Heather Wilson, Parent Child Center of Northwestern Counseling & Support Services

Overview

Members of the House Committee on Human Services, thank you for inviting my testimony today.

I am here today in response to bill H.778 introduced by Representatives Pugh and Brumsted. This bill proposes appropriating $1 million for the delivery of home visiting services. This amount could strengthen existing home visiting services for the early childhood population through Children's Integrated Services (CIS), but most importantly, it would allow for expansion of a robust service delivery of the home visits delivered by Parent Child Centers (PCCs) throughout the state.

I sit before you to provide information regarding the home visiting services provided by Parent Child Centers across the state of Vermont. First I will speak to the CIS home visiting service that could be impacted by H.778 through examples from my PCC, and secondly I will share information regarding the capacity for general home visiting services outside of CIS that are provided by all Parent Child Centers, using an example of an innovative approach unique to St. Albans.

CIS Strong Families Vermont

The home visiting through CIS is known as Strong Families Vermont. Strong Families Vermont has three components: sustained home visiting, responsive home visiting, and universal home visiting. CIS has been working on developing sustained home visiting, which they hope to be advanced with funds from H.778. CIS has not yet implemented universal home visiting, though it is listed on their continuum; however, PCCs offer universal home visiting, which is individualized in each region. In my region of Franklin/Grand Isle, sustained home visiting is offered by nurses from Franklin County Home Health Agency and family support workers from the PCC of NCSS.

Strong Families Vermont is working to establish two evidence-based sustained home visiting models for families. The two current models are the MECSH nursing model (Maternal Early Childhood Sustained Home-visiting) from Australia and the PAT family support model (Parents as Teachers) from St. Louis. MECSH allows for enrollment during pregnancy and up to 6 weeks postpartum. PAT allows for enrollment during pregnancy and through age 5. Both services are designed to be long-term, approximately two years in length.

There has been significant work to promote and expand MECSH, the nursing evidence-based model, throughout Vermont by the Department of Health and the Department for Children and Families Child Development Division. MIECHV (Maternal, Infant, and Early Childhood Home Visiting) funds are separate from the CIS bundle. These separate funds have provided a strong base for the MECSH program to grow, to ensure widespread training for supervisors and practitioners, and promotion through outreach materials and unique branding. Our home health agencies and home visiting nurses are well supported, fiscally and programmatically, and wish to continue to see their service strengthen and expand.

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The family support service through Strong Families Vermont is in need of this type of support, which the state CIS team is hoping could be provided by the funding proposed by H.778. I would love to see the same level of attention received by MECSH with promotion of the program through branded materials and outreach. Sustainable funding has been our biggest challenge. Only 3 of the 15 parent child centers across Vermont have been able to maintain PAT affiliate status. PCCs are impacted by the training requirement for supervisors and home visitors, and the result of staffing turnover. My team has been a part of two PAT training efforts, in the fall/spring of 2016/2017and the fall/winter of 2018. I only have 3 out of 7 trained home visitors still in their positions, and I also lost a trained administrator. These challenges have resulted in parent child centers not being able to provide PAT to fidelity, as well as a very small number of families being served by the model. This is frustrating as I believe PAT is an excellent home visiting model with strong outcomes for children and families, and a subsequent strong return on investment.

At NCSS, the majority of Strong Families Vermont home visits are actually Responsive Home Visiting, rather than PAT. This is in part due to the training issues previously described. Responsive Home Visiting does not require certification for home visitors or supervisors, a specific curriculum, and allows for time-limited responses. Families receive home visits from qualified staff with a family support lens to address social contributors (or determinants) of health, child development, and parenting. Caseload numbers are high in our region for this service as I am able to have all my staff provide these types of supports. Responsive Home Visiting is the family support service delivery used by Parent Child Centers with CIS contracts who do not offer PAT. Unlike nursing services, the state CIS team has not mandated a specific evidence-based home visiting model for Strong Families Vermont: Family Support Home Visiting. While our region could not train all home visitors on my team, we were very interested in embracing PAT when the model was announced, and I have dedicated time to support my home visitors and playgroup staff to ensure we are providing the PAT service with fidelity to the model.

<u>HEART Program at the PCC of NCSS</u>

In St. Albans, we realized the need to expand our programming beyond the home visiting offered through CIS. All Parent Child Centers are able to provide home visiting, as one of our core services, outside of CIS contracts. We are able to be responsive to community need. In St. Albans, that has meant developing our ability to provide universal home visiting regardless of Medicaid status and other factors.

In 2013, we collaborated with Franklin County Home Health Agency who reported a trend in high numbers of postpartum mothers screening positive for mental health needs. It was necessary to be innovative with our service delivery, which was made possible with the flexibility of our Integrating Family Services (IFS) pilot. We also needed to pursue professional development in perinatal mental health and that fall, we trained two staff, myself included, in Postpartum Support International (PSI): Components of Care. We created a pilot to offer mental health counseling in the home for perinatal

mothers, regardless of insurance, from May 2014-April 2015. Our referrals mostly came from home health and the Vermont Department of Health WIC program.

In another year, we had decided to allocate a permanent clinician position through IFS to provide this needed service. Our licensed mental health counselor has been in this role since 2016, and we have seen referrals steadily increase. We have expanded to include another clinician to pick up additional referrals, and anticipate the number of permanent clinician roles will grow in the future.

As our perinatal counseling referrals grew, so did our realization that we needed to find a way to respond to more families in an upstream, preventative manner to address the rates of postpartum depression, anxiety, and related disorders. This led to the creation of our HEART Program. HEART, Helping Everyone Access Resources and Thrive, is a *universal* home visiting program to support caregiver mental health during the perinatal period (pregnancy and the year postpartum). Our tagline, "Support for families, from hospital to home," covers a variety of needs and situations. HEART is for any person living in Franklin or Grand Isle counties who is pregnant, has given birth, experienced a loss, and/or is caring for a newborn baby in any capacity. HEART now includes four features 1) HEART Counseling 2) Perinatal Specialists who provide postpartum doula support 3) HEART for Youth for pregnant and parenting adolescents and 4) HEART Support Groups, free and open to any community member.

We have worked to strengthen the HEART Program through a variety of certifications and trainings. Our program supervisors and staff have certifications or training in the following areas: PSI, Dialectical and Behavior Therapy, Interpersonal Therapy, Newborn Behavioral Observation, Parents as Teachers, and Childbirth and Postpartum Professional Association. Our entire program will be certified at the end of the month in the Mothers & Babies model, an intervention based on cognitive behavioral therapy and attachment therapy that can be incorporated into existing home visits.

<u>Closing Statement</u>

Before closing, I think it is important to realize that H.778 sits amidst a few other related legislative requests. Currently the proposed Parent Child Center bill would reopen the statute to allow the network to be strengthened with a funding formula and an accountability structure for quality across the state. We have been certified in the Standards of Quality for Family Strengthening & Support, which will be added to all our other program measures such as contract performance measures and our unique peer review process. We are also advocating for an increase to our master grant over three years, to ensure all Parent Child Centers can continue to deliver critical and essential state services. We are requesting an additional $4million this year to increase our master grant base, as well as $1.5million in one-time funding to "catch-up" on deferred administrative and maintenance expenses that have resulted from decades of underfunding. PCCs are an underfunded resource that are excellently positioned to provide treatment and support through home visiting, and should be considered a recipient for any available funds.

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Another element is the advocacy for Children's Integrated Services in general. A recent impartial analysis determined that our new contracts are well below the actual cost of services by 21%. $2.4million is needed to cover the cost revealed by this study, and ensure that CIS agencies (PCCs, home health agencies, and designated mental health agencies) have the financial support needed for staffing and administrative costs.

If these efforts are successful in first shoring up the foundation of Parent Child Centers and then CIS, I believe H.778 will be better posed to make a significant impact for families. H.778 could provide much needed funding for the state Children's Integrated Services team to strengthen the current state of home visiting during pregnancy and the early childhood years. H.778 could allow for an expansion of their successful nursing model, but most importantly, it would allow for the fiscal support and technical assistance necessary for the Parent Child Center Network to fully implement an evidence-based home visiting model with a family support perspective for families, from pregnancy through age five.