Tennessee Home Visiting Programs Annual Report

July 1, 2014 – June 30, 2015

Tennessee Department of Health
Division of Family Health and Wellness
710 James Robertson Parkway
8th Floor, Andrew Johnson Tower
Nashville, TN 37243

ANNUAL HOME VISITING REPORT
FOR FISCAL YEAR 2015

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STATE OF TENNESSEE
DEPARTMENT OF HEALTH

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

BILL HASLAM
GOVERNOR

MEMORANDUM

To: The Honorable Bill Haslam, Governor
The Honorable Ron Ramsey, Lieutenant Governor
The Honorable Beth Harwell, Speaker of the House
Honorable Members of the Tennessee General Assembly

From: John J. Dreyzehner, MD, MPH, FACOEM
Commissioner

Date: February 23, 2016

RE: Annual Report for Home Visiting Programs

As required by Tennessee Code Annotated 68-1-125, 37-3-703 and 68-1-2408 the ***Tennessee Department of Health Annual Report – Home Visiting Programs*** for July 1, 2014 – June 30, 2015 is hereby submitted. The report reflects the status of efforts to identify, implement and expand the number of evidence-based home visiting programs throughout Tennessee.

The report includes process and outcome measures used to evaluate the quality of home visiting services offered to participating families. Measures from individual programs including the number of people served, the types of services provided, and the estimated rate of success in meeting specific goals and objectives are also included.

A total of 3,476 children and their families received home visiting services from July 1, 2014 – June 30, 2015 through evidence-based, research-based, or "promising approach" home visiting programs. All of these programs support families with young children through frequent visitation in their home (weekly, bi-weekly or monthly) over a substantial length of time (one to five years). Each of the programs has different enrollment criteria and model of service delivery which results in different outcomes for participants. Impacts found include improvements in maternal and newborn health, school readiness, decreased domestic violence and decreased child abuse and neglect. *It is also noteworthy, while not a home visiting program, the TDH supports another care coordination program directed at families called HUGS (Help Us Grow Successfully). This program has a home visiting component that provided 7,357 individuals in all 95 counties with opportunities to improve pregnancy outcomes as well as maternal and child health and wellness during FY15.*

The Department collaborates annually with the Tennessee Commission on Children and Youth (TCCY) to prepare this report. Ongoing partnerships with TCCY and other interested parties have strengthened the scope and quality of home visiting services available to Tennessee children and families.

This report will also be made available via the Internet at http://www.tn.gov/health/article/home-visitation-reports

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MEMORANDUM

TO: The Honorable Bill Haslam, Governor
The Honorable Ron Ramsey, Lieutenant Governor
The Honorable Beth Harwell, Speaker of the House
Honorable Members of the Tennessee General Assembly

FROM: Linda O'Neal, Executive Director

DATE: December 2015

RE: Annual Report for Home Visiting Programs

As required by Tennessee Code Annotated 68-1-125, 37-3-703 and 68-1-2408, the Tennessee Commission on Children and Youth (TCCY) has consulted with the Tennessee Department of Health in the submission of this ***Tennessee Department of Health Annual Report – Home Visiting Programs*** for July 1, 2014 – June 30, 2015.

TCCY is a strong supporter of quality home visiting programs as critical infrastructure for improving outcomes for vulnerable children and families. The primary recipients of home visiting programs in Tennessee are high-risk families, especially families in poverty and with high levels of stress that place children at risk of abuse or neglect and developmental deficits. Evidence-based and Promising Approach home visiting programs should be an integral part of strategic efforts to improve outcomes for Tennessee's youngest children. They are one of the most fundamental strategies for effective state efforts to prevent when possible and ameliorate the impact of Adverse Childhood Experiences (ACEs) when they cannot be prevented.

Brain development research makes clear the value of investing in young children. Now is a critical time for two state-funded home visiting programs, Child Health and Development (CHAD) and Healthy Start, as both currently operate primarily with non-recurring dollars. The preservation of these vital programs is essential to avoid eroding the foundation of services/opportunities for some of Tennessee's most vulnerable children and families to receive quality home visiting services. TCCY budget recommendations for FY 2017 encourage the restoration of these funds to full recurring status.

The information in this report documents the improved outcomes for children receiving home visiting services and the cost effectiveness of these programs relative to the cost of state custody for children who experience abuse or neglect. The Department of Health has made significant strides in quality home visiting in recent years that should be applauded, supported and expanded.

The Commission on Children and Youth is committed to efforts to maintain, improve and expand quality home visiting programs in Tennessee. They are a wise investment in Tennessee's future.

Executive Summary

The early years of life matter because the basic architecture of the human brain is constructed through an ongoing process that begins before birth and continues into adulthood. Like the construction of a home, the building process begins with laying the foundation, framing the rooms and wiring the electrical system in a predictable sequence. Early experiences literally shape how the brain gets built, establishing either a sturdy or a fragile foundation for all of the development and behavior that follows. A strong foundation in the early years increases the probability of positive outcomes. A weak foundation increases the odds of later difficulties, and getting things right the first time is easier than trying to fix them later. Home Visiting programs have been scientifically proven to improve outcomes for children by supporting a strong and solid foundation. Home Visiting is a critical component of a high-quality system which serves as a solution to many of the long-standing and nagging challenges faced as a state in our health, mental health, social services, child protection, and juvenile and criminal justice systems.

The Tennessee Department of Health (TDH) has successfully administered home visiting services since 1979. Currently, TDH administers home visiting programs across the state through contractual arrangements with local community-based agencies and local health departments. Evidence-based home visiting programs are not available in all counties across the state and capacity to serve the population of children under the age of five varies in the counties where services are available. As additional funding becomes available, TDH is committed to the implementation of evidence-based home visiting programs, where sufficient evidence of need exists to implement such programs.

A total of 3,476 families received services from one of the evidence-based, research-based or "promising approach" home visiting programs administered by TDH during the period of July 1, 2014 through June 30, 2015. Each of the programs has different enrollment criteria and model of service delivery which results in different outcomes for participants. All programs support families with young children by frequently visiting them in their home (weekly, bi-weekly or monthly) over a substantial length of time (one to five years). Impacts found include: improved immunization status of children; decreased child abuse and neglect; increased breastfeeding initiation; decreased smoking by mothers; increased screening of child development; and delayed subsequent pregnancies by mothers receiving services.

TDH is also utilizing the federal investment in evidence-based home visiting to implement the Welcome Baby Initiative which provides universal outreach to all new parents and provides an outreach contact to the highest risk children while expanding evidence-based home visiting programs in the most at-risk counties. Acknowledging that not all families require home visiting services, TDH has reviewed and developed clear distinctions of evidence-based home visiting programs' purposes and intensities to provide a continuum of early childhood services that assure families can receive "the right service at the right time".

TDH is working to assure key components of successful home visiting programs are in place, including well-administered programs, a competent workforce, robust data collection systems, and strong community partnerships. The Department looks forward to continued success and collaboration with other public and private partners in order to improve child health and well-being and support parents in the very important work of helping their children become healthy and successful.

Background

This report is submitted in compliance with the statutory requirements for a status report on evidence-based home visiting (TCA 68-1-125), Healthy Start (TCA 37-3-703), and the Nurse Home Visitor Program (TCA 68-1-2408). Additionally, this report provides a status report on the federal Maternal, Infant and Early Childhood Home Visiting Program and the state Child Health and Development Program in order to provide comprehensive information about all of the home visiting programs administered by the Tennessee Department of Health.

TCA 68-1-125 requires the Tennessee Department of Health (TDH) to annually review and identify the research models upon which the home visiting services are based, to report on the outcomes of those who were served, and to identify and expand the number of evidence-based programs offered through TDH in the state. The statute further states TDH shall work in conjunction with the Tennessee Commission on Children and Youth (TCCY) and other experts to identify those programs that are evidence-based, research-based and theory-based and report such findings to the Governor and specific committees of the state legislature in January of each year.

TCA 37-3-703 established the Healthy Start Pilot Program based on the national model and states that the program must be implemented in ten (10) or more counties of the state. The program focuses on improving family functioning and eliminating abuse and neglect of infants and young children in families identified as high risk.

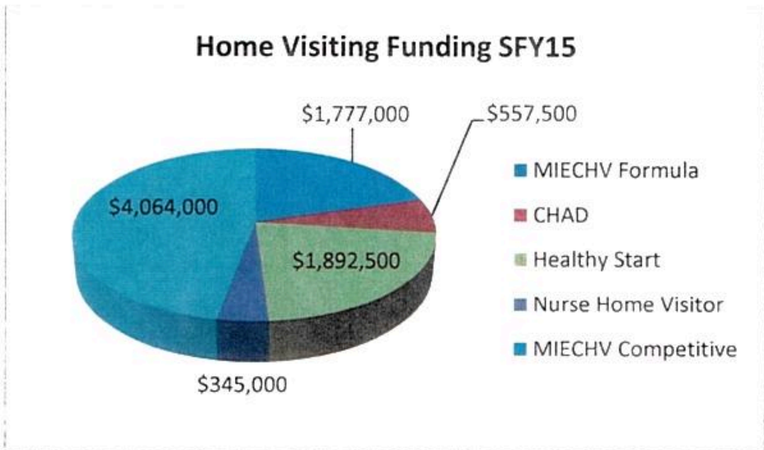
TCA 68-1-2408 established the Nurse Home Visitor Program based on the national evidence-based model known as the Nurse Family Partnership. Home visiting nurses carry a small caseload and enroll first time pregnant women for service prior to the 28th week of pregnancy and continue services up to the child's second birthday.

The federal Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) authorized the Maternal, Infant and Early Childhood Home Visiting Program which is jointly administered by the U.S. Department of Health and Human Services (HHS) and State of Tennessee. The purpose of this program is to (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. The statute reserves the majority of funding for the delivery of services through use of one or more evidence-based home visiting service delivery models. In addition, it supports continued innovation by allowing up to 25 percent of funding to be used for services that are promising approaches and do not yet qualify as evidence-based models.

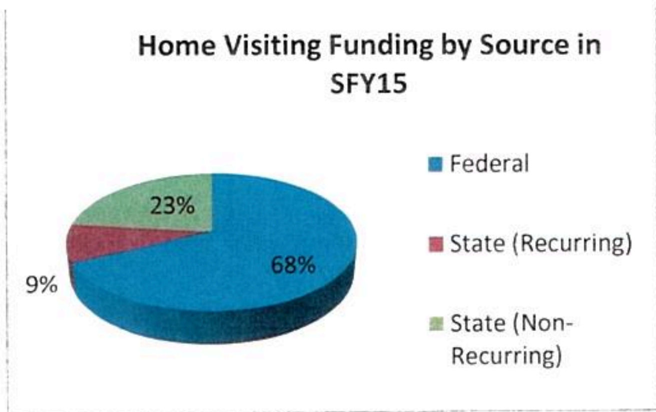
TCA 68-1-125 excludes any Medicaid-funded disease management or case management services or programs that may include home visits from being classified as home visiting programs. As such, the Help Us Grow Successfully (HUGS) Program funded by TennCare and administered by the TDH is not included in this report.

In Tennessee, home visiting programs are funded through a variety of funding sources from both state and federal funds. Funding for State Fiscal Year 15 includes:

1. State funding of $1,892,500 ($1,500,000 Non-Recurring plus $392,500 Recurring) for the Healthy Start Home Visiting Program;
2. State funding of $345,000 for the Nurse Home Visitor Program;
3. State funding of $557,500 ($450,000 Non-Recurring plus $107,500 Recurring) for the Child Health and Development Program; and
4. Federal funding of $5,841,000 for the Maternal, Infant and Early Childhood Home Visiting Program (Inclusive of both the formula grant and competitive grant).



The following demonstrates the distribution of funds between federal and state sources (distinguishing recurring and non-recurring funds):



Introduction to Home Visiting Programs

The early years of life matter because the basic architecture of the human brain is constructed through an ongoing process that begins before birth and continues into adulthood. Like the construction of a home, the building process begins with laying the foundation, framing the rooms and wiring the electrical system in a predictable sequence. Early experiences literally shape how the brain gets built, establishing either a sturdy or a fragile foundation for all of the development and behavior that follows. A strong foundation in the early years increases the probability of positive outcomes. A weak foundation increases the odds of later difficulties, and getting things right the first time is easier than trying to fix them later.

The interactive influences of genes and experience shape the developing brain. The active ingredient is the "serve and return" relationship between a child and his parents and other caregivers in his family or community. Like the process of serve and return in games such as tennis and volleyball, young children naturally reach out for interaction. This process starts in infancy – with facial expressions and babbling – and continues throughout the early years. If adults do not respond to the child's attempts at interaction, the child's learning process is incomplete. This has negative implications for later learning. But when children develop in an environment of relationships that are rich in responsive, back-and-forth interactions, these brain-building experiences establish a sturdy architecture on which future learning is built.

Just as a rope needs every strand to be strong and flexible, child development requires support and experiences that weave many different capacities together. Cognitive, emotional and social capacities are tightly connected in the brain. Language acquisition, for example, relies on hearing, the ability to differentiate sounds, and the ability to pay attention and engage in social interaction. Science therefore directs us away from debating which kinds of skills children need most, and toward the realization that they are all intertwined.

Science also points us to pay attention to factors that can disrupt the developmental periods that are times of intense brain construction, because when this activity is derailed, it can lead to lifelong difficulties in learning, memory and cognitive function. Stress is an important factor to consider. Everyday challenges, like learning to get along with new people or in new environments, set off a temporary stress response that helps children be more alert while learning new skills. But truly adverse childhood experiences – severely negative experiences such as the loss of a parent through illness, death or incarceration; abuse or neglect; or witnessing violence or substance abuse – can lead to a toxic stress response in which the body's stress systems go on "high alert" and stay there. This haywire stress response releases harmful chemicals into the brain that impair cell growth and make it harder for brain cells to form healthy connections, damage the brain's developing architecture and increase the probability of poor outcomes. This exaggerated stress response also affects health, and is linked to chronic physical diseases such as heart disease and diabetes.

Science tells us that many children's futures are undermined when stress damages the early brain architecture. But the good news is that potentially toxic stressors can be made tolerable if children have access to stable, responsive adults. The presence of good serve-and-return acts as a physical buffer that lessens the biological impact of severe stress.

The factors children are exposed to affect how well they progress, and communities play a big role. A child's wellbeing is like a scale with two sides; one end can get loaded with positive

things, while the other end can get loaded with negative things. Supportive relationships with adults, sound nutrition and quality early learning are all stacked on the positive side. Stressors such as witnessing violence, neglect or other forms of toxic stress are stacked on the other. This dynamic system shows us two ways we can achieve positive child outcomes: to tip to the positive side, we can pile on the positive experiences, or we can offload weights from the negative side. Children who are exposed to toxic stress are carrying a heavy negative load, and to tip these children toward the positive, innovative states and communities have been able to design high-quality programs for children to prevent adverse childhood experiences whenever possible, and respond to them with strong, nurturing supports to ameliorate their impact when they cannot be prevented. These programs have solved problems in early childhood development and shown significant long-term improvement for children.

As Tennesseans understand the impact of adverse childhood experiences, they recognize the importance of critical programs such as home visiting programs. Voluntary, evidence-based home visiting services have been identified as one of the most effective and cost-effective interventions to help parents support their young children's health and development, strengthen family functioning, and prevent adverse childhood experiences such as child abuse and neglect. In a home visiting program, trained professionals provide regular, voluntary home visits to expectant and new parents over time to assess child and family risks, provide health and developmental screenings and guidance, and provide referrals to other supports and services offered in the community. Evidence-based home visiting programs have been shown to result in improved maternal and child health in the early years; long-lasting, positive impacts on parental skills; and enhanced children's cognitive, language, and social-emotional development; all necessary for children to thrive during the early school years and throughout life.

Additionally, leaders in the State of Tennessee are committed to exploring a new and powerful idea for addressing systemic, persistent poverty in the state: a "two-generation" approach that seeks to address the needs of both vulnerable children and parents together. This approach serves both children and their parents with an array of services, supports, and learning and empowerment opportunities – all geared toward helping families envision and achieve brighter futures. In particular, evidence suggests that a two-generation approach focused on education, economic supports, social capital, and health and well-being has the potential to generate significant financial stability outcomes for low-income families.

Home visiting is a critical component of a two-generation approach that puts the whole family on a path to economic security as it is one of the only programs that focuses both on children and adults simultaneously. Because physical and mental health have a major impact on a family's ability to thrive and succeed, home visitors are uniquely positioned to address a parent's immediate health and well-being needs while fostering positive growth and development of their children. Home visiting has been shown to positively influence a parent's economic situation by focusing on not only job attainment, but also planning for a career and supporting further educational attainment. By helping parents create a better future for their child, home visiting programs are supporting parents to become greater contributors to society, build their own strong and stable families, and bolster communities and the economy.

Home visiting is a sound investment in our society's future which is confirmed by brain science. It improves outcomes for children now, and is a significant foundation for solutions to many of the long-standing and nagging challenges we face as a state in our health, mental health, social services, child protection, and juvenile and criminal justice systems.

Home Visiting Services Administered by the Department of Health

The Tennessee Department of Health (TDH) has successfully administered home visiting services since 1979. Since that time, several home visiting programs have been established utilizing a variety of approaches to meet the unique needs of Tennessee communities.

Currently, TDH administers home visiting services through contractual arrangements with community-based agencies or county health departments. The home visiting programs administered by TDH are categorized as evidence-based, research-based or a promising approach.

Evidence-based: As defined in TCA 68-1-125 means the program or practice is governed by a program manual or protocol that specifies the nature, quality and amount of service that constitutes the program and scientific research using methods that meet high scientific standards, evaluated using either randomized controlled research designs, or quasi-experimental research designs with equivalent comparison groups. The effects of such programs must have demonstrated using two (2) or more separate client samples that the program improves client outcomes central to the purpose of the program. This aligns closely with how evidence-based is defined by the federal Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) which authorized the Maternal, Infant and Early Childhood Home Visiting Program.

Research-based: As defined in TCA 68-1-125 means a program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based.

Promising Approach: As defined by the federal Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) a program is a promising approach if it has little to no evidence of effectiveness or has evidence that does not meet the criteria for an evidence-based model. A "promising approach" must be grounded in relevant empirical work and have an articulated theory of change. A "promising approach" must have been developed by or identified with a national organization or institution of higher education and must have developed an evaluation plan with a well-designed and rigorous plan to measure impacts.

Within each of these three categories are a variety of models. Each of the models has a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. The name, description and classification of the home visiting models implemented in Tennessee are as follows:

Model Name	Category	Model Description
Healthy Families America (HFA)	Evidence-based	HFA is designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. The model is best equipped to work with families who may have histories of trauma, intimate partner violence, mental health, or substance abuse issues. HFA services begin prenatally or right after the birth of a baby and are offered voluntarily, intensively and over the long-term (3 to 5 years after the birth of the baby).
Nurse Family Partnership (NFP)	Evidence-based	NFP is designed to work with low-income women who are having their first babies. Each woman is enrolled prior to 28 weeks of pregnancy and paired with a nurse who provides her with weekly home visits throughout her pregnancy until her child's second birthday. The program's main goals are to improve pregnancy outcomes, children's

		health and development and women's personal health and economic self-sufficiency.
Parents as Teachers (PAT)	Evidence-based	PAT is designed to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness. Services include one-on-one home visits, monthly group meetings, developmental screenings, and a resource network for families.
Child Health and Development (CHAD)	Research-based	CHAD is designed to work with adolescent parents and families of young children who experienced or are at high risk of experiencing abuse and/or neglect. CHAD services can begin prenatally or any time prior to the child's 6th birthday. Intensity and length of service varies depending on family's needs.
Maternal Infant Health Outreach Worker (MIHOW)	Promising Approach	MIHOW is designed as a parent-to-parent intervention that targets economically disadvantaged and geographically and/or socially isolated families with children birth to age 3. The program is designed to improve health and child development among these families. MIHOW employs parents from the local community as outreach workers and role models, who educate families about nutrition, child health and development, and positive parenting practices. The outreach workers also provide links to medical and social services.
Nurses for Newborns	Promising Approach	Nurses for Newborns is designed to provide a safety net for families in order to prevent infant mortality, child abuse, and neglect. In response to referrals from medical centers, physician offices, clinics, social service agencies, and direct requests from families, Nurses for Newborns sends specially trained pediatric nurses to the homes of pregnant women or parents with infants who face medical, social, or environmental risks. Services are provided as needed, and may be provided for up to two years after the infant's birth.

Per TCA 68-1-125, TDH and any other state agency administering funds for home visiting programs must ensure 50 percent of the funds expended in 2012-2013 and 75 percent of the funds expended in 2013-2014 **and each year after** are used for evidence-based models.

As demonstrated in the below chart, **eighty-eight percent** of the funds expended in FY2015 were used for evidence-based models.

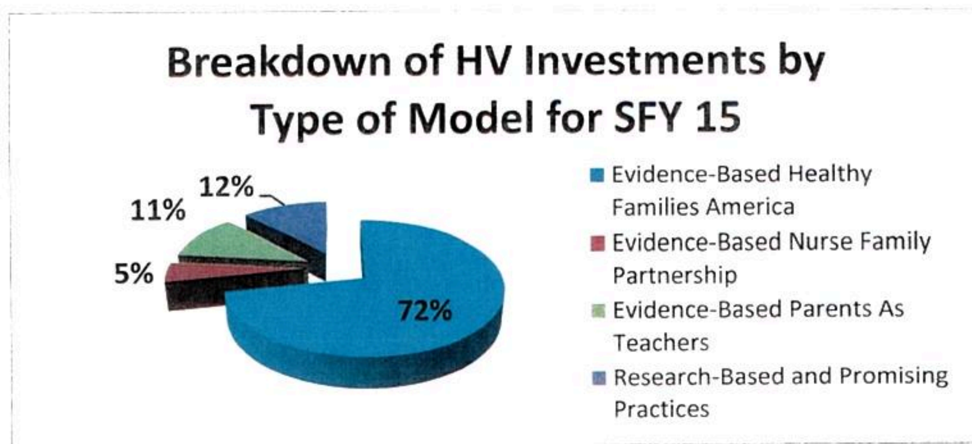


Table 1 summarizes Enrollment and Service Provision for each of the federal and state funded evidence-based, research-based and "promising approach" home visiting programs administered by TDH during FY2015 (July 1, 2014 - June 30, 2015).

Table 1. Summary of Home Visiting Program Enrollment and Service Provision

Funding Source: **FEDERAL**
Program Name: **MATERNAL, INFANT, & EARLY CHILDHOOD HOME VISITING (Formula funding)**
Funding Period: **July 1, 2014 through June 30, 2015**

Local Implementing Agency	Evidence-Based or Promising Approach Model	At-Risk County	Number Served to Date (as of 6/30/15)	Number of Home Visits	Annual Cost Per Child*
Nurses for Newborns Foundation	Nurses for Newborns (Promising Approach)	Davidson County (Promising Approach)	300	1398	$2250
Catholic Charities	Maternal Infant Health Outreach Worker (Promising Approach)	Davidson County (Promising Approach)	174	61	$2457
Helen Ross McNabb (formerly Child and Family Tennessee)	Nurse Family Partnership (Transitioned to Healthy Families America Model as of July 1, 2014)	Campbell County	79	383	$5067
Prevent Child Abuse Tennessee	Healthy Families America	Davidson County	117	1241	$3724
Chattanooga-Hamilton County Health Department	Parents as Teachers	Hamilton County	80	700	$3719
Centerstone	Healthy Families America	Maury County	76	320	$3731
LeBonheur Children's Hospital, Community Health and Well-Being	Healthy Families America, Nurse Family Partnership, & Parents as Teachers	Shelby County	61 (HFA) 25 (NFP) 100 (PAT)	1256 (HFA) 238 (NFP) 762 (PAT)	Across all Three Models $1513
Center for Family Development	Healthy Families America	Fort Campbell/ Montgomery County	57	527	$4108
		TOTALS	1069	6886	$3321

Table 1, continued. Summary of Home Visiting Program Enrollment and Service Provision

Funding Source: **FEDERAL**
Program Name: **MATERNAL, INFANT, & EARLY CHILDHOOD HOME VISITING (Competitive funding)**
Funding Period: **July 1, 2014 through June 30, 2015**

Local Implementing Agency	Evidence-Based Model	At-Risk County	Number Served to Date (as of 6/30/15)	Number of Home Visits	Annual Cost per Child*
Centerstone	Healthy Families America	Coffee	44	308	$1267
		Maury	33	111	
		Dickson	22	130	
		Lawrence	88	410	
The Exchange Club/ Holland J Stephens Center for the Prevention of Child Abuse	Healthy Families America	Cumberland	24	332	$3806
		Dekalb	25	273	
Helen Ross McNabb Center	Healthy Families America	Campbell	20	301	$2906
		Cocke	24	193	
		Sevier	54	470	
LeBonheur Children's Hospital, Community Health and Well-Being	Healthy Families America	Shelby	76	1099	$1778
LeBonheur Children's Hospital, Community Health and Well-Being	Parents as Teachers	Shelby	248	1830	
University of Tennessee (UT)-Martin	Healthy Families America	Dyer	28	244	$2942
		Lake	5	60	
		Lauderdale	14	187	
Prevent Child Abuse Tennessee (with a subcontract to Jackson-Madison County General Hospital in Hardeman, Haywood, Henderson and Madison counties).	Healthy Families America	Claiborne	9	106	$3910
		Davidson	104	975	
		Grundy	11	77	
		Hamilton	33	423	
		Hardin	12	86	
		Haywood	22	258	
		Hardeman	24	299	
		Henderson	23	201	
		Johnson	11	186	
		Madison	100	1123	
		Marion	5	14	
		McMinn	17	212	
		Monroe	12	182	
		Polk	4	120	
		Rhea	15	56	
		Scott	13	129	
		Sequatchie	4	0	

Local Implementing Agency	Evidence-Based Model	At-Risk County	Number Served to Date (as of 6/30/15)	Number of Home Visits	Annual Cost per Child*
		Totals	1124	10087	$2768

Funding Source: **STATE**
Program Name: **HEALTHY START**
Funding Period: **July 1, 2014 through June 30, 2015**

Local Implementing Agency	Evidence-Based Model	At-Risk County	Number Served to Date (as of 6/30/15)	Number of Home Visits	Annual Cost per Child*
Helen Ross McNabb	Healthy Families America	Jefferson	5	3378	$3491
		Knox	62		
		Hamblen	1		
The Exchange Club/ Holland J Stephens Center for the Prevention of Child Abuse	Healthy Families America	Putnam	28	1025	$3308
		White	20		
		Macon	4		
Jackson Madison County General Hospital	Healthy Families America	Madison	17	1199	$4020
LeBonheur Children's Hospital, Community Health and Well-Being	Healthy Families America	Shelby	65	2593	$3240
Metro Government of Nashville & Davidson County	Healthy Families America	Davidson	58	1967	$3800
Center for Family Development	Healthy Families America	Bedford	35	2464	$3256
		Franklin	16		
		Lincoln	19		
		Marshall	18		
		Montgomery	38		
University of Tennessee (UT)-Martin	Healthy Families America	Henry	9	1270	$3700
		Obion	19		
		Tipton	5		
Centerstone	Healthy Families America	Giles	15		$3800
		Hickman	12		
		Lewis	16		
Prevent Child Abuse Tennessee	Healthy Families America	Anderson	12		$3808
		Bradley	9		
		Union	6		
		Totals	489	13896	$3602

Table 1, continued. Summary of Home Visiting Program Enrollment and Service Provision

Funding Source: **STATE**
Program Name: **CHILD HEALTH AND DEVELOPMENT**
Funding Period: **July 1, 2014 through June 30, 2015**

Local Implementing Agency	Research-Based Model	At-Risk County	Number Served to Date (as of 6/30/15)	Number of Home Visits	Annual Cost per Child*
Anderson Co. Health Department	Child Health and Development	Anderson	28	199	Annual cost per child is estimated utilizing the state allocation divided by the total numbers served statewide. As such, county specific cost per child is not available.
Blount Co. Health Department	Child Health and Development	Blount	3	18	
Campbell Co. Health Department	Child Health and Development	Campbell	51	480	
Carter Co. Health Department	Child Health and Development	Carter	100	686	
Claiborne Co. Health Department	Child Health and Development	Claiborne	6	34	
Cocke Co. Health Department	Child Health and Development	Cocke	3	15	
Grainger Co. Health Department	Child Health and Development	Grainger	16	99	
Greene Co. Health Department	Child Health and Development	Greene	45	322	
Hamblen Co. Health Department	Child Health and Development	Hamblen	38	194	
Hancock Co. Health Department	Child Health and Development	Hancock	15	79	
Hawkins Co. Health Department	Child Health and Development	Hawkins	55	187	
Jefferson Co. Health Department	Child Health and Development	Jefferson	4	10	
Johnson Co. Health Department	Child Health and Development	Johnson	32	112	
Loudon Co. Health Department	Child Health and Development	Loudon	21	49	
Monroe Co. Health Department	Child Health and Development	Monroe	2	2	
Morgan Co. Health Department	Child Health and Development	Morgan	10	25	
Roane Co. Health Department	Child Health and Development	Roane	10	24	
Scott Co. Health Department	Child Health and Development	Scott	32	436	
Sevier Co. Health Department	Child Health and Development	Sevier	23	121	
Unicoi Co. Health Department	Child Health and Development	Unicoi	20	166	
Union Co. Health Department	Child Health and Development	Union	15	66	
Washington Co. Health Department	Child Health and Development	Washington	126	614	
		Totals	655	3938	$1023

Table 1, continued. Summary of Home Visiting Program Enrollment and Service Provision

Funding Source: **STATE**
Program Name: **NURSE HOME VISITOR**
Funding Period: July 1, 2014 through June 30, 2015

Local Implementing Agency	Evidence-Based Model	At-Risk County	Number Served to Date (as of 6/30/15)	Number of Home Visits	Annual Cost per Child*
LeBonheur Children's Hospital, Community Health and Well-Being	Nurse Family Partnership	Shelby	139	898	$3450
		Totals	139	898	$3450

Funding Source: **ALL STATE AND FEDERAL COMBINED**
Program Name: **ALL PROGRAMS**
Funding Period: July 1, 2014 through June 30, 2015

Total Number of Local Implementing Agencies	Categories and Models	Total Number of Counties With a Home Visiting Program	Total Number Served to Date (as of 6/30/15)	Total Number of Home Visits	Annual Cost per Child*
34	Evidence-based Programs: -Healthy Families America -Nurse Family Partnership -Parents as Teachers Research-based Programs: -Child Health and Development Promising Approach: -Maternal Infant Health Outreach Worker (MIHOW) -Nurses for Newborns	60	3476	35705	Range from $1023 to $5067

*Annual cost per child was calculated by dividing the agency's budget by the capacity of program (expected numbers to be served) during the state contract period.

Description of Home Visiting Programs

CHILD HEALTH AND DEVELOPMENT PROGRAM (CHAD)

The Child Health and Development (CHAD) program, the oldest home visiting program implemented by TDH, is designed to: 1) enhance physical, social, emotional, and intellectual development of the child; 2) educate parents in positive parenting skills; and 3) prevent child abuse and neglect. The program is offered in 22 counties in Northeast and East Tennessee through local public health departments and is staffed by health department employees. CHAD began as a research-based model based on the Demonstration and Research Center for Early Education model developed by Peabody College. All families can receive services from the birth of a child until the child turns 6 years of age.

The annual cost per family is $1,023.00. Funds to support this program come from State funds. CHAD was funded in FY2015 with mostly non-recurring dollars (that will be eliminated in FY2016 without continuation funding).

HEALTHY START

Healthy Start aims to reduce or prevent child abuse and neglect in enrolled families. Legislatively mandated by the Tennessee Childhood Development Act of 1994 (TCA 37-3-703), the Healthy Start program provides services in 23 counties through nine community-based agencies and staff employed by those agencies. Healthy Start is an evidence-based program based on the Healthy Families America model. Families at high risk of child abuse and/or neglect (as measured by the Kempe Family Stress Checklist) are eligible for enrollment in the program.

The Kempe Family Stress Checklist (KFSC) is a standardized instrument used by the Healthy Start program to measure indicators of stress and elevated risk for child abuse and neglect. Families whose stress scores are at or above the recommended cutoff level of 25 points are offered enrollment in the Healthy Start program. All 489 (100%) of the families receiving Healthy Start services were considered at risk for abuse/neglect based on the family KFSC score prior to initiation of service.

The annual cost per child is $3602. Funds to support this program come from State funds. Healthy Start was funded in FY2015 with mostly non-recurring dollars (that will be eliminated in FY2016 without continuation funding).

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING (MIECHV)

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is federal funding provided to states through a formula funded grant and competitive grants. TDH successfully applied and was awarded a three year competitive grant in 2012. Both

funding allocations are to be used to implement evidence-based home visiting programs in the most at-risk communities while strengthening the early childhood system. In 2010, Tennessee completed a statewide Needs Assessment related to home visiting services and utilized this information to develop an initial State Plan for expansion of home visitation services.

The formula MIECHV funding received in July 2011 supports services in five counties utilizing one of three evidence based models, including the Healthy Families America, Parents as Teachers, and Nurse Family Partnership models. As military families represented one of the priority populations in the legislation, one additional funded project is specifically targeting military families living off base in Montgomery County, where Fort Campbell Army Installation is located.

The Tennessee Department of Health was awarded two consecutive competitive MIECHV grants. These funds are being used to support evidence-based home visiting services in additional at-risk counties. Combined with the formula funded sites, evidence-based home visiting programs are offered in 30 counties, including: Campbell, Claiborne, Cocke, Coffee, Cumberland, Davidson, DeKalb, Dickson, Dyer, Grundy, Hamilton, Hardin, Haywood, Hardeman, Henderson, Johnson, Lake, Lauderdale, Lawrence, Madison, Marion, Maury, McMinn, Monroe, Polk, Rhea, Scott, Sequatchie, Sevier, and Shelby.

The annual cost per child for programs funded by formula and expansion funds is $3,045. Funds to support this program come from Federal funds.

NURSE HOME VISITOR PROGRAM

TCA 68-1-2408 designates TDH as the responsible agency for establishing, monitoring and reporting on the Nurse Home Visitor Program funded through a state appropriation. This state law requires the replication of the national evidence-based Nurse Family Partnership model with the goal of expanding the program as funds become available. The goals of the Nurse Family Partnership Program are to improve pregnancy outcomes, improve child health and development and improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work. The Nurse Home Visitor Program, implemented locally by Le Bonheur Children's Hospital in Memphis, began seeing families in June 2010 after staff were hired and trained. In FY2015, home visiting nurses provided services to 139 low-income, first time mothers who are enrolled before 28 weeks of pregnancy and serve them through the child's second birthday.

The annual cost per child is $3450. Funds to support this program come from State funds.

Home Visiting Impact: Outcomes

This section contains data on the outcomes for the evidence-based home visiting programs administered by TDH. It is important to note that outcomes vary across programs, based upon specific statutory requirements or requirements from the model developers of evidence-based programs. In order to align expected outcomes, TDH requires all evidence-based programs to collect and report the same information based on Tennessee's Benchmark Plan. The federal legislation that created the Maternal, Infant, Early Childhood Home Visiting Program required TDH to develop a comprehensive Benchmark Plan and demonstrate measurable improvement among eligible families participating in the program in at least four of the six following benchmark areas:

1. Improvements in prenatal, maternal and newborn health, including improved pregnancy outcomes.
2. Improvements in child health and development, including the prevention of child injuries and maltreatment, and improvements in cognitive, language, social-emotional and physical developmental indicators.
3. Improvements in school readiness and child academic achievement.
4. Reductions in domestic violence.
5. Improvements in family economic self-sufficiency.
6. Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

In addition to the above, Tennessee's approved Benchmark Plan included the stated performance measure, the type of measure (outcome or process), the data source (client, home visitor, or administrative records), the target population being measured, the tool or measure identified, and the measurement period. Information was also included on the type of comparison being made (individual, cohort, or cross-sectional comparison of data), the direction of improvement needed to demonstrate success, and the type of scoring that will be used to demonstrate change.

It is important to note that the data collected through this effort is performance management and quality data rather than impact data. The benchmark data allows TDH to monitor and assess progress over time. However, it does not report on the effectiveness of the program in achieving its ultimate intended outcomes. A separate effort at the federal level, the "Maternal, Infant, and Early Childhood Home Visiting Program Evaluation" (MIHOPE), is assessing the effect of MIECHV programs on child and parent outcomes, including with respect to each of the benchmark areas. For more information about the MIHOPE evaluation, see http://www.acf.hhs.gov/programs/opre/research/project/maternal-infant-and-early-childhood-home-visiting-evaluation-mihope.

Home Visiting Impact: Outcomes of Evidence-Based Home Visiting

On October 30, 2014, TDH successfully submitted the results of the Benchmark Plan for the first three years of implementation which demonstrated measurable improvement among eligible families participating in the program in all of the benchmark areas.

Highlights from the most recent results reported for four of the Benchmarks as of October 30, 2015 include the following*:

Benchmark	Outcome	Measurement	Healthier Beginnings (Federal Funding)	Healthy Start (State Funding)	Nurse Home Visitor (State Funding)
IMPROVED MATERNAL AND NEWBORN HEALTH	Increase entry into prenatal care	Percentage of women enrolled in program prior to delivery who report having received prenatal care in the first or second trimester of pregnancy	100%	100%	50%
	Decrease smoking in the home	Percentage of households with a smoker in the home at intake who report no smokers in the home at 12 months post-enrollment	22%	17%	N/A (No smokers in home at enrollment)
	Delay subsequent pregnancies	Percentage of mothers of an index child who are sexually active at 12 months post enrollment and currently use an effective method of contraception	93%	96%	100%
	Increase early identification of postpartum depression in mothers	Percentage of mothers who have been administered a standardized depression screen by 12 months post delivery	60%	56%	36%
	Increase breastfeeding initiation	Percentage of enrolled pregnant women who deliver a live infant who initiate breastfeeding	66%	57%	86%
DECREASED CHILD INJURIES, CHILD ABUSE, NEGLECT or MALTREATMENT	Decrease child injuries	Percentage of enrolled households who received age-appropriate injury prevention information/ training	81%	83%	81%
	Decrease child abuse and neglect	Percentage of children with suspected maltreatment reported	3.6%	2.4%	0%
	Decrease child abuse and neglect	Percentage of children with substantiated maltreatment	0.8%	0%	0%
	Decrease child abuse and neglect	Percentage of children who are first-time victims of maltreatment	0.8%	0%	0%

IMPROVED SCHOOL READINESS AND ACHIEVEMENT	Increase parent support for children's learning and development	Percentage of households with evidence of increased parental support for children's learning and development between 6 months to 18 months of age	79%	89%	100%
	Improved parent knowledge of child's development and their child's developmental progress	**Percentage of households with increased parental knowledge of child's development and their child's developmental progress between 6 months to 18 months of age**	**79%**	**92%**	**100%**
	Improved early identification of developmental concerns	Percentage of enrolled children screened for developmental delay within 12 months of enrollment	84%	97%	38%
	Improved early identification of developmental concerns	**Percentage of children screened for delays in social behavior, emotion regulation, and emotional well-being within 12 months of enrollment**	**79%**	**89%**	**67%**
	Improved parent emotional well-being or parenting stress	Percentage of households showing improvement in parent emotional well-being or reduction in parenting stress at 12 months post-enrollment	72%	89%	14%
REDUCED DOMESTIC VIOLENCE	**Improved screening of domestic violence**	**Percentage of women screened for domestic violence at enrollment**	**94%**	**90%**	**92%**
	Improved referrals for women experiencing domestic violence	Percentage of women with a positive domestic violence screen at enrollment that receive a referral for a local domestic violence services	8%	14%	0%
	Improved safety for women experiencing domestic violence	**Percentage of women with a positive domestic violence screen at enrollment for whom a safety plan is completed**	**0%**	**0%**	**0%**

In accordance with TCA 37-3-703(d),(1)(2)(3)(6), the following additional information about Healthy Start is provided for FY 2015.

83% of children enrolled in Healthy Start are up to date with immunizations at 2 years old.

99.5% of mothers delay a subsequent pregnancy for at least 12 months after the birth of the previous child.

PERCENT OF CHILDREN FREE OF ABUSE/NEGLECT AND REMAINING IN HOME FOR EACH OF PAST FIVE YEARS

Fiscal Year	% of children
2011	99.4%
2012	98.7%
2013	98.6%
2014	98.4%
2015	100%

COST BENEFITS ESTIMATE FOR HEALTHY START

In accordance with TCA 37-3-703(d)(4)(5), the following information is provided about the average cost of services provided by Healthy Start and the estimated cost of out-of-home placement that would have been expended on behalf of children who remain united with their families as a result of participation in Healthy Start. As shown below, the cost for providing Healthy Start and preventing child abuse and neglect is dramatically lower than the cost of children coming into custody.

Average Annual Cost per Child *Healthy Start Program*	$3,602[1]
Average Estimated Annual Cost per Child *Out of Home Placement: Foster Care*	$8,836.65[2]
Average Estimated Annual Cost per Child *Out-of-Home Placement: Residential Care*	$52,585.55[3]

[1] Annual cost is based on program budget divided by numbers proposed to be served

[2] Tennessee Department of Children's Services, $24.21 per day per child or $8,836.65 per year

[3] Tennessee Department of Children's Services, $144.07 per day per child or $52,585.55 per year

Home Visiting Impact: Outcomes of Promising Approaches

Tennessee, like many other states, has home visiting programs that currently do not have the evidence of effectiveness to meet the criteria for evidence-based models but are grounded in relevant empirical work and have an articulated theory of change.

Beginning October 1, 2013, TDH contracted with two programs, the Nurses for Newborns (NFN) and the Maternal Infant Health Outreach Worker (MIHOW) Programs which currently do not have the evidence of effectiveness to meet the criteria for evidence-based models but are grounded in relevant empirical work and have an articulated theory of change. Both contractors were identified through a competitive procurement process held in October of 2012 and contracts are currently established through September 30, 2016. Both programs have an established, well-designed and rigorous evaluation plan being conducted by an institution of higher education, one of which was approved in March 2014 and the other approved in May 2014. Approval was received from the Office of Planning, Analysis and Evaluation (OPAE) which serves as an agency source for policy analysis, data synthesis, organizational planning, external engagements, research, and evaluation. OPAE's work assists the U.S. Department of Health and Human Services (HHS) and other Federal and external stakeholders in their efforts to improve program performance and effectiveness which ultimately helps to attain their strategic planning goals. Both promising practices are expected to fully implement their evaluation plans during the three-year grant period.

Promising Approach: Evaluation of Nurses for Newborns (NFN)

Nurses for Newborns (NFN) is a home visitation model that serves as a safety net for at-risk families in order to prevent infant mortality and child maltreatment. NFN was originally developed in 1989 by a neonatal intensive care nurse who witnessed too many medically fragile infants discharged from the hospital to the home without proper follow-up, frequent returns to the hospital, and many deaths. After searching the current evidence at the time, she learned of the work conducted by David Olds and colleagues in Elmira, New York during the late 1970's. Using evidence emerging from this clinical trial, borrowing tenets from behavioral science theories, and her own multiple years of clinical experience she outlined the unique home visitation model for Nurses for Newborns. An important distinction between NFN and other nurse-delivered models, such as Nurse Family Partnership, is that it specifically targets all high-risk families with young children including medically fragile infants and mothers with both physical and mental challenges. Its philosophy is grounded in empowerment, focusing on strengthening families through early care, education and support.

The purpose of the evaluation is to determine the impact of the NFN home visitation model on infant weight gain and breastfeeding (research question 1), emergency room use (research question 2) and child abuse and neglect (research question 3). The evaluation will compare women who were enrolled in NFN with a matched comparison group of women who did not receive NFN services on these outcomes. The successful

completion of this project will add to the growing body of knowledge related to home visitation and in particular the impact of the Nurses for Newborns home visitation model.

Promising Approach: Evaluation of Maternal Infant Health Outreach Worker

The Maternal Infant Health Outreach Worker (MIHOW) program model was designed to improve health and child development for low-income families. MIHOW aims to improve prenatal care visit attendance, birth weight, infant care, family dynamics, parenting skills, child development, life skills, and community development. MIHOW trains and supports a network of community women who mentor other women in their homes to promote healthy pregnancies, healthy children, and healthy emotional bonds between children and their parents.

At inception, the program was intended to complement and address the special needs and strengths of parents in Appalachian communities and southern US towns and cities. Using a research-based curriculum, the primary tenet of the program model is to increase local capacity in communities with high levels of poverty through outreach on a mother-to-mother basis. The training of community women incorporated the strong self-help tradition in Tennessee, where self-reliance, particularly in Appalachia, is highly prized. Peer mentoring by trained community women helps to address the severe barriers mountain children confront in maintaining their health and entering school with good academic readiness skills. Many of these challenges are similar to those faced by inner city and rural children, particularly those living in poverty. Using a structured curriculum, community health workers conduct home visits and parenting groups. The trained community workers respond to each family's unique strengths and needs, listening attentively to parents' concerns, and teaching them about nutrition, health, and child development. Limited evaluation has been previously conducted to evaluate the impact of the MIHOW program in Hispanic communities.

This evaluation will be conducted through a partnership between Catholic Charities of Tennessee, Inc. and the Vanderbilt University School of Nursing. The purpose of this project is to evaluate the feasibility and efficacy of the MIHOW Program in a sample of Hispanic families. Outcomes being evaluated include infant feeding practices, infant safe sleep practices, rates of prenatal care, levels of parental stress, levels of positive parenting, and referrals for maternal depressive symptoms. The evaluation will determine whether maternal and infant outcomes are better in a group of Hispanic women enrolled in the MIHOW program (i.e., treatment group) compared to Hispanic women eligible but not enrolled in MIHOW but who receive a minimal intervention (i.e., control group). The successful completion of this project will add to the growing body of knowledge related to home visitation in general and specifically as efforts relate to Hispanic families.

Strengths and Opportunities Related to Home Visiting Services

TDH utilizes key data to inform its efforts to implement a coordinated, efficient, accountable system of home visiting services across the state. Building on the Governor's Children's Cabinet *Home Visitation Review*, published in July 2010, TDH has taken many steps to strengthen the home visiting system in Tennessee. This review identified and quantified the array of home visiting programs and services offered at that time, assisted the state in preparing for federal support for home visiting and provided recommendations to effectively position the home visiting programs to withstand potential budgetary constraints. Analysis of the geographical areas of the state most in need of home visiting services was conducted by TDH in September 2010 as part of the *Home Visiting Needs Assessment* required by the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program. Together, these two reports provide TDH with a strong framework for informed decisions about where and how to most effectively implement home visiting services.

Availability of Home Visiting Services

All TDH-administered home visiting programs are:

- Locally managed – each local implementing agency chooses the home visiting model that best meets the needs of its own at-risk community and provides the home visiting services to families in their own communities; and
- Voluntary – families choose to participate and can leave the program at any time.

Evidence-based home visiting programs are available in 50 of Tennessee's 95 counties. Collectively, 3,476 children were served by TDH-administered home visiting programs during FY2015. While home visiting availability has been expanded to more counties in recent years, capacity of home visiting programs to serve the population of children under the age of five who can benefit varies across the state. This is particularly striking when considering the estimates of children living in poverty. A lack of resources makes it challenging for parents to provide children's basic health and development needs like food, health care and quality child care. This increases the stress on parents and in the home. Exposure to chronic stress negatively influences a child's well-being, especially in the early years when the brain is developing rapidly.

Tennessee ranks 38th for the percent of children living in poverty and has an estimated twenty-six percent of all children living in poverty. Accessing services through a home visiting program provides an opportunity for families to be connected to community services that can address their health and wellness needs, receive guidance on how best to support their child's health and development, as well as take action toward improving their economic situation. Additional families could benefit from home visiting services were they more widely available. Of the number of children living in poverty, less than two percent are currently being served across the state. Only two counties are serving ten to fifteen percent of children living in poverty. Less than ten percent of children living in poverty are being served by home visiting in forty-eight counties and

forty-five counties do not have a TDH funded evidence-based home visiting program. Percentages served by county can be found in the Appendix at the end of this report.

Collaboration between Public and Private Sector Stakeholders

One of the central goals of the federal Maternal, Infant, and Early Childhood Home Visiting funds is to improve coordination among early childhood agencies and to increase referrals for other community resources and supports and thus improve access to needed services. Home visiting programs in Tennessee benefit from involvement in the Tennessee Young Child Wellness Council (TNYCWC), a statewide early childhood entity which is designated as the Governor's Early Childhood Advisory Council and consists of over 100 statewide partners, agencies and organizations. The TNYCWC is serving as a sustainable, coordinated state level structure that intentionally focuses on pregnancy, infancy and early childhood and builds upon the recent scientific evidence regarding the relationship between early experience, brain development and long term health and developmental outcomes. The TNYCWC is striving to increase multi-agency collaboration and coordination toward improved services and data sharing among the various agencies, organizations, providers and other partnerships relevant to young children. Members of the TNYCWC strengthen knowledge of one another's work; embrace a shared goal and agenda; and work to implement collectively identified strategies. TDH will continue to facilitate the TNYCWC and leverage opportunities to align and coordinate services to create a comprehensive early childhood system which includes home visiting services.

Data Collection for Program Evaluation and Continuous Quality Improvement

TDH remains firmly committed to collecting data to examine process and outcome measures related to its programs, including home visiting services. The importance of measuring program impact has grown in the last decade and is now one of the cornerstones of program implementation among home visiting programs in both the public and private sectors. By identifying and aligning common outcomes and measures, home visiting programs are using data to continuously improve and document the effectiveness of these services. This report includes the status of a few similar outcomes and measures regardless of the program implemented; however, there is wide variability in the amount and type of other data collected across the various home visiting programs in Tennessee. TDH has provided leadership to develop a set of uniform program measures and methods to collect data which will improve Tennessee's ability to evaluate effectiveness and impact of home visiting services and compare outcomes across programs. Additionally, TDH developed a comprehensive information collection and management data system to document progress toward common outcomes among all funded home visiting programs. These steps will assure more robust analysis of outcomes and impacts across the home visiting programs continue and strengthen services in the upcoming years.

Emphasis on Evidence-Based Services and Programs

TDH is committed to the implementation of evidence-based programs, where there is sufficient evidence of need and where resources exist to implement such programs. TDH is administering funds for home visiting programs successfully and ensuring that at least 75 percent of the funds expended in 2014-2015 were for evidence-based models. Three evidence-based models are being utilized by TDH administered programs including Healthy Families America, Nurse Family Partnership, and Parents as Teachers.

Beginning October 1, 2013, two "promising approaches" were established with the approval of HHS. The promising approaches, Nurses for Newborns (NFN) and the Maternal Infant Health Outreach Worker (MIHOW) Programs, were funded to respond to the diverse needs of children and families in Davidson County, especially parents who are adolescents, have medical or mental health challenges, or who are non-English speaking as well as parents who have a child with complex medical needs. Both Promising Approaches have finalized a rigorous and robust evaluation plan and are rapidly enrolling families in their services. Results from these evaluations are expected to be available in fall of 2016.

TDH supports a strong network of evidence-based home visiting programs and is ready to continue expansion in the next most at-risk counties as additional funding becomes available.

Development of Referral Systems to Assure Efficient Utilization of Services

Funding from the federal MIECHV grant is supporting a uniform outreach and referral initiative to assure that families are aware of and referred to available community programs, including home visiting programs. This initiative, Welcome Baby, consists of two major strategies.

First, all families of newborns receive a Welcome Baby packet which includes a letter from Mrs. Haslam, Tennessee's First Lady, within ten to fourteen days after birth. The letter is designed to welcome the new baby and provide new parents with the message that the first few years of a child's life are very important, parenting is not always easy, and there are resources available in our state to assist families of young children.

The Welcome Baby packet offers an opportunity to share information about important health messages such as the ABCs of Safe Sleep and protecting your child from toxic stress as well as two key unique Tennessee resources: Imagination Library/Books from Birth and KIDCENTRALTN. Imagination Library/Books from Birth is a Tennessee program designed to provide a book every month to a child from birth to age 5 without cost to the family. Enrollment has been proven to improve kindergarten readiness and home reading practices, including time spent reading with children and children's interest in books. Under the leadership of the Governor's Children's Cabinet co-chaired by Governor and First Lady Haslam, a statewide information portal, KIDCENTRALTN,

was launched July 15, 2013. Parents with young children in Tennessee can find comprehensive information on a variety of health, development, education and support topics and a comprehensive resource inventory of state funded and operated community-based programs and services. This resource is an important tool for families to learn about available supports that can provide timely support when needed.

Second, Welcome Baby is outreaching to families with newborns who reside in the 30 most at-risk counties. The Welcome Baby contact offers the parent of children at high risk for infant mortality the option of an outreach contact. Through this outreach contact, child and family needs are assessed and connections with community resources, including evidence-based home visiting programs, are provided as appropriate. The outreach contact occurs in the first two months after birth and includes an assessment of key health and development outcomes, including breastfeeding, safe sleep, parenting support, child development, insurance, well-child care visits and child care. A rigorous and robust evaluation plan of Welcome Baby has been developed with initial findings expected to be available in spring of 2016.

Conclusions

TDH has made great strides toward the development of a strong, integrated system of home visiting services. A summary of the accomplishments of TDH over the past three years include:

- Expansion of evidence-based home visiting services to thirty of the identified most at-risk counties in the state and to military families living off base of Fort Campbell Army Installation;
- Development of a data collection system to track process and outcome measures and a plan for an even more robust data collection and management system;
- Implementation of a home-visiting specific continuous quality initiative (CQI) curriculum to strengthen local activities leading to improved outcomes for program participants;
- Implementation of universal outreach to all newborns (~ 80,000 each year) and outreach and referral mechanisms to assure families of at-risk newborns (~15,000 each year) receive timely information and are aware of community resources, including home visiting programs;
- Development of a mechanism to share information about the impacts of toxic stress on a child's health and development with all parents of newborns (~80,000 each year);
- Strengthened collaboration with a variety of state level partners to promote information sharing, stronger collaboration around common goals, and increased understanding of one another's role in supporting the optimal development and wellness of young children.

Tennessee has been identified as a leader in the development and implementation of a home visiting system and has consulted with other state home visiting programs to share innovative practices and approaches being implemented. Tennessee was one of the first states to:

- Design core competencies for home visitors with a corresponding self-assessment;
- Develop a web-based training for all home visitors to assure knowledge of the core competency areas;
- Provide information and resources to all parents of newborns through the Welcome Baby Initiative; and
- Universally share information about the importance of preventing adverse childhood experiences.

Tennessee is fortunate to have a number of exciting partnerships to assure all Tennessee children realize their optimal development and wellness during the early years from birth through school age to create a foundation for life-long success. TDH looks forward to continued success and collaboration with public and private partners to offer home visiting in all 95 counties and to more families in order to improve child health and well-being and support parents in the very important work of helping their children prosper.

Appendix: Numbers Served by Evidence-based Home Visiting Programs by County, July 1, 2014 – June 30, 2015**

COUNTY	MIECHV – Formula (Families served) Phase 1	MIECHV – Competitive (Families served) Phase 2	HEALTHY START (Families served)	NURSE HOME VISITOR PROGRAM (Pregnant women served)	TOTALS SERVED BY COUNTY	TOTAL NUMBER OF CHILDREN UNDER 5	ESTIMATED NUMBER OF CHILDREN UNDER 5 LIVING IN POVERTY	ESTIMATED PERCENTAGE OF CHILDREN UNDER 5 LIVING IN POVERTY SERVED BY HOME VISITING
ANDERSON	*	*	12	*	12	3,963	1,255	0.96%
BEDFORD	*	*	35	*	35	3,149	1,107	3.16%
BENTON	*	*	*	*	0	790	301	0.00%
BLEDSOE	*	*	*	*	0	667	245	0.00%
BLOUNT	*	*	*	*	0	6,387	1,778	0.00%
BRADLEY	*	*	9	*	9	5,647	1,964	0.46%
CAMPBELL	79	20	*	*	99	2,117	934	10.60%
CANNON	*	*	*	*	0	772	180	0.00%
CARROLL	*	*	*	*	0	1,663	469	0.00%
CARTER	*	*	*	*	0	2,829	1,316	0.00%
CHEATHAM	*	*	*	*	0	2,329	498	0.00%
CHESTER	*	*	*	*	0	987	233	0.00%
CLAIBORNE	*	9	*	*	9	1,485	446	2.02%
CLAY	*	*	*	*	0	471	205	0.00%
COCKE	*	24	*	*	24	1,799	978	2.45%
COFFEE	*	44	*	*	44	3,307	1,229	3.58%
CROCKETT	*	*	*	*	0	865	202	0.00%
CUMBERLAND	*	24	*	*	24	2,624	900	2.67%
DAVIDSON	117	104	58	*	279	45,191	14,808	1.88%
DECATUR	*	*	*	*	0	603	248	0.00%
DEKALB	*	25	*	*	25	1,031	228	10.96%

COUNTY	MIECHV – Formula (Families served) Phase 1	MIECHV – Competitive (Families served) Phase 2	HEALTHY START (Families served)	NURSE HOME VISITOR PROGRAM (Pregnant women served)	TOTALS SERVED BY COUNTY	TOTAL NUMBER OF CHILDREN UNDER 5	ESTIMATED NUMBER OF CHILDREN UNDER 5 LIVING IN POVERTY	ESTIMATED PERCENTAGE OF CHILDREN UNDER 5 LIVING IN POVERTY SERVED BY HOME VISITING
DICKSON	*	22	*	*	22	3,128	599	3.67%
DYER	*	28	*	*	28	2,290	528	5.30%
FAYETTE	*	*	*	*	0	2,255	605	0.00%
FENTRESS	*	*	*	*	0	886	313	0.00%
FRANKLIN	*	*	16	*	16	2,013	446	3.59%
GIBSON	*	*	*	*	0	3,246	971	0.00%
GILES	*	*	15	*	15	1,617	418	3.59%
GRAINGER	*	*	*	*	0	1,189	380	0.00%
GREENE	*	*	*	*	0	3,234	1,271	0.00%
GRUNDY	*	11	*	*	11	698	288	3.82%
HAMBLEN	*	*	1	*	1	3,867	1,792	0.06%
HAMILTON	80	33	*	*	113	20,177	5,047	2.24%
HANCOCK	*	*	*	*	0	359	181	0.00%
HARDEMAN	*	24	*	*	24	1,292	507	4.73%
HARDIN	*	12	*	*	12	1,365	514	2.33%
HAWKINS	*	*	*	*	0	2,823	791	0.00%
HAYWOOD	*	22	*	*	22	1,051	459	4.79%
HENDERSON	*	23	*	*	23	1,698	575	4.00%
HENRY	*	*	9	*	9	1,690	553	1.63%
HICKMAN	*	*	12	*	12	1,214	332	3.61%
HOUSTON	*	*	*	*	0	451	175	0.00%
HUMPHREYS	*	*	*	*	0	917	259	0.00%
JACKSON	*	*	*	*	0	569	252	0.00%
JEFFERSON	*	*	5	*	5	2,624	592	0.84%

COUNTY	MIECHV – Formula (Families served) Phase 1	MIECHV – Competitive (Families served) Phase 2	HEALTHY START (Families served)	NURSE HOME VISITOR PROGRAM (Pregnant women served)	TOTALS SERVED BY COUNTY	TOTAL NUMBER OF CHILDREN UNDER 5	ESTIMATED NUMBER OF CHILDREN UNDER 5 LIVING IN POVERTY	ESTIMATED PERCENTAGE OF CHILDREN UNDER 5 LIVING IN POVERTY SERVED BY HOME VISITING
JOHNSON	*	11	*	*	11	705	216	5.09%
KNOX	*	*	62	*	62	25,865	6,132	1.01%
LAKE	*	5	*	*	5	321	201	2.49%
LAUDERDALE	*	14	*	*	14	1,629	731	1.92%
LAWRENCE	*	88	*	*	88	2,868	985	8.93%
LEWIS	*	*	16	*	16	676	177	9.04%
LINCOLN	*	*	19	*	19	1,895	564	3.37%
LOUDON	*	*	*	*	0	2,516	892	0.00%
MACON	*	*	4	*	4	1,574	472	0.85%
MADISON	*	100	17	*	117	6,512	2,496	4.69%
MARION	*	5	*	*	5	1,403	521	0.96%
MARSHALL	*	*	18	*	18	1,841	551	3.27%
MAURY	76	33	*	*	109	5,719	1,472	7.40%
MCMINN	*	17	*	*	17	3,058	1,001	1.70%
MCNAIRY	*	*	*	*	0	1,473	573	0.00%
MEIGS	*	*	*	*	0	485	130	0.00%
MONROE	*	12	*	*	12	2,580	835	1.44%
MONTGOMERY	57	*	38	*	95	15,801	4,123	2.30%
MOORE	*	*	*	*	0	238	47	0.00%
MORGAN	*	*	*	*	0	964	332	0.00%
OBION	*	*	19	*	19	1,718	511	3.72%
OVERTON	*	*	*	*	0	1,315	410	0.00%
PERRY	*	*	*	*	0	467	213	0.00%
PICKETT	*	*	*	*	0	210	33	0.00%

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POLK	*	4	*	*	4	779	161	2.48%
PUTNAM	*	*	28	*	28	4,190	1,585	1.77%
RHEA	*	15	*	*	15	1,677	546	2.75%
ROANE	*	*	*	*	0	2,510	754	0.00%
ROBERTSON	*	*	*	*	0	4,467	1,069	0.00%
RUTHERFORD	*	*	*	*	0	18,645	3,604	0.00%
SCOTT	*	13	*	*	13	1,320	436	2.98%
SEQUATCHIE	*	4	*	*	4	839	170	2.35%
SEVIER	*	54	*	*	54	5,155	1,213	4.45%
SHELBY	186	324	65	139	714	66,703	25,485	2.80%
SMITH	*	*	*	*	0	1,053	111	0.00%
STEWART	*	*	*	*	0	731	228	0.00%
SULLIVAN	*	*	*	*	0	7,685	2,565	0.00%
SUMNER	*	*	*	*	0	10,150	1,873	0.00%
TIPTON	*	*	5	*	5	3,843	764	0.65%
TROUSDALE	*	*	*	*	0	415	99	0.00%
UNICOI	*	*	*	*	0	745	201	0.00%
UNION	*	*	6	*	6	1,201	344	1.74%
VAN BUREN	*	*	*	*	0	266	154	0.00%
WARREN	*	*	*	*	0	2,447	1,159	0.00%
WASHINGTON	*	*	*	*	0	6,560	1,369	0.00%
WAYNE	*	*	*	*	0	765	286	0.00%
WEAKLEY	*	*	*	*	0	1,849	603	0.00%
WHITE	*	*	20	*	20	1,444	510	3.92%

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WILLIAMSON	*	*	*	*	0	11,795	956	0.00%
WILSON	*	*	*	*	0	7,124	1,345	0.00%
TOTAL SERVED	**595**	**1,124**	**489**	**139**	**2,347**	**395,520**	**118,580**	**1.98%**

* Program not available in county

** This table reports the number of families served by evidence-based models and does not include the 474 families served by the two promising approach models (Nurses for Newborns and Maternal Infant Health Outreach Worker) or the 655 families served by the research based model (Child Health and Development).

Statement of compliance with 2012 Tenn. Pub. Acts, ch. 1061 (the "Eligibility Verification for Entitlements Act") as required by TCA 4-57-106(b). The Tennessee Department of Health, including local health departments, boards and commissions, has implemented protocols and policies to verify that every adult applicant for "public benefits" is a United States citizen or a "qualified alien" within the meaning of ch. 1061.