Testimony to House Human Services Committee

February 13, 2020

Home Visiting (H.778)

My name is Chloe Learey, I am the Executive Director of The Winston Prouty Center for Child and Family Development in Brattleboro. The Prouty Center is the fiscal agent and primary provider for Children's Integrated Services in the Brattleboro AHS region, and we subcontract with our local designated agency, HCRS, for some early childhood family mental health services. Prouty also holds contracts for providing other community-based services including Family Supportive Housing, and Community Child Care Support Services, which includes eligibility determination for childcare financial assistance and childcare referral services. Our Early Learning Center provides early education to 60 children, infants through age 5.

Winston Prouty is not the Parent Child Center in the region, although we look very similar to some of the PCCs.

I am thrilled to see House Bill 778 and the recognition that home visiting services for families with young children is a key strategy for building strong families by giving parents skills and resources for supporting optimal development. I am also proud of the fact that Vermont has created a home visiting system in Children's Integrated Services, and that we can build on this system to achieve our goals. I understand that Breena Holmes and Morgan Cole described the CIS Strong Families framework in testimony to this committee last week, describing the continuum of home visiting services which includes

Universal Home Visiting, Responsive Home Visiting and Sustained Home Visiting.

The Winston Prouty Center currently provides Responsive Home Visiting services through CIS. We have 2 part-time maternal child health nurses and 3 part-time family support workers. This is short-term (3 months to 1 year) support which meets families where they are and flexibly responds to a diversity of needs, from breastfeeding to budgeting, fuel assistance to finding childcare.

We also have staff trained in 2 Sustained Home Visiting models, which is the longer-term, evidence-based approach. We do not currently implement these models for 2 different reasons. First, Maternal Early Childhood Sustained Home visiting (MECSH), a nurse-based model, is part of CIS and designated by the Vermont Department of Health to be implemented by Visiting Nurse Associations.

The other Sustained Model is Parents as Teachers or PAT, a social work based model, which we are not using because it was not a good fit for the families that we find ourselves serving. Sustained home visiting models like PAT have set curriculums and formats to follow, which are evidence-based and great, but are not always easy to use when families are worried about meeting basic needs and making choices between paying electric bills and putting food on the table or facing issues like homelessness.

We have found that Responsive Home Visiting is better able to meet the diversity of family needs in such situations while still finding opportunities to help parents support their child's development. Lynn Kemp, who developed MECSH, calls this "parenting well despite the circumstances."

The system of care for families with young children is well integrated in our region, and CIS home visiting works closely with many partners to make this so. For instance, our nurses coordinate the New Moms group at the local hospital and participate in pregnancy groups at our local obstetrician's office. Our 2 pediatric practices have a primary CIS Family Support Worker contact so we can coordinate care, and our CIS coordinator is embedded at The DCF Family Services Division office each week for a half day to facilitate communication around families we share.

Ideally, we have a robust continuum of integrated services that include the range from universal to responsive to sustained home visiting. CIS is the model that we have chosen as a state to make this vision a reality, and we need to continue investing in the model if we want it to be a strong foundation on which to build the continuum. Right now there are 2 ways the foundation needs bolstering: we need a data system and we need to pay an adequate case rate.

We currently track CIS data by hand via spreadsheets. It is both inefficient and prone to inaccuracies from human error. Through the lens of Results Based Accountability (RBA) we do a lot of counting "how much" (i.e. how many people served), a little bit of "how well" (i.e. meeting timelines) and less of "is anybody better off" in a way that is more measurable than the narratives regions provide with 6-month reports. I know CIS has a positive impact. How can we measure our outcomes fully if we do not have a good, electronic data collection system?

Second, we know we are underfunding the CIS system based on information from the Burns and Associates study. The recommended

case rate is $634, and the state can only pay $502 based on the existing budget. How do we expect our system to be strong if we are not adequately funding it at the baseline? Children's Integrated Services is the base for home visiting in Vermont and if we do not provide the resources needed to maintain the foundation it will not matter what we build on top.

One of the greatest strengths of CIS is that it is a flexible model that can accommodate regional differences, and it is how we provide care and services in the real world to real families. We can standardize the desired outcomes we want to achieve through home visiting without dictating how services are delivered – for instance, what the balance of service is or which models of home visiting are implemented and where. If we use this funding to invest in one specific model we risk perpetuating some of the existing flaws which undermine CIS.

We will not be able to leverage this strength unless we have a data system that tracks outcomes in a standardized way, and unless we invest in the underlying CIS structure we have already created. It is a good system which can be made better if we give it the resources it needs.

I welcome any questions you may have.