child relationship (Shonkoff & Phillips 2000).

The empirical base for this conclusion grew out of the early brain research, translated for popular consumption by the Carnegie Foundation's "Starting Points" report (1994) and a special issue of "Time" (Spring/Summer, 1997).

In addition, longitudinal studies on early intervention efforts implemented in the 1960s and 1970s found marked improvements in educational outcomes and adult earnings among children exposed to high-quality early intervention programs (Campbell, et al., 2002; McCormick, et al., 2006; Reynolds, et al., 2001; Schweinhar, 2004; Seitz, et al., 1985). These data also confirmed what child abuse prevention advocates had long believed—getting parents off to a good start in their relationship with their infant is important for both the infant's development and for her relationship with parents and caretakers (Cohn, 1983; Elmer, 1977; Kempe, 1976).

The key policy message from this body of research is that learning begins at birth and that to maximize a child's developmental potential requires more comprehensive methods to reach new borns and their parents. Individuals may debate how best to reach young children; few dispute the fact that such outreach is essential for insuring children arrive at school ready to learn.

Why Home Visitation?

A particular focus on home visitation within the context of developing a system to support new parents and their young children emerged, in part, from the work of the U. S. Advisory Board on Child Abuse and Neglect in the early 1990s (U.S. Advisory Board 1990,1991). Drawing on the experiences of many western democracies and the State of Hawaii in taking home visitation "to scale" as well as the initial promising results of David Olds's nurse home visitation program in Elmira, New York (Olds, et al., 1986), the U.S. Advisory Board concluded that "no other single intervention has the promise that home visitation has" (U.S. Advisory Board, 1991: 145). Although the Olds data showing initial reductions in reported rates of child abuse among first-time, low-income teenage mothers was often cited as evidence the method worked, the fact that at least a dozen assessments of other home visitation efforts had demonstrated gains in such diverse outcomes as parent-child attachment, improved access to preventive medical care, parental capacity and functioning, and early identification of developmental delays was equally influential (Daro, 1993). This pattern of findings, coupled with the strong empirical support for initiating services at the time a child is born and Hawaii's success in establishing its statewide system, provided a compelling empirical and political base for the initial promotion of more extensive and coordinated home visitation services.

The Evidence of Success

Over the past 15 years, numerous researchers have examined the effects of home visitation programs on parent-child relationships, maternal functioning and child development. These evaluations also have address such important issues as costs, program intensity, staff requirements, training and supervision, and the variation in design necessary to meet the differential needs of the nation's very diverse new-parent population. Some of these studies have confirmed the initial faith placed in the strategy by the U. S. Advisory Board; others find that many questions remain unanswered, even as states continue to expand services in this area.

Attempts to summarize this research have drawn different conclusions. In some cases, the authors conclude that the strategy, when well implemented, does produce significant and meaningful reduction in child-abuse risk and improves child and family functioning (AAP Council on Child and Adolescent Health, 1998; Geeraert, et al., 2004; Guterman, 2001; Hahn, et al., 2003). Other reviews draw a more sobering conclusion (Chaffin,2004; Gomby, 2005). In some instances, these disparate conclusions reflect different expectations regarding what constitutes "meaningful" change; in other cases, the difference stems from the fact the reviews include different studies or place greater emphasis on certain methodological approaches (e.g., randomized controlled studies).

It should not be surprising to find more promising outcomes over time. The database used to assess program effects is continually expanding, with a greater proportion of these evaluations capturing post-termination assessments of models that are better specified and better implemented. In their examination of 60 home visiting programs, Sweet and Appelbaum (2004) documented a significant reduction in potential abuse and neglect as measured by emergency room visits and treated injuries, ingestions or accidents (ES = .239, $p < .001$). The effect of home visitation on reported or suspected maltreatment was moderate but insignificant (ES = .318, ns), though failure to find significance may be due to the limited number of effects sizes available for analysis of this outcome ($k = 7$).

Geeraert, et al. (2004) focused their meta-analysis on 43 programs with an explicit focus on preventing child abuse and neglect for families with children under 3 years

of age. Though programs varied in service delivery strategy, 88 percent (n = 38) utilized home visitation as a component of the intervention. This meta-analysis, which included 18 post-2000 evaluations not included in the Sweet and Appelbaum summary, notes a significant, positive overall treatment effect on CPS reports of abuse and neglect, and on injury data (ES = .26, $p < .001$), somewhat larger than the effect sizes documented by Sweet and Appelbaum.

Stronger impacts over time also are noted in the effects of home visitation on other child and family functioning. Sweet and Appelbaum (2004) note that home visitation produced significant but relatively small effects on the mother's behavior, attitudes, and educational attainment (ES ≤ .18). In contrast, Geeraert et al. (2004) find stronger effects on indicators of child and parent functioning, ranging from .23 to .38.

Similar patterns are emerging from recent evaluations conducted on the types of home visitation models frequently included within state service systems for children aged 0 to 5. Such evaluations are not only more plentiful, but also are increasingly sophisticated, utilizing larger samples, more rigorous designs, and stronger measures. Many of these evaluations, however, are not published in peer review journals, and therefore not captured in the types of meta-analyses outlined above. Although positive outcomes continue to be far from universal, parents enrolled in these home visitation programs report fewer acts of abuse or neglect toward their children over time (Fergusson, et al., 2005; LeCroy & Milligan, 2005; Mitchel-Herzfeld, et al., 2005; Old, et. al., 1995; William, Stern & Associates, 2005); more positive health outcomes for the infant and mother (Fergusson, et al., 2005; Kitzman, et al., 1997); more positive and satisfying interactions with their infants (Klagholz, 2005); and a greater number of life choices that create more stable and nurturing environments for their children than either participants in a formal control group or than various comparison groups identified on the basis of similar demographic characteristics and service levels (Anisfeld, et al., 2004; LeCroy & Milligan, 2005; Wagner, et al., 2001). One home visitation model that initiates services during pregnancy has found that its teenage participants reported significantly fewer negative outcomes by age 15 (e.g., running away, juvenile offences and substance abuse) (Olds, et al., 1998).

Home visits offered later in a child's development also have produced positive outcomes. Toddlers who have participated in home visitation programs specifically designed to prepare them for school are entering kindergarten demonstrating at least three factors correlated with later academic success—social competency, parental involvement, and early literacy skills (Levenstein, et al., 2002; Allen & Sethi, 2003; Pfannenstiel, et al., 2002). Longitudinal studies of home visitation services initiating services at this developmental stage have found positive effects on school performance and behaviors through sixth grade (Bradley & Gilkey, 2002) as well as lower high school dropout and higher graduation rates (Levenstein, et al., 1998).

In addition to documenting the positive impacts of home visitation services, these studies are contributing to a broader understanding of how to do this work better. When mothers are enrolled during pregnancy, not only are birth outcomes more positive but mothers enrolled during this period have stronger parenting outcomes than women enrolled post-natally (Mitchel-Herzfeld, et al., 2005). Although positive impacts have been observed by programs employing home visitors with various educational backgrounds and skills, one study, which examined the relative merits of different types of home visitors within the context of a program designed to be provided by nurses, found nurses more effective in achieving program goals than a group of paraprofessionals (Olds, et al., 2002). Others have found that outcomes are more robust when home visitation is partnered with other early intervention services or specialized support (Anisfeld, et al., 2004; Daro & McCurdy, in press; Klagholz, 2005; Love, et al., 2002).

Despite continued variation in program objectives and approach, agreement is growing around a number of key factors that represent the types of programs most likely to accomplish expectations. This list includes:

Solid internal consistency that links specific program elements to specific outcomes;

Forming an established relationship with a family that extents for a sufficient period of time to accomplish meaningful change in a parent's knowledge levels, skills and ability to form a strong positive attachment to her infant;

Well-trained and competent staff;

High-quality supervision that includes observation of the provider and participant;

Solid organizational capacity; and

Linkages to other community resources and supports.

As the number and breadth of interventions targeting the 0-5 population grow, the need to carefully allocate resources becomes more acute. Each model, be it home

visitation, Pre-K programs, or child health insurance programs, needs to demonstrate both its effectiveness and its added value to a system of early intervention. Current empirical evidence suggests that home visitation does offer this type of added value. Early Head Start and various meta-analyses find more robust outcomes when families are offered both home-based and center- or group-based options (Daro & McCurdy, in press; Love, et al., 2002). When the primary objective of the intervention is enhancing school readiness or improving developmental outcomes, it is clear that children who are offered the opportunity for several hours a day of structured, high-quality, early education, in addition to home visitation services do better in school, seem more socially poised and have more positive life outcomes. This added value appears not only to improve parent-child interactions but also to reduce the type of negative behavioral patterns that others have identified among children spending long hours in child-care settings. And, not surprisingly, when a child's behavior improves, relationships with parents are more positive and abuse rates might potentially be lowered.

Assuring Continuous Program Improvement

Greater positive impacts among a broad range of home visitation models reflect, in part, two trends—improved program quality and improved conceptual clarity. With respect to quality, most of the major national home visitation models are engaged in a series of self-evaluation efforts designed to better articulate those factors associated with stronger impacts and to better monitor their replication efforts. For example the Nurse Family Partnerships (NFP) maintain rigorous standards with respect to program site selection. Data collected by nurse home visitors at local sites is reported through the NFP's web-based Clinical Information System (CIS), and the NFP national office manages the CIS and provides technical support for data entry and report delivery. These data provide information to sites about program management, details on how closely a site is following the program model, and compare individual sites with other NFP sites to help nurse home visitors refine their practice.

Since 1997, Healthy Families America's (HFA) credentialing system has monitored program adherence to a set of research-based critical elements covering various service delivery aspects, program content, and staffing. In an effort to promote ongoing quality improvement, the standards have been revised periodically to meet the changing needs of families and programs. At present, over 80 sites use a common data collection system developed by the national staff to monitor implementation and ensure compliance with these standards. In addition, an implementation study conducted in 2004 brought researchers and practitioners together to examine key challenges within the service delivery process, including issues of participant and staff retention, service intensity, staff supervision, and service content.

And, after 3 years of extensive pilot testing and review, Parents as Teachers (PAT) released its Standards and Self-Assessment Guide in 2004. Every 3 years, PAT programs are expected to complete a self-assessment process that covers service delivery and program management indicators, which emphasize continuous quality improvement.

In addition to model-specific efforts, representatives from six national models (NFP, HFA, PAT, Parent Child Home Program, HIPPY, and Early Head Start) have worked collaboratively as part of a Home Visit Forum since December 1999 to explore possible areas of mutual need and interest and to establish a vehicle for cross-program cooperation. At the time it was established, the Forum committed to achieving three major goals, considered central to advancing research and service provision in the field of home visiting:

Strengthening the empirical and clinical capacity to assess and improve home visit services and outcomes;

Developing strategic multi-model research inquiries and reinforcing the reciprocal links back to practice, training, and model development; and

Creating and supporting efforts to share and explore the implications of lessons learned with the broader home visitation field.

Over time, this process has resulted in the refinement of each model's theory of change, in the development of shared standards with respect to staff training and supervision, and in the commitment to advocate for program expansion within a framework of best practice standards supported by empirical evidence.

Achieving Broader Outcomes

Home visitation is not the singular solution for preventing child abuse, improving a child's developmental trajectory or establishing a strong and nurturing parent child relationship. However, the empirical evidence generated so far does support the efficacy of the model and its growing capacity to achieve its stated objectives with an increasing proportion of new parents. Maintaining this upward trend will

require continued vigilance to the issues of quality, including staff training, supervision, and content development. It also requires that home visitation be augmented by other interventions that provide deeper, more focused support for young children and foster the type of contextual change necessary to provide parents adequate support. These additions are particularly important in assisting families facing the significant challenges as a result of extreme poverty, domestic violence, substance abuse or mental health concerns.

Preventing negative outcomes such as academic failure and poor social emotional development will not be achieved through tunnel vision or the adoption of a single intervention. The roots of these and similar problems are buried in both the individual and in the social context. For any intervention to realize a notable and sustained reduction in a participant's risk factors or improvements in key protective factors, the planning process must consider the complementary changes that need to occur in the major institutions and norms that influence a parent's actions and shape a child's social environment. High expectations for home visitation services must be accompanied by a commitment by state and federal legislators to the types of systemic change that will create a context in which early learning interventions can thrive. Although programs such as early home visitation can change a parent's willingness to access health services, health services need to alter their structure and funding procedures to become more accessible. Home visitation programs can better prepare a child to learn, but public education systems need to be better prepared to accept children who will continue to face educational challenges.

Those planning and implementing home visitation programs for new borns and their parents can not limit their vision or interests to a narrow scope of work. They must look beyond the confines of their own efforts and create explicit connections to the work of others. At the most basic level, home visitation programs must include a set of necessary "wraparound" services that are offered to program participants that will build an effective bridge to their child's preschool education. Equally important but rarely tackled is the effort to define the conditions for change in relevant institutions or mainstream efforts. Blending funding streams, reducing central control and bureaucratic requirements, and providing greater local autonomy require more than a minor adjustment in existing operations. The task is not simply instituting a new model program, but rather discerning and resolving the adaptive challenges that would face the nation's social, educational, and health institutions were we to make a serious commitment to supporting young children and their families.

All journeys begin with a single step. The Education Begins at Home Act provides states an important vehicle for identifying the best way to introduce home visitation into its existing system of early intervention services. Chapin Hall's review of this process suggests states are already responding to this challenge by requiring that any model being replicated reflect best practice standards, embrace the empirical process and be sustainable overtime through strong public-private partnerships (Wasserman, 2006). The ultimate success of this legislation will hinge on the willingness of state leaders to continue to support data collection and careful planning and on the willingness of program advocates to carefully monitor their implementation process and to modify their efforts in light of emerging findings with respect to impacts.

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Mr. OSBORNE. Thank you very much, Doctor.

And, Chief Burack?

STATEMENT OF JAMES BURACK, CHIEF, MILLIKEN, CO, POLICE DEPARTMENT

Chief BURACK. Thank you, sir. Mr. Chairman and members of the Subcommittee on Education Reform, thank you for the opportunity to present this testimony.

My name is Jim Burack. I am the chief of police in Milliken, Colorado. I have been there for 5 years. Milliken is a community about 45 miles north of Denver. We have a population of about 5,000 folks.

My public safety career has included services as a patrol officer, as a Marine Corps prosecutor, as a special assistant U.S. attorney, as counsel with the police executive research forum here in Washington, and, most recently, as the Marine civil affairs officer in charge of judicial engagement and reform for Anbar Province, Iraq, last year.

I am also a member of Fight Crime, Invest in Kids, an organization of more than 3,000 police chiefs, sheriffs and prosecutors who have come together to analyze the research on what keeps kids from becoming criminals.

As police chief, I know there is no substitute for tough law enforcement. Yet, cops know better than anyone that we cannot arrest and imprison our way out of the crime problem.

The great challenge of policing is to identify that mix of proven prevention and enforcement strategies that work to make our communities safer. And as the agency that is usually the first responder to social service emergencies 24/7, police know the need to target at-risk youth and the environment that produces them if they are to forge an effective crime control strategy.

My police department, like thousands across the country, has embraced community problem-solving as its service delivery model. That does not mean we are not aggressive enforcers, only that we try to deal with recurring problems proactively and in partnership with the community.

We work closely with the boys' and girls' club. We have a full-time school resource officer at a middle school. We are facilitating a school dropout prevention and intervention program.

These are all worthy programs that largely focus on our at-risk youth. But we sometimes ask if our contact with at-risk kids for a few hours during school or at boys' and girls' club after school can really overcome the abuse and neglect or negative influences that these kids endured in their early years.

At the point we arrest a juvenile or young adult, it is sometimes too late. Even though the majority of children who are abused or neglected are able to overcome their maltreatment and become productive adults, many victims of abuse and neglect cannot.

Not only are they more likely to abuse and neglect their own children, they are also more likely to become violent criminals.

Fortunately, in-home parent coaching programs, also known as home visiting programs, can help stop this cycle. They offer frequent voluntary home visits by trained individuals to help new parents get the information, skills and support they need to promote

healthy childhood development and raise their children in a safe home.

There are several models of home visiting that help young children get off to a good start life, and I want to focus on the Nurse Family Partnership, or NFP, a proven crime fighting strategy that improves child and family outcomes in a wide range of area, including health, academic achievement, employment, and criminality.

For example, NFP can prevent nearly half of abuse and neglect cases among at-risk children. That is not catching child abuse and neglect and responding to it. That is preventing it from ever happening in the first place.

By the time those home visited kids reach their teens, they have about 60 percent fewer arrests than the kids left out of the program. Home visited kids are more prepared for school. They have fewer hospitalizations for injuries, and they are less likely to have behavior problems.

Home visited moms also benefit. They are more likely to be employed and are less likely to be arrested.

NFP also generates, as we heard earlier from a fellow witness, also generates over $3 of savings for every $1 invested, with two-thirds of that savings derived from reduced crime. On average, that amounts to more than $17,000 in net savings for every family in the program.

Now, unfortunately, there is a great deal of unmet need among at-risk families nationally. But an approach with proven results, like in-home parent coaching, should be more widely replicated across the Nation and it frequently takes Federal leadership to encourage communities to experience the value of certain programs, and we believe this is one of those opportunities that will pay dividends for generations to come.

I and my colleagues with Fight Crime, Invest in Kids, who are leaders of American law enforcement, are grateful that this subcommittee is holding today's hearing and we encourage the subcommittee to continue to move forward and schedule the markup early next year on the "Education Begins at Home Act," introduced by Representatives Davis, Platts and Osborne.

I am reminded of a comment a friend and fellow member of Fight Crime, Invest in Kids told a reporter recently.

Dean Esserman, who is the chief of police in Providence, Rhode Island, said that "This nation has rightly focused on homeland security for the last 5 years, but we cannot afford to simultaneously neglect hometown security, and this is a measure that could significantly improve the outlook on crime in hometown America."

So we encourage Representative Castle, when he is back, Representative McKeon, my own representative, Congresswoman Musgrave, and all of their colleagues on the Education and Workforce Committee to move forward the "Education Begins at Home Act" early next year.

Thank you so much, and I would be happy to try to answer any questions you may have.

Thank you, sir.

[The prepared statement of Chief Burack follows:]

Prepared Statement of James Burack, Milliken, CO, Chief of Police

Mr. Chairman and Members of the Subcommittee on Education Reform: Thank you for the opportunity to present this testimony. My name is Jim Burack and I have been the Chief of Police in Milliken, Colorado for the last five years. Milliken is a community of just over 5,000 about 45 miles north of Denver. My public safety career has included service as a patrol officer, as a Marine Corps prosecutor, as a Special Assistant U.S. Attorney in Southern California, as Counsel with the Police Executive Research Forum here in Washington, and as a Marine civil affairs officer in charge of judicial engagement and reform for Anbar Province, Iraq last year. I am also a member of FIGHT CRIME: INVEST IN KIDS, an organization of more than 3,000 police chiefs, sheriffs, prosecutors, and victims of violence, who have come together to analyze the research on what keeps kids from becoming criminals.

As a police chief, I know there is no substitute for tough law enforcement. Yet cops know better than anyone that we cannot arrest and imprison our way out of the crime problem. The great challenge of policing is to identify that mix of proven prevention and enforcement strategies and tactics that work to make our communities safer. As the agency that is the first responder to social service emergencies 24/7, police know that they need to target at-risk youth and the environment that produces them if they are to forge an effective crime control strategy.

My police department, like thousands across the country, has embraced community problem-solving as it service delivery model. That does not mean we're not aggressive enforcers, only that we try to deal with recurring problems proactively and in partnership with the community. We work closely with the Boys & Girls Club, we have a full-time School Resource Officer in our Middle School, we're facilitating a school drop-out prevention and intervention program—all worthy programs that largely focus on our at-risk youth. But we sometimes ask if our contact with at-risk kids for a few hours during school or at the Boys & Girls Club after school can really overcome the abuse or neglect, or negative influences that child endured in his early years.

At the point we arrest a juvenile or young adult, it is sometimes too late. Even though the majority of children who are abused or neglected are able to overcome their maltreatment and become productive adults, many victims of abuse and neglect can not. Not only are they more likely to abuse or neglect their own children, they are also more likely to become violent criminals. Research shows that, based on confirmed cases of abuse and neglect in just one year, an additional 35,000 violent criminals and more than 250 murderers will emerge as adults who would never have become violent criminals if not for the abuse or neglect they endured as kids.

Fortunately, in-home parent coaching programs, also known as home visiting programs, can help stop this cycle. They offer frequent, voluntary home visits by trained individuals to help new parents get the information, skills and support they need to promote healthy child development and raise their children in a safe home.

There are several models of home visiting that help young children get off to a good start in life. They each serve a slightly different population and have different, but complementary goals: the Nurse Family Partnership, Healthy Families America, Parents as Teachers, Early Head Start, Home Instruction for Parents of Preschool Youngsters and the Parent Child Home Program. I want to focus on the Nurse Family Partnership, or NFP, a proven crime-fighting strategy that improves child and family outcomes in a wide range of areas including health, academic achievement, employment and criminality.

The NFP provides at-risk new moms with two and a half years of visits from trained nurses, beginning during pregnancy. Random control trial scientific research shows in-home parent coaching can be one of our strongest weapons in the fight against crime. Research, originally published in the Journal of the American Medical Association, shows that the NFP can prevent nearly half of abuse and neglect cases among at-risk children. That's not catching child abuse and neglect and responding to it—that's preventing it from ever happening in the first place.

By the time those home-visited kids reach their teens, they have about 60% fewer arrests than the kids left out of the program. Home-visited kids are more prepared for school, have fewer hospitalizations for injuries and are less likely to have behavior problems, setting them up for success. Home-visited moms also benefit. They are more likely to be employed, have fewer subsequent pregnancies and are less likely to be arrested.

Analysis by the Rand Corporation and the Washington State Institute for Public Policy determined that NFP also generates over three dollars of savings for every dollar invested, with two-thirds of the savings derived from reduced crime. On average that amounts to more than $17,000 in net savings for every family in the program.

Unfortunately, there is a great deal of unmet need among at-risk families nationally. Every year, over 600,000 low-income women in the U.S. become mothers for the first time, resulting in 1.5 million mothers (who are pregnant or have a child under the age of two) who are eligible for the NFP. However, the program is only able to serve about 20,000 mothers annually, while other models serve an additional 400,000 at-risk and other families. That leaves hundreds of thousands of at-risk mothers across the country without the benefit of one of these programs.

An approach with proven results like in-home parent coaching should be more widely replicated across the nation. It frequently takes federal leadership to encourage communities to experience the value of certain programs. We believe this is one of those opportunities that will pay dividends for generations to come.

I and my colleagues with Fight Crime: Invest in Kids who are leaders of American law enforcement, are grateful that this Subcommittee is holding today's hearing and I encourage the Subcommittee to continue to move forward and schedule a markup early next year on the Education Begins at Home Act, introduced by Representatives Davis, Platts and Osborne. We look forward to similar movement next year on a companion bill in the Senate, sponsored by Senators Bond, DeWine, and Talent.

The law enforcement leaders of Fight Crime: Invest in Kids join the many, bi-partisan co-sponsors of the Education Begins at Home Act in support of this important legislation. We know that a small investment now will help stop abuse and neglect, improve children's school readiness and reap dividends down the road by saving lives and money.

I'm reminded of a comment a friend and fellow member of Fight Crime: Invest in Kids told a reporter recently. Dean Esserman, the Chief of Police in Providence, RI, said recently that this nation has rightly focused on homeland security for the last five years, but we cannot afford to simultaneously neglect hometown security. This is a measure that could significantly improve the outlook on crime in hometown America.

We urge Representative Castle, Representative McKeon, my own Representative, Congresswoman Musgrave, and all of their colleagues on the Education and the Workforce Committee to move forward the Education Begins at Home Act early next year. Thank you, and I would be happy to answer any questions that you may have.

Mr. OSBORNE. Well, thank you very much. Sorry I mispronounced your name. I tried to put a Czech connotation on there, coming from that type of area. So, anyway, Chief Burack, thank you for being here. Appreciate it very much.

I will begin the questioning. I will try to be fairly brief, because we may have a vote in 45 minutes or less, 25 minutes. So I think if every panelist will try to keep their answers short and concise, we might be able to get this done before then.

And, Ms. Ridge, you talked a lot about being cost-effective, your program, and others, as well. Do you have an estimate as to about what this costs per family and what it would take to reach most of the families who are in need of this type of program in the country? Because, obviously, we are just doing bits and pieces here and there.

But any thoughts you or any panelist would have on that question I would appreciate.

Mrs. RIDGE. As far as the number of families that are in need, I would not be expert enough to give you that information. I would be happy to submit, in written testimony, a response to that, the numbers. The numbers are great.

Nurse Family Partnership targets first-time pregnancies for low-income mothers. And I think what our typical site is, our minimum is a 100 families. We have four nurses and a nurse supervisor and we estimate that it is $.5 million for each year.

So we prefer a larger site, 200 families, but the minimum site is a 100 families.

Mr. OSBORNE. So you would be talking roughly $5,000 per family, if you did a 100 families at $500,000, something like that.

Mrs. RIDGE. Well, it depends on the number of families. It is $.5 million to do a site and so if you have 200 families, it is $.5 million divided by 200 families.

But I think the important thing to note is that cost that you save, the cost savings that you save are so far out and a part of any kind of formula looking at this, but that is the precise cost.

Mr. OSBORNE. I certainly agree with you, it is cost-effective. I think two or three different witnesses mentioned a three-to-one ratio. So if you spend $500,000, that means you are saving a $150,000 in social costs and other negatives.

So I certainly agree with that.

Do any of the other panelists have any observations on cost or number of families nationwide that would need a program like this? Because, obviously, the Federal Government can't do everything, but maybe in partnership with the states, we could reach more.

And so you see the need out there. I was in the coaching profession for 36 years and when I first started coaching in 1962, the number of people we saw from one-parent families was minimal, and usually it was because one parent or the other was deceased.

By the time I finished that career 36 years later, roughly one-half of children were growing up without both biological parents.

That is one reason I was so interested in your comment that it increased father presence by 46 percent, because if you get back to a lot of the base problems that we are looking at, fatherlessness is huge. It is not the only problem, but it is huge.

Any other observations any of you have in terms of cost per family in programs that you have observed?

Ms. SCOVELL. The costs vary from program to program. And the Nurse Family Partnership is certainly at the high end, but it is a very high quality program.

The programs that are delivered with an equal attention to detail probably can be delivered for $2,000, $2,100 a family, $1,500 a family. But it also depends on what kind of environment the program is being implemented in.

There is a lot of other ancillary services around that the home visitation program can then partner with and use. So it is really moving the system forward as opposed to thinking about what would it take for the single intervention to do the job.

You are really trying to change the culture in which that program is located.

Mr. OSBORNE. I appreciate your comments on the fact that you have to have multiple partnerships throughout the community and best practices are critical, because we can spend a lot of money doing something that doesn't work very well.

I think that is one thing that sometimes the Federal Government is really good at is spending money on things that maybe aren't real effective. And so we need measurable, quantifiable goals, and I think that is one of the purposes of the legislation proposed is to make sure that we do target it effectively.

Well, my time is about it and, in the interest of brevity, I will turn it over to Ms. Woolsey at this point.

Ms. WOOLSEY. And I would yield to Danny Davis.

Mr. OSBORNE. And I understand she will yield to Danny Davis.

Mr. DAVIS OF ILLINOIS. Well, thank you very much, Mr. Chairman. I want to thank the ranking member for yielding, also.

Let me thank all of the witnesses.

And, Ms. Ridge, let me just appreciate your outstanding public service work. I think it is, indeed, commendable in the way that you have made use of yourself.

In your experiences with the home visiting program, do you find a level of receptivity? I notice the individuals are first time pregnancies for low-income families.

What is the receptivity that you often experience?

Mrs. RIDGE. First of all, thank you, Congressman Davis, for your kind remarks. We have a lot of partners in Pennsylvania working on behalf of children and families.

I think in a voluntary program, which is what Nurse Family Partnership is, we found great receptivity and I think, in part, some of that can be attributed to the use of registered nurses.

What we have found with this particular home visitation program, the Nurse Family Partnership, is that registered nurses are highly trusted and bring great credibility and perceived authority in addressing the needs and concerns of a young mother and young parents.

So I think that has a lot to do with the receptivity.

Mr. DAVIS OF ILLINOIS. Thank you very much.

Chief Burack, I must say that I am fascinated by your community's conceptualization of policing and crime prevention.

How did the community arrive at such a comprehensive definition of what a police department is engaged in as a way to reduce crime?

Chief BURACK. Congressman, I guess that might be a—that is a difficult question probably to answer in a few minutes.

But I think there has been a change of culture, of expectations about what American law enforcement is capable of doing in this era and I think that is happened over the last two decades, with the leadership from Congress, and I think there is a renewed expectation of community about what they expect from our police.

And I think we have been incredibly successful and I think you see law enforcement leaders across the country, including in your district, who have done the very same things that we have done, sir.

Mr. DAVIS OF ILLINOIS. Well, I must tell you that I think it needs to be packaged and just simply sent around the country as the way for law enforcement to really look at our long-range objectives and what we attempt to do. So I certainly commend you.

Dr. Daro, we have had lots of comments about cost-effectiveness and during this day and age, practically everything that we do, given the state of the economy, given the usefulness of money and where does it come from and how can we get it.

What do we know about the cost-effectiveness of programs that are currently being used and being worked with pretty much across the board?

Ms. DARO. Economists like Jim Hickman, at the University of Chicago, will say if you look at the numbers, investing in early

childhood is the best bet any country could do, because the returns on your investment are tenfold over the years.

So waiting until a child is harmed, waiting until a parent-child relationship has gone south doesn't see to get you as grand a savings as you can if you invest early.

The data that Ms. Ridge talked about is certainly strong, because the Nurse Family Partnership has been around for 30 years and it is 30 years of follow-up data.

Increasingly, the home visitation programs that were implemented maybe 10 years ago are just now getting a cohort of children, where we can begin to show the same savings in terms of better school outcome, less need for remedial education, identifying children earlier that have learning disabilities, so we don't spend a lot more money trying to remediate the problems later on.

So all of those are potential for savings.

I have to say, though, when people go down the cost-benefit road, costs are in real time. Benefits are in future time. And most legislative decisions are made in real time.

So when we are looking for the adaptive challenges we face in investing in early childhood, one of them is beginning to look at how we consider legislation and how so we want a return on our investment. We need to be able to have a long-term focus and know that children will benefit from this, but it is going to be a while, and those savings may not come back to the same agency that invested in the program to start with.

Mr. DAVIS OF ILLINOIS. Thank you all very much. And, Mr. Chairman, I would just ask unanimous consent to put into the record two statements.

One is an issue brief from Chapin Hall, "Implementation of Home Visitation Programs," and the other one is a written statement from the American Psychological Association, called "Perspectives on Early Childhood Home Visitation Programs."

Thank you. And I yield back the balance of my time.

Mr. OSBORNE. Thank you, Mr. Davis. And so ordered, on your statements.

I would like to turn to one of the co-authors of the legislation, Mr. Platts.

Mr. PLATTS. Thank you, Mr. Chairman. I appreciate Chairman Castle and his staff in scheduling this hearing and your standing in for the chairman. We certainly have Mike in our prayers with his recovery.

Also, I am honored to join with our colleague, Representative Davis, in sponsoring this legislation.

When I look at early education, I look at it from the perspective of, one, as a former child myself and the education I got at home from my mom and my dad, but especially mom, and then as a parent of 7-and 10-year-olds and the blessings that my children have had with my wife being able to be at home and coming home, after our first child was born, from the not-for-profit sector, executive, and being home.

But know that that is more the exception today, having that opportunity.

But what I think this hearing is about is the importance of early education, whether it be parent education, parent visitation, home

visitation, or other programs, because we rarely have a debate about higher education funding and when we do, it is about we are not spending enough.

But we seem to have more trouble when we come to early education initiatives and it is a more heated debate of whether it is a good investment. And the evidence, as our four panelists, and I thank each of you for your testimony, so well captured that if we invest early, the return is so significant and the benefits to the child are so impressive, and, in reality, the benefits to the taxpayer.

And when you see the studies that 85 percent of brain development, neuron development is zero to 3 years of age, so from an opportunity to learn down the road, what we do in these early years is so critical.

I am delighted that we are having this hearing and kind of laying the foundation for what I hope will be a very successful effort in the coming months and session to move this legislation.

I am certainly delighted with all of you participating and your efforts in your respective positions. As a very proud Pennsylvanian, Ms. Ridge, it was an honor to serve in Harrisburg in the state house with you and Governor Ridge and your family's leadership and service to our commonwealth is going to be long, long remembered because of how blessed we were by you and the Governor in so many ways, including here in the area of the Nurse Family Partnership effort.

I do have a couple of quick questions I will get in before I use up all my time.

One is, in just your respective dealings with the Nurse Family Partnership, Parents as Teachers, and the various programs, the selection process.

While we are going to push for our bill and more funds, there are probably still going to be areas where you are going to have to pick and choose.

What do you think is the best approach and how do you, the respective programs, look at your clients, the parents that are involved? How are they selected, screened, as far as being able to participate?

And once they are in, is there a requirement—I will use the term contract for their participation, to get the benefits of the program, because we are going to invest the taxpayer funds, the expectation that they are going to make an investment back in giving their time.

Is there any kind of formal contract that the programs enter into or is it more of a good faith that they are going to participate, make the meetings, participate in any of the events?

And, Ms. Ridge, maybe we will start with you and go across.

Mrs. RIDGE. Well, as far as the Nurse Family Partnership program guidelines, I would rather submit that as written testimony to the actual process for selection and retention.

I think that is an important point for any home visitation program, not just Nurse Family Partnership.

I think because of the comprehensiveness of Nurse Family Partnership, I think you see a tremendous participation through up to

the child's second birthday and there are varying degrees of retention for most of the home visitation programs.

So I think those specific statistics I would be happy to submit with written testimony.

Ms. SCOVELL. As a program director with Parents as Teachers at a local level, I know that we really give priority to parents who were referred directly from the hospital.

We have a really close relationship with our local hospitals and the nurses there will make direct referrals to us. So we do give those referrals the highest priority.

We have lots of partnerships with various community organizations and we work closely with social service and DFS and they tend to have high priority, as well, when they come into our program.

But we try to balance out all the parent educators' caseloads so that they have a mix of parents who are considered risk and nonrisk, because at the program level and the service delivery level, the parent educator really needs to have a balance.

Otherwise, there is high turnover and burnout rate and we really, really look forward to working with a variety of families and giving all families that opportunity for parenting education.

I agree that there are varying degrees of retention. We do have a high percentage of our children in Sussex County graduate at age 3 through the program.

It is a good faith effort. We don't have a formal contract, but we do have parents who really, as in the testimony, who really are committed to being the best they can be and they feel that continuation of services until graduation for them and their children really is a viable option.

Ms. DARO. Prevention is, by definition, in my mind, a voluntary engagement process. And so there is nothing that is keeping families there.

But what we find in our research and what does keep families there is families go through a little benefit-cost analysis in their mind every day and they are constantly saying, "Am I getting something out of this program that is worth my investment in it?"

So to the extent that the program stays the course, to the extent the staff relationships are strong, programs can, indeed, retain families on what would be considered a voluntary basis.

Chief BURACK. Since we are going down the line, I will add a couple comments. I think the really exciting part of this for law enforcement is the potential, the potential to really enhance that partnership between the deliverers here, whether it is the Nurse Family Partnership or the other programs, and I think the real benefits, as law enforcement becomes more receptive and understanding of what these programs can do and the benefits that they can—the costs we can save in the near term and the benefits that we are going to receive in the long term.

Mr. PLATTS. Thank you, Mr. Chairman. We are going to have additional rounds, if time permits?

Mr. OSBORNE. We can do that if you want. We have votes in about 15 minutes and I have noted that sometimes when you want people back from votes, it is a little tough to get them back here. So we will do the best we can.

Mr. Scott?

Mr. SCOTT. Thank you, Mr. Chairman.

Chief Burack, I have been intrigued by your testimony, because you have suggested that we could reduce crime 60 percent and save money while we are doing it.

Does that include gang involvement?

Chief BURACK. I think that is a fair speculation, sir. I don't have the numbers. We could certainly see if the research has referred to that particularly, but I think there would be every expectation, especially in my community.

And Congresswoman Musgrave can attest to these, we have some gang issues in my small town and I have every hope that this would have some impact there. r. SCOTT. Well, you cite the RAND Corporation as a study. We like mandatory minimums. My other committee is the Crime Subcommittee in Judiciary. So, you know, that committee loves mandatory minimums, which the RAND Corporation has studied and concluded that it does nothing to reduce crime and wastes the taxpayers' money.

You, on the other hand, have come up with a RAND study that shows something that not only reduces crime, but saves money.

Which do you think is the more intelligent approach?

Chief BURACK. That is a hard question. I think I like the one that I was talking about, Congressman.

Mr. SCOTT. We also love to define more juveniles as adults. Now, that is been studied, too. That actually increases the crime rate, because in juvenile court, you can get services, not only services for the juvenile, but also family services and anything else, education and anything else the juvenile needs.

The adult court judge can only let the juvenile walk out on probation or lock him up with adult criminals, rapists, robbers and drug dealers.

Does it make more sense to follow the strategy that reduces crime 60 percent and saves money in the process or codify a slogan that actually increases the crime rate?

Mr. OSBORNE. Are you leading the witness, sir?

Mr. SCOTT. Doing the best I can.

Chief BURACK. How can I say no to that? I think law enforcement is pretty sensitive to the special needs of juveniles.

I don't want to go out of my lane here, but we feel very strongly that early childhood interventions like this are a cost-effective way to reduce those adverse impacts later on.

Mr. SCOTT. We have a bill, called "Gangbusters," which essentially tries more juvenile as adults, which increases crime, has mandatory minimums, which waste taxpayers' money, death penalty, which, for juveniles has been shown to do nothing to reduce crime.

That was pretty much the sum and substance of the legislation. It didn't have anything in there for the NFP program or something that actually reduces crime, certainly nothing that saved the taxpayers money.

Should we revisit the issue and try to do something a little more intelligently on this issue?

Chief BURACK. You know, with all due respect, Congressman, I would love to have a longer conversation, but I am not sure I am

qualified right now or prepared to respond to that, other than to say that I think the programs we are talking about today are really the focus and we in law enforcement support them.

Mr. SCOTT. They have been studied and they work and they reduce crime.

For children that are abused, did somebody suggest there is an intergenerational problem, that children who are abused tend to abuse their children and it goes on and on?

Chief BURACK. I certainly cited some statistics that suggest that, yes, sir.

Mr. SCOTT. So that if we take your strategy, Chief, not only do we reduce crime for this generation, but generations to come and save more money in the process.

I appreciate your testimony, because it seems to me that you have a much more intelligent approach to crime prevention than we have done in the Crime Subcommittee and I would hope that we would review your work and do something a little more intelligently than we are doing.

Thank you, Mr. Chairman. I yield back.

Mr. OSBORNE. Thank you, Mr. Scott.

Ms. Musgrave?

Mrs. MUSGRAVE. Thank you, Mr. Chairman.

Well, Chief, I will be easier on you than Representative Scott was. I wanted to say to you, all of you, that I have heard "low income" mentioned over and over today.

And, you know, some of the most horrific crimes in Colorado have been committed by young people that certainly did not come from a low-income home.

So, I don't know, I get a little gristly about that. I think that sometimes we make the assumption that jus because people are poor, that they are ignorant when they raise their children and they are engaged in a lot of negative behaviors.

So now that I got that off my chest, I want to say I agree so much with the chairman that the presence of the father in the home is very significant and I don't care where you are on the political spectrum, I think that the facts are very clear on that issue.

And I would just like to say that something that is really been on my heart and the heart of many on this committee is methamphetamine, and, boy, talk about a challenge that we are facing.

At times, it just seems insurmountable. And you talk to law enforcement about what is going on in these homes and these little children exposed to enormous risk, total neglect, abuse, and, I mean, it is just overwhelming.

And in Colorado, it is just a scourge and I just have to say to the chief, and I agree with much of what Representative Scott said, you know, we have got to have some hope out there. We have got to have something on the other end to keep you guys in law enforcement going and all of you other professionals that are trying to intervene at a time when it can make such a significant difference.

And could you, Chief, just address the meth issue? I hope that is being easier on you than he was. But could you talk about that a little bit and its impact on families and communities?

Chief BURACK. Congresswoman, I appreciate your leadership in Colorado on this and you have brought your committee back and testified there.

It is hard to overstate the impact that it has on families. But I can just tell you, anecdotally, even in the little town of Milliken, we have a meth problem. It impacts families, it impacts kids, and it is hard to overstate the impact it has on communities and the crime problem.

And we can see it on that micro scale and there is no question that throughout the county and throughout this country, it is having an impact.

Mrs. MUSGRAVE. How successful do you think professionals are, whether in law enforcement or social services, in getting the kid out of that environment as quickly as possible?

Chief BURACK. I think the results are mixed. Enforcement efforts I think are incredibly important. There needs to be some deterrent.

We need to have ways of keeping those kids, who are the most susceptible to that kind of behavior, away from that kind of stuff, and that is the dilemma for us, is to try to figure out a way to keep those kids, as they age, that they are not going to start engaging in the use of methamphetamine and every other kind of illegal substance, including alcohol, and that is part of our challenge.

Mrs. MUSGRAVE. Thank you. Thank you, Mr. Chairman.

Mr. OSBORNE. Thank you very much.

Susan Davis?

Mrs. DAVIS OF CALIFORNIA. Thank you. Thank you, Mr. Chairman. And thank you to all of you for being here and to the sponsors of the bill.

I am actually very heartened that we are discussing this today, because I know, as a former school board member and, also, in the state legislature, to me, this was the most commonsensical thing that we could do, and, yet, there was always a tremendous amount of pushback.

And I wonder if you could share with us, as we prepare to hopefully consider a bill of this nature in the coming year, if there are areas that we need to anticipate that are problematic.

One of the things that you have presented, and, you know, it is been a few years since I had a chance to work on this, as well, is that there is more data out there and that is very helpful, because we really didn't have a lot of that.

I would look for more data in terms of students' ability to progress in school and, certainly, longitudinally, in terms of students who are able to stay out of school, teenage pregnancy, all those particular issues.

But as you point out, we don't always have that luxury of long-term data. Is there an area that you could point us to, in anticipation, that you can see our problems, and sometimes its ideological and I understand that, call it political, whatever you want to call it, but how do you feel, in the programs that you worked with, that you were able to combat some of those concerns and, realistically, to help people see the benefits in the long term?

Ms. DARO. As someone that is worked in prevention for 20 years, it is a very hard concept to convey to people. People think it is in-

trusive, "You are trying to interrupt my way of taking care of my kid and who are you to say that?"

And I like to tell people if you think of someone stopping you on the street and asking you for $5, you would be much more put out than if they offered to give you $5.

And the message of prevention is this is a gift, this is something we need to offer you. I love the universal appeal of the program, because what I worry about when we keep trying to target it, we keep trying to say let's just get those bad parents, let's find those people that don't do the right things, that is a hard thing to do before something wrong has happened.

We don't have the kind of methods to say whether a parent who is simply angry with their child, that will escalate to something else.

By offering it universally, you say to people there is a threshold, there is a relationship that all parents need to establish with their children, that parenting is a difficult job, and then you go about the business of giving more services to families that have greater challenges.

You don't try to say there is one dosage that will work for everybody. You say here is a threshold, here is the bottom line we want for everybody, and then go about the business of finding those families and children that are specifically challenged, and you need to involve a lot of partners in that process.

Ms. SCOVELL. I agree with Dr. Daro. And I want to applaud Congresswoman Musgrave, because she talked about stereotyping families and the low-income family oftentimes getting the stereotype of not being able to be the best parent or not having the opportunity to do that.

We work with a variety of parents and I can honestly tell you that low-income families have needs and high-income families have needs and all the families in between have needs.

We work families—I am working with an RN right now who just had triplets and she actually worked in labor and delivery at the local hospital, and she just said, "I just don't know what to do, never mind with one child. I have a medical model and I understand what I have to do medically, but I really am nervous and I really need support."

And this is a woman who was married, who had family supports in the community, but who really got involved in the program and has been so just excited about it, because she really said that our parent educator who comes in really gives her an opportunity to focus on one child at a time and that child's development, and she is really appreciative of it.

So thank you, Congresswoman, for making that point.

I agree with Dr. Daro. It is a universal appeal and we would like to have all families to be able to have that opportunity.

Mrs. DAVIS OF CALIFORNIA. Thank you.

Ms. Ridge?

Mrs. RIDGE. Congresswoman, I would also like to say that any kind of home visitation and especially to improve school readiness for children in this country is really a multi-pronged sort of problem and issue and has solutions that have to meet different needs.

And I think in the case of Nurse Family Partnership, 30 years ago, when Dr. David Olds started this program, it was a case of trying to help a group of mothers who have—it is not necessarily that they are low-income, but they have few resources. And if you look at the public health model, they have many risk factors.

And so I think it is important that all the models be evaluated and that in certain instances, we need to target our efforts. I think one of the reasons that I got involved with Nurse Family Partnership is that it was one of the 11 blueprint violence reduction programs which we offered to communities in Pennsylvania in the late 1990's.

And in 1995, when my husband had the special legislative session on crime and the reform of juvenile justice, he said we can't just get tough on crime, we have to get smart about it and that prevention had to be an important strategic part of any solution to major problems.

So I think part of what I am trying to say is that prevention is a difficult concept for people to understand. It is not something that—and it is a long-term investment, which is difficult in a political arena, where you have terms of office and you have budgets that are an annual basis.

So I think it is just to keep those points in mind.

Mrs. DAVIS OF CALIFORNIA. Thank you. Thank you, Mr. Chairman.

Mr. OSBORNE. Thank you very much.

At this time, I would yield to the ranking member, Ms. Woolsey.

Ms. WOOLSEY. Thank you, Mr. Chairman.

Congressman Musgrave, you are going to faint, because I agree with you 100 percent. Honestly, I was sitting here putting all my thoughts together and we cannot assume that it is poor families that abuse their children, what a stigma that is and how wrong that is.

Certainly, having less income is a frustration that causes actions that aren't always positive, but there are a lot of other things that do, too. And it is not only low-income families that need the tools for the first time in parenting.

I mean, a first baby is a first baby, and I can remember mine. I mean, I never felt so stupid in all my life and that was 45 years ago. And my daughter, 2 years ago, had her first child and they sent a nurse practitioner to the house. She just picks that woman's brains and learns so much. So all levels of income.

I haven't signed on to this legislation, but I think the funding is flawed. First of all, it doesn't provide nearly enough for California. But, second of all, I think we need to start with low-income, but we should make available, maybe on a sliding scale, for families that can afford this help, because that help is very necessary.

We have learned a lot. First of all, we have learned that investing up front saves a lot more. For a $1 we invest up front, what is it, $7 or $8 later, at least, and that is probably undervaluing that $1.

So, Chief, I would like to say to you that it is clear why you have been the chief for 5 years, you were probably 12 when you started, you are good.

And I would like all of you, and starting with the chief, to talk to me not just about moms, but about dads. I know mom is the one that brings the babies there and that has to be, but, you know, in today's society, when both parents work, if a child's lucky enough to have two parents.

In my family, I have three sons and a daughter. My sons and my son-in-law are full parents. I mean, they change as many or more diapers than the moms do. They do more learning with the kids.

But how do we make that happen? How do we get dad involved? Starting with the chief.

Chief BURACK. I guess I agree with you wholeheartedly. They are clearly an important part of the question.

I am going to have to defer to, I guess, my colleagues here, who have worked sort of on the delivery, the service delivery model, exactly how they have engaged that father figure.

But I certainly can tell you, from the street level, that is a key element in these kids' upbringing.

But the reality is we have lots of single mom homes and if we are looking at the risk factors and looking at the folks we need to focus on, and I can certainly tell you that anecdotally from the street, that is a good place to start at this time.

Ms. WOOLSEY. And maybe we shouldn't say dad. Maybe we should say a male figure in their life.

Doctor?

Ms. DARO. One of the beauties of going into the home is you are dealing with everybody that is there. And so you are not asking them to come into a service program, but you go into the home and when dad's there.

The home visitors that I have worked wit tell me that when you are there, you can engage them in the process. You can show them how the child learns. You can show how the child responds to them.

You can help them get some enjoyment out of this child, because once people get a feedback, I mean, any father in the room, when you have held that baby and the first smile you get or the first connection you get, that is powerful, that is the communication, and that is what the program can work with, not only with the moms, but also with the dads.

Second, I think it is reminding the father, the other partner in the home, about the financial responsibility of taking care of this family, that it is part of the partnership. It is not just the emotional support, but the ability to be there and provide some financial support to the family.

Ms. WOOLSEY. Well, sometimes it is just the opposite. They think, "I brought the paycheck home, that is all I need to do."

Ms. DARO. Yes. But, also, many of the families that the home visitors are going to, there is no paycheck showing up there. That would be great, but that is not always the case.

So it is really trying to work with both. And I think, also, going back to high schools and working with adolescent males, beginning to tell them what it is to have a positive relationship, a respectful relationship, and programs that have been doing that around relationship-building with teens are showing some very positive results.

Ms. SCOVELL. I think one of the strategies we use at the local programming level is scheduling. Our home visitors are available daytime, evenings and weekends.

So we really have an opportunity to try to get those partners involved as much as possible, if we can.

We also do high school teen groups, as well, and we work with dads and we have separate dad groups and mixed dad and mom groups, and they are quite interesting sometimes.

I think one of the stories that I was thinking about when we were talking about dads was videotaping a family play session and dad was on the floor. And he was a volunteer fireman, we have volunteer fire fighters only in Sussex County, Delaware.

And the mom was saying that dad's never around, "You are always out of the house, you are working full-time, you are always at the fire hall and what not."

And I was videotaping this playtime and the fire alarm went off and the dad just up and out and left. And then when I went back the next time for the home visit, I shared the videotape and we were talking about the parent-child interaction, and the dad started crying.

He said, "You know, for years"—and the child was 3. He was exiting our program and graduating. And the dad said, "You know, for years, my wife was telling me that this was as very abrupt kind of dismissal and I never really got to say goodbye. I just left."

And when he saw it on videotape in one of the play sessions, it really hit him hard and he said, "You know, I understand now. So that when I leave my house, I am going to say goodbye to my son and I am going to kiss him and I will tell him that I will be back."

So that is just one story of many, many, many stories we have at the programming level. The dads and father figures and male figures are really, really important.

We do home visits, again, in the home, which is their territory, and the whole family is invited. We have some family members with grandparents. You were talking about having a grandchild.

There is one family that I visit, both grandmoms are there with the mom and the dad comes, when he can come, to the home visit.

So it is challenging and we don't have a 100 percent dad involvement, but we do encourage it as much as we can.

Mrs. RIDGE. I would just like to add to Dr. Daro and Ms. Scovell, the same sort of sentiment, and that is that the program objectives in the home visitation are to involve both parents in the birth of this child, the health of this child, development of this child.

And I think, again, going back to the presence of the registered nurse, this trained professional, who brings with her—we have found, and Dr. Olds has done focus groups and done evaluation, that with the nurses, there is no stigma to having the nurses come.

I think the one question that was asked by one of the previous Representatives about the receptivity, I think that has a lot to do with it.

And so I think the nature of home visitation programs really gives an opportunity to involve the fathers.

Ms. WOOLSEY. Thank you. This has been a wonderful panel. Thank you, Danny. Thank you, Todd. Thank you, coach.

Mr. OSBORNE. Thank you, Ms. Woolsey.

Mr. Platts asked for a second round of questions and I think it is my turn, but I will certainly yield to you, Todd, at this point, if you would like to ask a question.

Mr. PLATTS. Coach, Mr. Chairman, I am glad to follow your lead, if you would like to go first.

Well, thank you. Actually, I have very much enjoyed the dialog and so many points have been hit.

And I think the example or the issue of dads being involved and Representative Davis—it might have been Representative Scott talking about the generational benefits.

And in the testimony we hear, and, Chief, you highlighted, I think, especially in yours, the prevention of child abuse and the research numbers and what it shows, is what we prevent.

But I think it is also important to emphasize what we promote is the generational good example, is when the mom or dad gets that good example of parenting skills and they give it to their children.

Then when their children become parents—because I say, as a dad of two, the example I follow is my dad's example to five of us and how he did it and stayed sane, I don't know.

But he gave me the example of how to be a hands-on dad. I simply follow his example now, and that is something you can't quantify. And I think that is the challenge of these programs.

And, Ms. Ridge, you talked about an understanding that the dollar issue is—what we spend today, the way we score programs here, is just money out. We don't score the savings in.

So it is always a case that this is going to cost money. Well, no, we know it is going to save money. But the way we score funding here, it doesn't show it. And I think that is something we have to work to overcome as a body, is to say if we are talking $400 million, well, many billions we are going to save down the road, you know, is something that we need to factor in.

On that, I was curious, either in the programs, in a broad sense, Doctor, you are familiar with or both of the specific programs, there are tax dollars through the school district, through the state.

Are there private matches in your program, in an effort to have private dollars match the public dollars in any way, or is it fairly pretty much all public dollars, state or local?

Mrs. RIDGE. There are a variety of ways that communities that have Nurse Family Partnership sites in their communities pay for them. There are public dollars, there are private dollars.

They raise matching dollars. There are Medicaid dollars that are used. I mean, there are different varieties. And in Pennsylvania now, the nurse home visitation program is administered through the Department of Public Welfare and so there are state dollars, there are Federal dollars, and there are private dollars, and, in some cases, there are also local community dollars.

So it is a real combination.

Ms. DARO. That would be true for all the models I have looked at. Really getting people to buy into the process is a strong part of the program development process.

Mr. PLATTS. With the legislation we have, it is a straight grant program. Should we be looking at considering a mandatory match?

In other words, instead of just a grant, should it be 80/20, 80 us, 20, to ensure—one concern I have of the way we have the bill drafted is that we are going to provide dollars that are just going to replace existing dollars being spent, not complement existing dollars.

So we don't grow the programs, we just more fund them through the Federal Government. And it is a hard thing to get at, how to ensure that, without tying the hands of the state and local partners.

Is that something we should we be worried about or do you think that the partners in Pennsylvania and Delaware and across the country, that there is a commitment there that these really will be additional dollars, not supplanting those dollars already being spent?

Ms. DARO. I can speak to Illinois. We have made a major investment in early education, set up an early learning council. Thirty percent of the dollars that are allocated to this have to go to the 0-to-3 population.

I don't think there is anything in Illinois that would shake that resolve. And what this will allow the states to do, in Illinois, is to do an even better job of what they are trying to do.

Ms. SCOVELL. At the local level, we do get state funding through the Delaware Department of Education. But I know that in each of the Parents as Teachers programs, we have a waiting list always for more families to be served.

We also have families who need to be served with more intensive services and we just have a waiting list. So more moneys would be really beneficial.

Mrs. RIDGE. I would echo what Ms. Scovell said. I think there are some communities that really don't have resources and I would hate for those communities not to have the benefit of a home visitation program because they can't get the local match.

I think local matches do give communities more buy-in and certainly help to grow the program, but what we have found is that you also, in some instances, have to really provide the entire funds for a community, depending on its situation.

Mr. PLATTS. Just one final comment and, Dr. Daro, you kind of touched on the importance of the universality.

And, again, from leg experience, I share that and how we achieve that to have that base level exposure and then you kind of specialize or broaden the assistance given.

As a first time parent 10 years ago, going to a prenatal class, my wife and I, with people from all cross-sections of the community, but we were all in the same boat.

In fact, we run into a lot of them to this day, you know, as first time parents now 10 years later, and the experience of being there together from all different walks benefited all of us then and to this day.

So I agree that if we are able to do it to give that initial exposure and then build on that to those who have the greater need is something that we want to try to work at.

So, Mr. Chairman, thank you again for the opportunity to have a second round.

Mr. OSBORNE. Thank you.

Just parenthetically, your comments on scoring are well taken. We have a stop underage drinking bill, costs $40 million, aimed at educating adults on what underage drinking is doing. It is a $56 billion problem in the country, not to mention the loss of life, and we are going to have trouble with that bill, because it costs $40 million to save $56 billion or parts of $56 billion.

So we tend to get things backwards.

I know that Mr. Davis had a question, so yield to you.

Mr. DAVIS OF ILLINOIS. Thank you, Mr. Chairman. What I really wanted to do was to thank Mr. Platts and his staff and to thank you and your staff.

It has really been a pleasure working with you to get us to this point.

I also appreciate the discussion that we have had this morning and I was just thinking how much I appreciate the comments of Representative Musgrave, as I was reflecting and recalling my own childhood.

And I also wanted to thank my mother, because she, obviously, had a great deal of interest in this kind of activity. She had 10 children. I guess we would have been low-income, more than likely, we didn't have any money.

But she just simply believed that her children ought to know how to read before they went to school and she also believed that they should know their ABCs, know how to count to a 100. But my father thought that you should know your ABCs, he would say, both forward and backwards.

And they lived in rural Arkansas and they were African-Americans, at a time very different from the times now. And so, obviously, they weren't trying to prevent crime, because there was no crime, not really, but they were trying to enhance quality of life, I think.

So in addition to the crime prevention aspect, I also think that quality of life enhancement is a great aspect and a great component of this kind of activity.

I also appreciate the discussion relative to male involvement. I recall, in the Head Start reauthorization, we had an amendment to set aside resources to increase or try and convince programs to increase male involvement, because that is such a great lead and a strong component of the early development, especially of children.

As a matter of fact, I am of the opinion that one of the reasons that African-American males drop out of school at such an early age and in greater numbers than many other children is because they don't come into contact with any African-American male teachers or involved African-American males during the early stages of their educational development. They just don't see them, because they are not there.

And so this has been a great discussion, from my vantage point, and I want to thank Chairman Castle and I want to thank you, Ms. Woolsey, for the support that both of you have given to bring this to the point where we would have a discussion today.

My last comment would simply be to the panel. Could you take a moment to explain the whole notion of qualifications?

I mean, when we talk about home visiting, what qualifications should there be and what should we expect people to know and be able to do as they go into the homes?

And I thank you very much.

Ms. DARO. Home visitation is a relationship-based program. It is about setting a connection between a provider and a participant. So one of the most important skills is the ability to form relationships.

Crafted on that, though, needs to be a clear understanding about a set of knowledge and information that comes both from your own professional training and home visitors are nurses, home visitors are social workers, home visitors are child development specialists, and sometimes effective home visitors are people that come from the community that have life experience.

They understand what it takes to raise children in very difficult circumstances.

What we are seeing increasingly, though, in home visitation programs is the combination of individual. So that you may have someone going into the home, but a home visitor has access to a variety of individuals that can help augment their additional work in the home.

So they come with a set of skills. They come with solid training in the curriculum or the program they are implementing, and then, on top of that, they need to have strong ongoing supervision.

Mrs. RIDGE. I just wanted to add, in the Nurse Family Partnership program, obviously, a registered nurse is the home visitor, and that is the way the model is developed.

I think nurses have a special skill set to do that important relationship-building in a very nurturing way. And I think it is important in any kind of legislation to make certain that there is ongoing maintenance, training of those staff that are going into homes, that that is an important element that should be considered in the legislation.

Ms. SCOVELL. May I make a comment, Mr. Davis, please?

With our local program, Parents as Teachers, one of the things I pride myself on, as program supervisor, is that even though we are funded through the Department of Education in a local school district, our parent educators are a mix of teachers and nurses, social workers and counselors.

And I think it is really important to understand that, because when we come together as a team to do program development, to do case management on individual families, we have a lot of the resources right there within our own agency.

And then, of course, we have partnerships in the community that we need to really continue on. But I just wanted to make that comment.

Thank you.

Mr. DAVIS OF ILLINOIS. I just want to thank my own staff person, who has two young children, Dr. Jill Hunter-Williams, and maybe that is one of the reasons she has been so into this. But she has really done a great job.

And so, Jill, thank you very much.

Mr. OSBORNE. Mr. Scott, did you have a question?

Mr. SCOTT. Thank you, Mr. Chairman.

I noticed that in the comments, there seemed to be two different models for the home visits, the nursing model and an educators model. Is that right?

Mrs. RIDGE. Well, I think that those are two that are presented here, but I think probably Dr. Daro can speak to—there are probably even other models that are out there of home visitation programs.

Mr. SCOTT. Are some more effective than others?

Mrs. RIDGE. Well, what Nurse Family Partnership has done is studied its own specific model and has long-term data to talk about effectiveness, not just the cost part of it, but the human part of it, which is really the more important part of it.

Mr. SCOTT. What objective measures should we look at to determine whether or not a program is successful?

Mrs. RIDGE. I think in the case of this subcommittee, of this particular committee, the school readiness would be an important element.

I think one of the most important aspects of any home visitation program is there has to be, I think, independent evaluation of the effectiveness of the program.

Mr. SCOTT. In my other committee, I mentioned I am on the Crime Subcommittee, we have found that not being able to read by the third grade is an indicator that you are going to have to build prisons in a few years, and that is one marker that the Crime Subcommittee notes.

Are there other markers? You mentioned school readiness. Being ready for school pre-K?

Mrs. RIDGE. Right, and, also, I think you can look at a lot of the public health models. Dr. Daro is an expert on this.

But I talked about the communities that care strategic planning framework that we did in Pennsylvania that caused us to offer blueprint programs to those communities.

There are other factors, family conflict. Academic failures is a major indicator, a risk factor. And I think probably Dr. Daro can make a much more comprehensive response to that.

Ms. DARO. Well, the short answer is the appropriate outcomes are the outcomes the program has targeted for change. So it is hard to day there is one universal set of outcomes, because programs may approach this issue differently.

There are also some outcomes that can occur pretty early on. If it is a parent-child relationship program, you want to look at the attachment between the parent and child.

You want to look at access to healthcare services. Are they linked up with a medical home? Are they getting their immunizations on time? Is mom taking care of her health?

If there are employment issues or a housing crisis, you want to know they are linked up those other kinds of programs.

Looking forward, then you want to begin to follow that child and see when they show up at school, are they eager and ready to learn, are they engaging in the process, is the parent involved in the education process.

Mr. SCOTT. Can you measure eager?

Ms. DARO. Eager? You can measure social/emotional health, which is part of it. That is a big part of it.

You can say how well is this child able to manage their emotions? How well is this child able to set up a relationship with teachers and their peers? And how well does this child do in really motivating themselves to set and achieve certain goals?

Mr. SCOTT. That is a measurable outcome that you can affect.

Ms. DARO. That is a measurable outcome.

Mr. SCOTT. If their score is low, you can improve the score?

Ms. DARO. You look at whether they are on task over time and who is doing well in that domain and who is not doing well in that domain.

Mr. SCOTT. Now, you have got, as I understand, about 15,000 school systems throughout America.

If a school system wanted to pick up one of these programs, do they have to reinvent the wheel?

Ms. DARO. Do they have to?

Mr. SCOTT. Reinvent the wheel. I mean, do they have to come up with their own program and do their own research?

Ms. DARO. No, and that is the beauty of this legislation. It really gives them some really good building blocks to use in constructing their programs.

They could take a model off the shelf, and there are a lot of models that are mentioned in the legislation and many are represented here, or they may say, "We are going to take a careful look at what our objectives are and what resources we have in our community and what does our target population look like," and then craft a program that embraces the most positive elements of effective service delivery.

And that is, I think, what the research can contribute to. When we talk about evidence-based practice, that is really what we mean. It is really practice that has been tested over and over again and we know that those kinds of relationships with families have bigger impacts than those that don't have those features.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. OSBORNE. Thank you, Mr. Scott. I want to thank the witnesses for their valuable time and testimony and members for their participation.

If there is no further business, the subcommittee stands adjourned.

Thank you.

[Whereupon, at 12:06 p.m., the subcommittee was adjourned.]

[Additional material submitted by Dr. Daro follows:]

Response by Dr. Daro to Written Questions Submitted by Congressman Davis

1. Value of Varied Research Techniques

Home visitation efforts, as with all social interventions, are well served when they embrace the evaluation process and engage in continuous program improvement. In general, two lines of inquiry guide the development of program evaluations and other forms of applied research—does the program make a measurable difference with participants (efficacy) and does a given strategy represent the best course of action within a given context (effectiveness). In the first instance, evaluators place heavy emphasis on randomized clinical trials which involve the random assignment of potential participants to the intervention and to a control group (which may receive an alternative intervention or no intervention). Such studies are viewed as the best and most reliable method for determining if the changes observed in program participants overtime are due primarily to the intervention rather than to other factors (e.g., the natural learning or improvement that comes in the course of one's nor-

mal development or social contacts). As noted in my written testimony, a growing number of randomized trials assessing home visitation programs are surfacing in the literature, providing increased evidence of the strategy's efficacy—home visitation programs when well crafted and carefully implemented produce positive outcomes for children and their parents.

Maximizing the utility of program evaluation efforts, however, requires more than just randomized clinical trials. This diversity is needed to improve the quality of home visitation programs and successful replication. With respect to program quality, program evaluators are currently engaged in myriad studies to address key implementation questions—how do families view the home visits they are being offered, why do they accept or not accept offers to enroll in these programs, what other support options do new parents want to see within their community, and how do new parents view their relationship with home visitors. The issue of program fidelity, central to randomized clinical trials, takes on new meaning when one goal of the intervention is to be responsive to a family's needs and a community's strengths. Even within the context of a well specified curriculum or service protocol, each home visit represents a unique exchange between provider and participant, an exchange that is shaped by a family's immediate needs and a home visitor's service delivery style. By assuming families who received a similar number of home visits or who remain enrolled for a similar length of time have had the same service experience, randomized trials can easily overstate or understate an intervention's potential and, more importantly, fail to document the important variations in service delivery that account for differential impacts. Using only randomized clinical trials to assess home visitation programs reduces the ability of program evaluations to generate the types of findings central to achieving continuous program improvement.

Second, making home visitation programs more widely available means that the strategy has to successfully enroll and retain an increasingly diverse pool of new parents. A randomized clinical trial generally recruits a specific target population and provides them financial incentives to remain enrolled in the program. If home visitation is to be "taken to scale" within the context of voluntary enrollment, it will need to be attractive not only to those families who have successfully used social services in the past but also to those families who have been unable to utilize support due to a lack of information, a lack of trust, or a lack of sufficient self-worth to demand what is needed to support them as parents. These questions cannot be addressed simply by knowing if a program worked for the "average" participant better than it did for the "average" control (the key outcome of randomized trials). To answer these questions, we need to implement multiple research designs, including randomized trials but not exclusively randomized trials; utilize multiple methods of assessment, including standardized measures but not exclusively standardized measures; and learn from multiple standards of evidence, relying on statistically significant findings but not exclusively relying on statistically significant findings. Understanding how home visits impact families require more than randomized clinical trials. Equally important is the information that can be gleaned from the stories participants and providers tell in response to structured interviews, well-developed single cases studies and in response to well-developed theories of change models. Knowledge development and responsible public policy needs both randomized clinical trials and an array of well-developed process and implementation studies.

2. Key Qualifications for Home Visitors

Limited data exists on the relationship between a home visitor's profession or status (e.g., nurses, social workers, child development specialists, community resident, etc.) and program outcomes. Very few studies have been developed to test the relative merits of different types of providers in delivering the same intervention. One study based on this methodology did find nurses more effective than para-professionals (i.e., high school graduates from the community). However, it is difficult to generalize this finding to all home visitation programs in that the home visitation model being test was designed as an intervention for nurses. Home visitation models which embrace a different set of program goals and employ other types of professionals have demonstrated positive findings. Also, significant variation exists in the degree to which home visitation programs are linked to other services and the extent to which programs adopt a "team approach" to staffing cases. Many home visitation and parent education programs partner with other agencies offering specific health or child development services, resulting in a multidisciplinary approach to assessing and managing direct services for families. Within such systems of care, a parent's home visitor may be only one of several professionals or community supports addressing the family's needs. Given the growing trend among prevention services to offer multiple components and hire diverse staff, a unique focus on a

home visitor's educational background or professional identity may become less salient in the future.

Rather than focus on the narrow issue of professional status or education, the more productive discussion may lie in identifying the personal skills and quality of the home visitor and the training and supervision these providers receive in the course of their work. Home visitation programs are, in large part, an intervention that hinges on the relationship between the service provider and new parent. As such, the qualifications of the service provider are central in both retaining the participant in voluntary prevention services and producing more consistent outcomes. Evaluations of various home visitation programs have observed better retention rates and more robust outcomes when home visitors are successful in establishing a strong relationship with the participant, one that is characterized by mutual respect and opportunities for joint problem solving and case planning (e.g., being able to set appropriate expectations for the parent's own behaviors and for their interactions with their child).

Independent of the educational and personal qualifications of home visitor, a strong theme emerging from repeated evaluations of these efforts is the critical importance of solid initial training and ongoing reflective supervision. Regardless of an individual's degree or prior experience, all new home visitors need to be provided specific initial training on the home visitation model's theory of change, curriculum and target population. Reflective supervision is focused on learning from work with families and is supportive and collaborative in nature. It occurs on a regular and reliable schedule and is characterized by active listening and thoughtful questioning by both supervisor and supervisee. The process can involve multiple strategies including group supervision, individual supervision, and peer supervision. Organizations that embrace this type of supervision have clearly articulated goals and insure that all staff share the program's goals and commitment to excellence.

3. Home Visitation's Cost Effectiveness

Home visitation programs as well as models that include home visitation as one of several services provided young children and their parents have demonstrated the potential to save significant dollars over time. Comparative reviews of multiple interventions completed by Washington State Institute for Public Policy and the RAND Corporation find that early investment in strengthening parent-child relationships and supporting an infant's healthy development through home visitation programs and other early interventions can produce notable savings in terms of increased tax revenues due to increased employment; decreased welfare outlays; reduced expenditures for education, health, and other services; and lower criminal justice system costs. However, these studies also note that not all early intervention programs reap significant savings and that most savings are realized only if one takes a long-term view of program effects. As I noted during the hearing, program expenses occur in "real" time while the savings from such investments are found only in the future. Just as one does not expect an immediate return on any economic investment, investments in children will require patience. The available evidence suggested the investment is a sound one but not without a certain level of risk. Maximizing the return on a substantial investment in supporting new borns and their parents will require the investment in programs that embrace quality standards and marrying this investment with a commitment to continuous program improvement.

[Additional material submitted by Mrs. Ridge follows:]

Supplemental Testimony of Mrs. Ridge and Responses to Questions Submitted by Congressman Davis

In addition to my written testimony, I would like to address several aspects of the Nurse-Family Partnership program model that were illustrated and questioned throughout today's hearing.

The Nurse-Family Partnership (NFP) serves first-time, low-income mothers and their families as a strong and effective method to end the cycle of poverty. NFP has over 30 years of data that show multi-generational outcomes—the program has demonstrated outcomes that improve the health and well-being of first-time mothers, their children and families.

A cornerstone of NFP is the extensive research on the model conducted over the last three decades. Randomized trials were conducted with three diverse populations beginning in Elmira, New York, 1977; in Memphis, Tennessee, 1987; and Denver, Colorado, 1994. All three trials targeted first-time, low-income mothers. Dr. David

Olds' research continues today, studying the long-term outcomes for mothers and children in the three trials. This research demonstrated how the functional and economic benefits of the NFP model are greatest for families at greater risk. In the Elmira study, most married women and those from higher socioeconomic households managed the care of their children without serious problems and were able to avoid lives of welfare dependence, substance abuse, and crime without the assistance of the nurse home visitors. Similarly, their children on average avoided encounters with the criminal justice system and the use of cigarettes and alcohol. In contrast, low-income, unmarried women and their children in the comparison group in Elmira were at much greater risk for these problems, and the NFP program was able to avert many of these outcomes for this at-risk population. Cost analyses suggested that the program's cost savings for government were solely attributed to benefits accrued by this higher-risk group. Among lower risk families, the financial investment in the program was a loss in one RAND analysis. Similarly, although evidence from the Memphis and Denver trials support the impact of the NFP model on improving elementary school readiness, improvements in language development and executive functioning at child age 4 were most significant among low resource mothers in Denver. Due to this pattern of results, NFP recommends targeting high risk mothers for NFP services. In the current political climate where the resources for universal access to the NFP model are unlikely to be made available, the evidence from the trials indicates that resources should target the highest risk populations.

NFP works closely with local public health agencies, community health centers, schools, etc. to refer first-time mothers to a NFP program site within their area. NFP serves a diverse population—some urban, some rural—but each mother enters the NFP program looking for resources on how to take care of herself and her first child. NFP nurses and parents make a 2 and 1/2 year commitment to each other, starting no later than the 28th week of pregnancy and continuing until the child's 2nd birthday. NFP enjoys strong retention rates, as most parents develop a close, personal relationship with their nurses throughout the approximately 64 schedule visits over the course of the program, often referring to them as "my nurse".

An important component of the NFP program model is the qualifications and training of NFP nurses. All nurses are highly educated, registered nurses, many of whom have experience in the public health sector and enjoy being able to work within the community. Many NFP nurses left the nursing field after becoming "burned out" and have returned because NFP's work relates to the reasons why they became nurses in the first place. NFP nurses undergo a rigorous 60 hour training course closely monitored by the NFP National Service Office's professional development team. Currently, over 750 registered nurses are administering the NFP program model nationwide.

Most of the local NFP implementing agencies are county health departments. The NFP National Service Office has a contract with each local implementing agency that delineates each party's obligations, and specifies what the local agencies must do to meet NFP quality and reporting standards. Subject to regional salary variations, it costs approximately $500,000/year/100 families to deliver the NFP model, with some efficiencies of scale achieved for programs with over 200 families.

NFP outcomes are not limited to only the mothers and their first child but extend to the entire family involved in caring for the child. NFP encourages the involvement of the child's father or father figure within the household. Additional family members are encouraged to participate in the home visits and learn about caring for the new baby as a family. NFP nurses work to improve families' economic self-sufficiency by helping parents to envision their own future, plan future pregnancies, continue their education, and secure long-term employment.

Due to the Subcommittee's strong interest in early school readiness, the following information provides additional context on NFP's positive impact in this area. Overall, the results from the 3 trials show that the NFP model may increase children's academic and behavioral adjustment to elementary school. A more detailed discussion of why the program has a growing impact on children's cognitive and language development is presented in a Pediatrics article by David Olds and his colleagues (published in 2004). A key excerpt from that article reads as follows:

In interpreting the program's impact on children's development, it is important to note that the combination of compromised neurologic development attributable to poor prenatal health and harsh punitive parenting can be particularly damaging to children's cognitive and behavioral development and this program affected these earlier risks. Moreover, closely spaced subsequent pregnancies and lack of financial resources are associated with compromised child development. We have hypothesized that the beneficial effects of the program on child outcomes are attributable to the combination of improved prenatal health, improved parental caregiving, and improved maternal life course. Preliminary analyses suggest that parental

caregiving and maternal life course are likely to play important roles in explaining the enduring effect of the Memphis program on children's cognitive functioning and behavioral adjustment.

Dr. Olds' research demonstrates that the NFP program model dramatically decreases these earlier risk factors.

Responses to Questions Submitted by Congressman Danny K. Davis

1. When I explain home visiting to people, some people have asked how home visiting is useful given that most families work and won't be at home. What have your experiences revealed about how these programs work given parental work schedules?

Home visits are conducted at times when clients are available—evenings and weekends if necessary, sometimes even at school when dealing with teens who go back to school. Moreover, many of our working clients work at part time jobs and with highly varied hours. Often their day off is on a weekday or they are working shift work. One of NFP's goals is to assist clients with securing adequate and appropriate child care given these non-standard work hours. In addition, many of NFP's clients are not working when they first meet their NFP nurse and only develop the skills and resources to seek and sustain employment over the course of the NFP program. Finally, the NFP visit schedule is somewhat flexible by design to accommodate our programmatic goal of clients returning to work and school. If the clients have maintained a strong relationship with their respective nurses and are resilient enough in terms of their development, NFP allows fewer visits, or more phone contact, to occur for short periods of time in order to accommodate the parents' schedules.

2. As you know, the Education Begins at Home Act has a required data collection and evaluation component. From your experiences, how best can we ensure that the data we collect is most helpful to the providers?

We appreciate the importance of the data collection and evaluation components of the Education Begins At Home Act, and commend the efforts of Representative Danny K. Davis to improve the Act earlier this year by clarifying the characteristics of a "quality early childhood visitation program" and identifying central parameters for evaluation to improve our understanding of program success. In order to maximize program quality and fidelity to the research model as we have moved from science to practice during the replication process nationwide, NFP has placed great emphasis on developing an effective data collection and evaluation system, described in more detail in my written testimony. From NFP's experience, the following considerations and design elements ensure that the data we collect is productive for our nurses.

First, the data elements collected by NFP serve as markers for important aspects of program implementation that NFP local supervisors and administrators continually track to assure that the program is being effectively implemented. We just make that oversight easier by providing quarterly, or more frequently if needed, reports from the National Service Office (NSO) to our local partners.

Second, the NFPNSO provides technical assistance to local sites on quality improvement and building a community of practice. In that role, the NSO reviews those evaluation data to determine where individual local programs are thriving and where they need assistance. Regular consultation calls with local NFP nurse supervisors focus on interpreting the data and determining strategies for improving program performance, both in nursing practice with families and in program administration or management. NFPNSO provides assistance to local sites on tracking program implementation and collaborates with site administrators toward solutions where improvement is needed. Therefore, help is provided to local sites can on how the data can be used.

Finally, the National Service Office gathers input at the front end as well. Currently, data collection changes are underway largely in response to what we have heard from the field—changes requested by local supervisors and nurses. The NFP NSO balances requests from the local sites with the expertise of our NSO staff and our research partners to guide the data collection process. This is an ongoing process—we continue to collect feedback from the field, review these findings internally and with the experts, and revise our data collection and reporting system as needed.

In conclusion, the Nurse-Family Partnership data collection and evaluation process is a dynamic and responsive system that is tailored to both the best science and how best to meet the practical needs of our provider partners on the ground. One of the central features of this system is the ability to provide reports in real-time to our local partners. Ongoing, regular communication between the providers and the data team is an essential component of the NFP system that ensures relevance to providers. Another essential feature is the detailed nature and scientific rigor of the data collected.

[Newspaper article submitted by Mrs. Ridge follows:]

[From the Columbus Dispatch, September 3, 2006]

Nurse-family Partnerships Coming to Columbus

The newest Nurse-Family Partnership site will be at Children's Hospital's Center for Child and Family Advocacy.

The partnership provides nurses who try to teach young, poor, first-time mothers how to be good parents and, in turn, improve the health of their children. It seems to be a perfect fit at the center, said Dr. Philip Scribano, the center's medical director.

The center focuses on the treatment and prevention of child abuse and domestic violence, and it was looking for a home-visiting program that fit its goals, Scribano said.

A nurse visits a woman in her home during her pregnancy and continues until her child turns 2. Those visits often create close relationships, so that nurses have influence in their clients' lives.

"The client needs to trust that this person has her best interest at heart," Scribano said.

The center chose the Nurse-Family Partnership instead of other home-visiting programs because of how rigorously it studies itself in an effort to improve, he said.

The partnership has collected data since its beginning in 1977 to see how well it does its job. Longterm studies at the first site in Elmira, N.Y., as well as in Memphis, Tenn., and Denver have found that the partnership improves the lives of the mothers and children.

The Columbus site will add to that knowledge, David Olds, the founder of the Nurse-Family Partnership, said in a presentation to Columbus-area social-service and health agencies last week.

The Columbus site will contribute heavily to a Nurse-Family Partnership study on domestic violence, which will try to find ways to decrease violence among clients, said Jack Stevens, a Children's Hospital psychologist who will be the Columbus site's principal investigator.

Columbus will have Ohio's fourth partnership site, but it will be funded differently from those in Cincinnati, Dayton and Hamilton.

Those sites get most of their money through Help Me Grow, a state Health Department program. That funding is steady, but it requires more paperwork and client oversight than the Columbus program.

The Columbus site will cost $1.3 million for the first three years. The money is coming from the Columbus Foundation, Cardinal Health, Central Benefits Health Care Foundation and the federal government.

One of the Columbus program's challenges, officials said, will be to find money after those first three years.

"We would not be starting this program unless we believed we could sustain it," said Yvette McGee Brown, president of the Center for Child and Family Advocacy.

For the first three years, the Columbus site will have four nurses and one supervisor. Each nurse will have no more than 25 clients, which is what the Nurse-Family Partnership wants. (The 15 nurses in Dayton have more than 30 clients each).

The mothers will be identified through Ohio State University Medical Center, which already has 800 potential clients.

"Demand will exceed capacity," Scribano said.

The Columbus site is hiring nurses, he said, and should be operating by November.

[Additional material submitted by Ms. Scovell follows:]

Supplemental Testimony of Ms. Scovell in Responses to Questions Submitted by Congressman Davis

Question 1—When I explain home visiting to people, some people have asked how home visiting is useful given that most families work and won't be at home. What have your experiences revealed about how these programs work given parental work schedules?

Parents as Teachers parent educators routinely meet with families during the day, in the evenings and on weekends to better accomodate busy parents' work schedules. This flexibility encourages both parents, if available, and other family members to participate in the home visit. Furthermore, our parent educators are

available to conduct personal visits outside of the home, at alternate locations, that are most convenient for the family.

In rural Sussex County, Delaware we have many parents doing seasonal work on farms or at the shore and some parents who do shift work in the poultry industry. One of the most important elements of home visiting is the development of a trusting, reciprocal relationship between the home visitor and parent. We sometimes refer to this as "the dance". Once a relationship is established, scheduling a time to meet becomes less complicated because both the home visitor and parent are flexible with their time in order to assist one another. Times for home visits may change from month to month depending on the parents, and the home visitor's, schedule.

Question 2—As you know, the Education Begins at Home Act has a required data collection and evaluation component. From your experiences, how best can we ensure that the data we collect is most helpful to the providers?

Data collection and analysis already play a critical role in Parents as Teachers service delivery, so I fully support the data collection and evaluation component of the Education Begins at Home Act. On the local level, the data we collect helps us better understand the characteristics of the families we are serving which in turn helps us identify opportunities to enhance services to families or reach out to other cohorts of families. Evaluation helps us achieve our goal of continuously improving the quality of our service delivery so that it aligns with Parents as Teachers quality standards. Collecting data from other home visiting programs would provide us with valuable benchmarking information, both nationally and locally, that would further enhance our ongoing quality improvement goals.

I feel strongly that information on quality and outcomes should be collected in an efficient and streamlined way with maximum support and resources for service providers. To this end, I think it is critically important to get the input of the frontline home visitors when determining the data collection and evaluation requirements. Local programs do not want multiple or redundant data reporting mechanisms that ultimately take time away from serving families. Furthermore, it would be ideal if the data could be summarized in real time so we can access the data on an ongoing basis which will allow us to respond more quickly to the needs of families, rather than relying on outdated data.

Finally, I believe it is important to collect data that connects directly to the true objective of the Education Begins at Home Act—school readiness and parental involvement. Parent educators across the country can provide vivid examples of how they have made a difference in parents' and children's lives—increasing children's school readiness and promoting parent involvement in their children's education. We now look forward to the opportunity to measure and demonstrate these outcomes for the Education Begins at Home Act.