Tennessee
Home Visiting Programs
Annual Report

July 1, 2016 – June 30, 2017

Tennessee Department of Health
Division of Family Health and Wellness
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ANNUAL HOME VISITING REPORT
FOR STATE FISCAL YEAR 2017

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STATE OF TENNESSEE
DEPARTMENT OF HEALTH
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MEMORANDUM

To: The Honorable Bill Haslam, Governor
The Honorable Randy McNally, 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, Tennessee Department of Health

Date: January 2018

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, 2016 – June 30, 2017 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. Included are measures from individual programs including the number served, the types of services provided, and the estimated rate of success in meeting specific goals and objectives.

A total of 2,716 children and their families received home visiting services from July 1, 2016 – June 30, 2017 through evidence-based or research-based home visiting programs. 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 that result in different outcomes for participants. **Impacts 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 6,725 individuals in all 95 counties with opportunities to improve pregnancy outcomes as well as maternal and child health and wellness during SFY17.

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 Randy McNally, 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 2017

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, 2016 – June 30, 2017.

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 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. For every $1 invested in evidence-based home visiting, there is a return on investment of $1.80 - $5.70 (according to the 2017 National Home Visiting Yearbook from the National Home Visiting Resource Center). TCCY supports and applauds the Department of Health for requesting the state funding for evidence-based home visiting to be restored to the previous funding level of $3.4 million and moved to recurring. The preservation and expansion 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 2018 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

Home visiting programs have been scientifically proven to improve outcomes for children by supporting a strong and solid foundation in the early years of life when the brain is being constructed. Home Visiting is a critical component of a high-quality early childhood system which serves as a solution to many of the long-standing and complex challenges faced as a state in our health, mental health, social services, child protection, and juvenile and criminal justice systems. The early years of life are especially important as the basic architecture of the human brain is constructed during this period 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 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. During FY 2017, home visiting services assisted many Tennessee families in establishing a firm foundation.

A total of 2,716 families received services from one of the evidence-based or research-based home visiting programs administered by TDH during the period of July 1, 2016 through June 30, 2017; this includes Evidence-based Home Visiting and/or CHAD (Child Health and Development) services. Each program has different service delivery models and thus enrollment criteria that result in different outcomes for participants. All programs support families with young children through weekly, bi-weekly or monthly visits in the family home over a length of one to five years. Some of the resulting outcomes include: improved immunization status of children; decreased child abuse and neglect; increased breastfeeding initiation; decreased smoking by mothers; increased child development screening; and delayed subsequent pregnancies by mothers receiving services.

Currently, TDH administers home visiting programs across the state by means of service contracts with local community-based agencies and county and regional health departments. Evidence-based Home Visiting (EBHV) programs are not available in all counties across Tennessee, and the capacity to serve eligible families varies in the counties where services are available. Were additional funding to become available, TDH would plan to expand EBHV programs in communities identified as high-priority based on health-related risk factors.

TDH also utilizes the federal Maternal, Infant, and Early Childhood Home Visiting, or MIECHV, investment in EBHV to implement the Welcome Baby Initiative. Welcome Baby provides universal outreach to every new parent in Tennessee and delivers an outreach contact to those families of children identified as highest risk. Recognizing that not all families need home visiting services, TDH maintains clear distinctions of EBHV program primary emphases. As such, TDH early childhood initiatives are working to advance a “no wrong door” approach so that families can receive the most appropriate services for their needs.

TDH has accomplished great advances in the development of an integrated system of home visiting services. A summary of the accomplishments of the TDH EBHV system include:

- Continued implementation of EBHV services to the counties identified as most at-risk in the State, and to military families living off-base of Fort Campbell Army Installation;

- Maintenance of and continued improvements to a data collection system to track process and outcome measures;
- Addition of a Continuous Quality Improvement epidemiologist to the Early Childhood Initiatives team solely to maintain and enhance home-visiting specific continuous quality improvement initiatives (CQI) to further strengthen outcomes for program participants;
- Collaboration between the TDH Early Childhood Initiatives team and the TDH Tobacco Prevention team to provide tobacco cessation trainings to the home visiting workforce on “the 5 A’s”: Ask, Advise, Assess, Assist and Arrange, and develop tobacco cessation toolkits to distribute to each home visiting program-enrolled caregiver that self-reports tobacco use;
- Increased family retention among EBHV programs as a result of a strategic action plan that included: surveying the home visiting workforce to identify workforce development issues and the planning and delivery of subsequent trainings delivered based on identified needs; quarterly calls to each EBHV implementing agency to discuss agency family retention data and identify possible solutions for keeping families engaged; implementation of Continuous Quality Improvement (CQI) plans by each EBHV implementing agency that address issues impacting retention rates specific to implementing agency;
- The Tennessee Commission on Children and Youth (TCCY) developed and provided statewide trainings of trainers on childhood brain development and Adverse Childhood Experiences, or ACEs. The goals of the training include an increased awareness of the negative effects of ACEs on social, emotional and physical health across the lifespan. As a result, home visiting and other providers are able to implement ACEs informed services.
- Additional workforce development programming to ensure the home visiting workforce is trained based on a survey of the workforce; and
- Strengthened collaboration with a variety of state-level partners to promote information sharing and systemic collaboration around common goals.

Tennessee has been identified as a leader in the development and implementation of a home visiting system and has provided consultation 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 and mitigating adverse childhood experiences, or ACEs.

TDH maintains robust interagency partnerships to further ensure all children in the state have the means through numerous child and family services to achieve optimal development and wellness. TDH looks forward to continued success and collaboration with public and private partners to improve child health and well-being and provide needed supports to parents and caregivers to establish a healthy foundation for their children.

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.

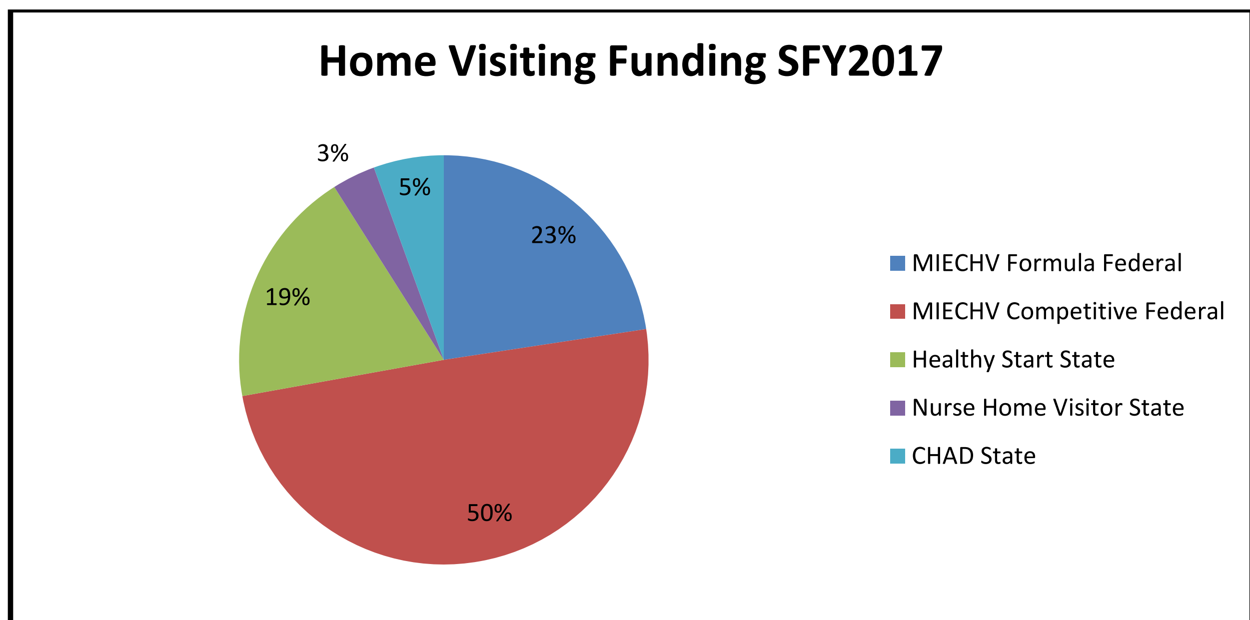
The federal Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) authorized the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program which is jointly administered by the U.S. Department of Health and Human Services (HHS) and the State of Tennessee. The purpose of this program is 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.

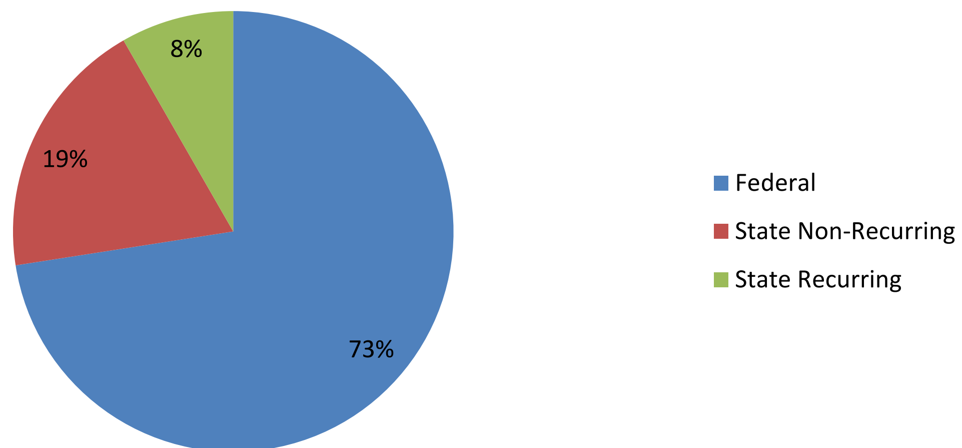
TCA 68-1-125 excludes any Medicaid-funded disease management or case management services or programs that may include home visits from being classified as home visiting programs. As such, the Help Us Grow Successfully (HUGS) Program funded by TennCare and administered by the TDH is not included in this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

In Tennessee, home visiting programs are funded through both state and federal funds. Funding for State Fiscal Year 2017 includes:

Funding Type	Funding Source	Recurring/ Non-Recurring State Funding	Funding Amount
MIECHV Formula	Federal	NA	$2,269,000
MIECHV Competitive	Federal	NA	$4,978,133
Healthy Start	State	$1,500,000 Non-Recurring $392,500 Recurring	$1,892,500
Nurse Home Visitor	State	$345,000 Recurring	$345,000
CHAD	State	$450,000 Non-Recurring $107,500 Recurring	$557,500
Total	**NA**	**Total Non-Recurring: $1,950,000** **Total Recurring: $845,000**	**$10,042,133**

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





Federal MIECHV funding sources provided 73% of all EBHV funding in SFY2017. At the time of report publications, federal funds have not been re-authorized for MIECHV, and Congress will need to act to re-authorize funding to continue EBHV services in the state.

Introduction to Home Visiting Programs

EBHV is one of the key services known to prevent and mitigate the impact of ACEs. Home visitors support the development of positive parenting and teach how essential parent-child interactions are for healthy brain development. Additionally, home visiting services help to prevent and mitigate ACEs by providing screening and support for depression, domestic violence, and child abuse and neglect; building relationships and resilience; and connecting the family to community resources. Home Visiting is an essential service to ensure TDH moves upstream and prevents the long term impacts of ACEs including:

- Poor health outcomes, including increased obesity, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, and broken bones
- Increased negative health behaviors like smoking, alcoholism, and drug use
- Decreased Life Potential, including lower graduation rates, academic achievement, lost time from work.

The influences children are exposed to affect how well they develop and communities play a big role in that development. A child's well-being is like a scale with two sides; one side a positive load and the other side a negative load. Supportive relationships with adults, sound nutrition and quality early learning are positive influences. Stressors such as witnessing violence, neglect or other forms of toxic stress are negative influences. This dynamic system demonstrates that positive child outcomes may be achieved by increasing and strengthening positive influences. These positive experiences mitigate, or diminish, the effects of the toxic stress. High-quality infant and early childhood programs prevent adverse childhood experiences when possible, and

ameliorate the impact when they cannot be prevented. These programs have shown significant long-term improvement for children.

As Tennesseans understand the impact of adverse childhood experiences, they recognize the significance of home visiting programs. Voluntary EBHV services are one of the most effective and economical interventions to support child health and development, strengthen family functioning, and prevent adverse childhood experiences. 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 improve maternal and child health in early years; make lasting, positive impacts on parental skills; and enhance children's cognitive, language, and social-emotional development. These are necessary characteristics for children to thrive.

In November, 2015, Tennessee started the "Building Strong Brains: Tennessee ACEs Initiative". This Initiative is a major statewide effort to establish Tennessee as a national model for how a state can promote culture change in early childhood. The Building Strong Brains Initiative is based on a philosophy that preventing and mitigating adverse childhood experiences, and their impact, is the most promising approach to help Tennessee's children lead productive, healthy lives while ensuring the future prosperity of the state.

The Tennessee state initiative is born from research gathered in the CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study, one of the largest investigations of childhood abuse and neglect and its effects on life-long health and well-being. The study found that the greater the exposure to things such as domestic violence, addiction, and depression in early childhood, the greater the risk for later-life problems such as higher risk for chronic illnesses, poverty, depression and addictive behaviors (Building Strong Brains Tennessee Public and Private Sector Partners, https://www.tn.gov/dcs/topic/building-strong-brains-tennessee-aces-initiative). EBHV services are an antidote to mitigate and prevent the impact of ACEs.

Leaders in the state of Tennessee are committed to exploring a new methodology for addressing systemic, persistent poverty in the state: a "two-generation" approach that addresses the needs of both vulnerable children and parents together. This approach serves both children and their parents with a range of services, supports, education 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 self-sufficiency 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 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. 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 wise investment in the future prosperity of Tennessee. Home visiting services improve outcomes for children and families now, and are 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. The American Academy of Pediatrics summarizes the significant and broad reaching impact of investments in early childhood:

> ***Advances in the study of toxic stress represent a paradigm shift in our understanding of health across the human lifespan. Science now indicates that sound investment in interventions that reduce toxic stress and childhood adversity are likely to strengthen the foundation of physical and mental health and generate even larger returns for all of society.***

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 and county health departments. The home visiting programs administered by TDH are categorized as an evidence-based or research-based 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.

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.

Per TCA 68-1-125, TDH and any other state agency administering funds for home visiting programs must ensure that 75 percent of the funds expended are used for evidence-based models.

The preponderance of funds expended in FY2017 was used for evidence-based models. The following section provides a description of each funding source along with funding as well as Enrollment and Service Provision for each of the federal and state funded evidence-based and research-based home visiting programs administered by TDH during SFY2017 (July 1, 2016 - June 30, 2017).

Funding Source: Maternal, Infant, Early Childhood Home Visiting (MIECHV), Federal

Description: The **Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program** is federal funding provided to states through formula and competitive grants. Both funding allocations are to be used to implement evidence-based home visiting programs in the most at-risk communities, further strengthening the early childhood system. In 2010, Tennessee completed a statewide needs assessment related to home visiting services and used the information to develop an initial State Plan for expansion of home visitation services.

The formula MIECHV funding (first 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. Military families represent one of the priority populations in the legislation, thus one additionally funded project specifically targets military families that live off base in Montgomery County, Tennessee, 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 as well as to military families living off base of Fort Campbell Army Installation.

The annual cost per child for programs funded by the MIECHV Formula funding is **$3,846.23** and the annual cost per child for MIECHV Competitive funds is **$5,501.83.**

MIECHV Formula (MIECHV, Phase 1) Grant, during State Fiscal Year July 1, 2016- June 30, 2017

Local Implementing Agency	Evidence-Based or Promising Approach Model	At-Risk County	Number Served July 1, 2016-June 30, 2017	Number of Home Visits	Annual Cost Per Child*
Helen Ross McNabb	Healthy Families America	Campbell County	44	554	$4,961
		Knox County	28		
Prevent Child Abuse Tennessee	Healthy Families America	Davidson County	87	394	$4,115
Chattanooga-Hamilton County Health Department	Parents as Teachers	Hamilton County	81	749	$4,451
Centerstone	Healthy Families America	Maury County	50	277	$6,058
LeBonheur Children's Hospital, Community Health and Well-Being	Healthy Families America, Nurse Family Partnership, & Parents as Teachers	Shelby County Tipton County	(HFA) 74 (NFP) 26 (PAT) 62 (PAT) 1	Across all three models: 1,247	Across all Three Models $2,488
Center for Family Development	Healthy Families America	Fort Campbell/ Montgomery County	77	710	$3,303
		TOTALS	**530**	**3,931**	**$3,846.23**

MIECHV Competitive (MIECHV, Phase 2) Grant, during State Fiscal Year July 1, 2016- June 30, 2017

Local Implementing Agency	Evidence-Based Model	At-Risk County	Number Served July 1, 2016- June 30, 2017	Number of Home Visits	Annual Cost per Child*
Centerstone	Healthy Families America	Coffee	50	820	$4,671.76
		Maury	13		
		Dickson	26		
		Lawrence	41		
		County not shared[1]	1		
		Centerstone Total	131		
The Exchange Club/ Holland J. Stephens Center for the Prevention of Child Abuse	Healthy Families America	Cumberland	13	204	$7,923.08
		Dekalb	9		
		County not shared[2]	4		
		Exchange Club Total	26		
Helen Ross McNabb Center	Healthy Families America	Campbell	23	590	$4,908.70
		Cocke	23		
		Sevier	46		
		Helen Ross McNabb Center Total	92		
LeBonheur Children's Hospital, Community Health and Well-Being	Healthy Families America	Shelby	83	1,871	$3,212.55
	Parents as Teachers		188		
		LeBonheur Children's Hospital Total	271		
University of Tennessee (UT)-Martin	Healthy Families America	Dyer	41	880	$5,693.72
		Haywood	1		
		Lake	9		
		Lauderdale	18		
		University of Tennessee (UT)-Martin Total	69		
Prevent Child Abuse Tennessee	Healthy Families America	Anderson	1	1,671	$7,884.00
		Claiborne	16		
		Davidson	92		
		Grundy	19		
		Hamilton	26		
		Johnson	13		
		Marion	9		
		McMinn	10		
		Monroe	15		
		Polk	2		
		Rhea	13		
		Scott	20		

[1] Agency did not attribute services to a particular county.
[2] Agency did not attribute services to a particular county.

MIECHV Competitive (MIECHV, Phase 2) Grant, during State Fiscal Year July 1, 2016- June 30, 2017					
Local Implementing Agency	Evidence-Based Model	At-Risk County	Number Served July 1, 2016- June 30, 2017	Number of Home Visits	Annual Cost per Child*
		Sequatchie	12		
		County not shared[3]	2		
		Prevent Child Abuse Tennessee Total	250		
Jackson-Madison County General Hospital		Hardeman	13	1,245	$5,164.71
		Hardin	15		
		Haywood	10		
		Henderson	14		
		Madison	65		
		County not shared[4]	2		
		Jackson-Madison County General Hospital Total	119		
		TOTALS	**958**	**7,336**	**$5,501.83**

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. Individual HFA sites select the specific characteristics of the target population they plan to serve (such as first-time parents, parents on Medicaid, or parents within a specific geographic region); however, the HFA National Office requires that all families complete the Parent Survey (formerly the Kempe Family Stress Checklist), a comprehensive assessment to determine the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences.

The annual cost per child is **$3,950.94**. Funds to support this program come from State funds. Healthy Start was funded in FY2017 with mostly non-recurring dollars (that will be eliminated in FY2018 without continuation funding).

Funding Source: Healthy Start, State					
Local Implementing Agency	Evidence-Based Model	At-Risk County	Number Served July 1, 2016- June 30, 2017	Number of Home Visits	Annual Cost per Child*
Helen Ross McNabb	Healthy Families America	Jefferson	8	247	$4,000.00
		Knox	39		
		Hamblen	1		
		Helen Ross McNabb Center Total	48		
The Exchange Club/ Holland J Stephens Center for the Prevention of Child Abuse	Healthy Families America	Putnam	27	596	$3,093.75
		White	17		
		Macon	20		
		Exchange Club Total	64		

[3] Agency did not attribute services to a particular county.

[4] Agency did not attribute services to a particular county.

Funding Source: Healthy Start, State					
Local Implementing Agency	Evidence-Based Model	At-Risk County	Number Served July 1, 2016- June 30, 2017	Number of Home Visits	Annual Cost per Child*
Jackson Madison County General Hospital	Healthy Families America	Madison	25	185	$4,020.00
		Jackson Madison County General Hospital Total	25		
LeBonheur Children's Hospital, Community Health and Well-Being	Healthy Families America	Shelby	55	483	$2,945.45
		Lebonheur Total	55		
Metro Government of Nashville & Davidson County	Healthy Families America	Davidson	30	217	$6,333.33
Center for Family Development	Healthy Families America	Bedford	22	768	$3,570.18
		Franklin	21		
		Lincoln	20		
		Marshall	18		
		Montgomery	30		
		County not shared[5]	3		
		Center for Family Development Total	114		
University of Tennessee (UT)-Martin	Healthy Families America	Henry	11	538	$3,700.00
		Obion	19		
		Tipton	10		
		UT Martin Total	40		
Centerstone	Healthy Families America	Giles	17	322	$4,092.31
		Hickman	28		
		Lewis	20		
		Centerstone Total	65		
Prevent Child Abuse Tennessee	Healthy Families America	Anderson	19	203	$5,440.48
		Bradley	15		
		Decatur	1		
		Union	7		
		Prevent Child Abuse Tennessee Total	42		
		Totals	**483**	**3,559**	**$3,950.94**

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 **$853.75**. Funds to support this program come from State funds. CHAD was funded in FY2017 with mostly non-recurring dollars (that will be eliminated in FY2018 without State continuation funding).

Funding Source: Child Health and Development (CHAD), State					
Local Implementing Agency	Research-Based Model	At-Risk County	Number Served July 1, 2016- June 30,2017	Number of Home Visits	Annual Cost per Child*
Anderson Co. Health Department	Child Health and Development	Anderson	3	8	Annual cost per child is estimated
Blount Co. Health Department	Child Health and Development	Blount	0	0	

[5] Agency did not attribute services to a particular county.

Funding Source: Child Health and Development (CHAD), State					
Local Implementing Agency	Research-Based Model	At-Risk County	Number Served July 1, 2016- June 30,2017	Number of Home Visits	Annual Cost per Child*
Campbell Co. Health Department	Child Health and Development	Campbell	27	230	utilizing the SFY2017 state allocation divided by the total numbers served statewide. As such, county specific cost per child is not available.
Carter Co. Health Department	Child Health and Development	Carter	94	553	
Claiborne Co. Health Department	Child Health and Development	Claiborne	12	40	
Cocke Co. Health Department	Child Health and Development	Cocke	2	15	
Grainger Co. Health Department	Child Health and Development	Grainger	7	28	
Greene Co. Health Department	Child Health and Development	Greene	103	525	
Hamblen Co. Health Department	Child Health and Development	Hamblen	33	120	
Hancock Co. Health Department	Child Health and Development	Hancock	17	143	
Hawkins Co. Health Department	Child Health and Development	Hawkins	60	272	
Jefferson Co. Health Department	Child Health and Development	Jefferson	2	4	
Johnson Co. Health Department	Child Health and Development	Johnson	26	177	
Loudon Co. Health Department	Child Health and Development	Loudon	7	34	
Monroe Co. Health Department	Child Health and Development	Monroe	6	36	
Morgan Co. Health Department	Child Health and Development	Morgan	32	93	
Roane Co. Health Department	Child Health and Development	Roane	7	33	
Scott Co. Health Department	Child Health and Development	Scott	35	226	
Sevier Co. Health Department	Child Health and Development	Sevier	29	133	
Unicoi Co. Health Department	Child Health and Development	Unicoi	47	345	
Union Co. Health Department	Child Health and Development	Union	8	55	
Washington Co. Health Department	Child Health and Development	Washington	93	440	
		Totals	**650**	**3,510**	**$853.75**

Funding Source: Nurse Home Visitor, State

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 FY2017, home visiting nurses provided services to 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 **$3,631.00**. Funds to support this program come from State funds.

Local Implementing Agency	Evidence-Based Model	At-Risk County	Number Served July 1, 2016- June 30, 2017	Number of Home Visits	Annual Cost per Child*
LeBonheur Children's Hospital, Community Health and Well-Being	Nurse Family Partnership	Shelby	95	471	$3,631.00
		Totals	**95**	**471**	**$3,631.00**

Summary of All Funding Sources, State and Federal					
Total Number of Local Implementing Agencies	Categories and Models	Total Number of Counties With a Home Visiting Program	Number Served July 1, 2016- June 30, 2017	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 (CHAD)	**61**	**2,716**	**18,810**	Range from **$853.75** to **$7,923.08**

*Annual cost per child was calculated by dividing the agency's budget by the number served during the state contract period.

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 fidelity requirements of the Evidence-based Home Visiting models. 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, and Early Childhood Home Visiting (MIECHV) program required TDH to develop a comprehensive Benchmark Plan and demonstrate measurable improvement among families enrolled in EBHV programs 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.

Healthy Start Outcomes

In accordance with TCA 37-3-703(d),(1)(2)(3)(6), the following additional information about Healthy Start is provided for FY 2017.

Immunizations
88.4% of children enrolled in Healthy Start are up to date with immunizations at 2 years old. This is lower than in previous years, but may be associated with changes in data collection that occurred in FY2017.

Subsequent Pregnancies
There were no subsequent pregnancies in less than 12 months.

Child Abuse and Neglect

Percent of Children Free of Abuse/ Neglect and Remaining in Home For Each of the Past Five Years	
Fiscal Year	**% of children**
2012	98.7%
2013	98.6%
2014	98.4%
2015	100%
2016	100%
2017	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*	$3,950.94[6]
Average Estimated Annual Cost per Child *Out of Home Placement: Foster Care*	$8,836.65[7]
Average Estimated Annual Cost per Child *Out-of-Home Placement: Residential Care*	$52,585.55[8]

[6] Annual cost is based on program budget divided by numbers served
[7] Tennessee Department of Children's Services, $24.21 per day per child or $8,836.65 per year
[8] Tennessee Department of Children's Services, $144.07 per day per child or $52,585.55 per year

Domain	Construct	Performance Measure	MIECHV (Federal Funding)	Healthy Start (State Funding)	Nurse Home Visitor (State Funding)	Highlights
Maternal and Newborn Health	Preterm Birth	Percent of infants (among mother enrolled prenatally before 37 weeks gestation) who are born preterm following program enrollment	12.1	15.70	17.40	The observed preterm birth rate is higher than the state (11.23%) and national rates for preterm birth. A third of home visiting preterm births to Evidence Based Home Visiting participants occurred in Shelby County, which has a higher preterm birth rate (13.15%) than TN. Per the 2016 CDC Breastfeeding Report Card, 71.1% of TN mothers with births in 2013 initiated breastfeeding and 42.5% breastfed through at least 6 months. In the EBHV population, 62.1% of mothers initiated breastfeeding, dropping to 22.9% at 6 months. Among TN WIC participants (proxy for low income/at-risk), 8.5% of mothers breastfed through at least 6 months.
	Breastfeeding	Percent of infants (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at 6 months of age	22.9	34.60	18.80	
	Depression Screening	Percent of primary caregivers who are screened for depression using a validated tool within 3 months of enrollment (postpartum enrollees) or 3 months of delivery (prenatal enrollees)	72.8	86.50	91.70	
	Well Child Visit	Percent of children enrolled in home visiting who received the last recommended visit based on the AAP schedule	73.1	86.20	73.90	
	Postpartum Care	Percent of mothers enrolled prenatally or within 30 days of delivery who received a postpartum visit within 8 weeks of delivery	58.7	68.50	48.00	
	Tobacco Cessation Referrals	Percent of primary caregivers enrolled in HV who reported using tobacco use or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment	87.1	92.00	100.00	
Child Injury, Abuse, Neglect and Maltreatment	Safe Sleep	Percent of infants enrolled in HV that are always placed to sleep on their backs, without bed-sharing or soft bedding	57.5	61.90	28.60	Though there were a total of 310 cases of reported maltreatment for children served by EBHV, only 25 cases were substantiated by DCS, for a rate of 1.2%.
	Child Injury	Rate of injury related visits to the ED since enrollment among children enrolled in HV	11.3	3.60	0.00	
	Child Maltreatment	Percent of children enrolled in HV with at least 1 investigated case of maltreatment following enrollment within the reporting period	12.9	23.80	3.40	
School Readiness	Parent Child Interaction	Percent of primary caregivers enrolled in HV who receive an observation of caregiver-child interaction by the home visitor using a validated tool	67	54.20	80.00	
	Early Language and Literacy Activities	Percent of children enrolled in HV with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily, every day	84.3	84.00	88.90	
	Developmental Screening	Percent of children enrolled in HV with a timely screen for developmental delays using a validated parent-completed tool	77.8	68.00	33.30	
	Behavioral concerns	Percent of home visits where primary caregivers enrolled in home visiting were asked if they have any concerns regarding their child's development, behavior, or learning	84.9	81.70	68.20	

Domain	Construct	Performance Measure	MIECHV (Federal Funding)	Healthy Start (State Funding)	Nurse Home Visitor (State Funding)	Highlights
Crime/Domestic Violence	Intimate Partner Violence Screening	Percent of primary caregivers enrolled in home visiting who are screened for IPV within 6 months of enrollment using a validated tool	77.7	40.8 0	37.50	
Family Economic Self-Sufficiency	Primary caregiver education	Percent of primary caregivers who enrolled in home visiting without a high school degree or equivalent who subsequently enrolled in, maintained continuous enrollment in, or completed high school or equivalent during their participation in home visiting	13.8	7.90	8.30	In Tennessee, Medicaid coverage for new mothers ends after the postpartum period.
	Continuity of insurance	Percent of primary caregivers who had continuous health insurance coverage for at least 6 consecutive months	55.7	69.3 0	52.90	
Referrals and Coordination	Complete d Depressio	Percent of primary caregivers referred to services for depression who receive one or more service contacts	44.8	115.4 0	0.00	
	Completed Developmental Referrals	Percent of children enrolled in HV with positive screens for developmental delays who receive services in a timely manner	46.7	71.4 0	No positive screens	
	IPV Referrals	Percent of primary caregivers enrolled in HV with positive screens for IPV who receive referral information to IPV resources	100	100.0 0	No positive screens	

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 Revi*ew, 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. Conversely, there are 45 counties in Tennessee where Evidence-based Home Visiting is not available. Collectively, 2,716 children were served by TDH-administered home visiting programs during SFY2017 (this figure includes Evidence-based Home Visiting and CHAD programs). 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 varies across the state. Currently Evidence-based Home Visiting programs serve just 1.7% of Tennessee's poor children (*Percentages served by county can be found in the Appendix at the end of this report).* Parental stress resulting from a lack of resources further compounds any toxic stress that may be experienced by children and families with greatest need. Exposure to chronic stress negatively influences child well-being, especially during the formative early years of brain development.

The 2017 Kids Count Data Book reports that Tennessee ranks 35th in the Nation for overall child well-being. The Data Book includes the following key statistics:

- 21% of children in Tennessee live in poverty,
- 29% of children in Tennessee live in homes where their parents lack secure employment,
- 7% of Tennessee teens are not in school and not working (http://www.aecf.org/m/resourcedoc/aecf-2017kidscountdatabook.pdf)

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.

The Tennessee Department of Human Services (DHS) partnered with Nurse Family Partnership and East Tennessee State University to begin serving more families through Evidence-based Home Visiting services in 2017. DHS is using Temporary Assistance for Needy Families (TANF) funding to expand Nurse Family Partnership (NFP) to the following counties in Northeast Tennessee: Sullivan, Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, and Washington. As of June 30, 2017, there were 48 families enrolled in the DHS NFP program, with a cost per child of $9,550.

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 increase referrals to other community resources and supports, thus improving access to needed services. The Tennessee Young Child Wellness Council (TNYCWC) is a statewide, early childhood entity designated as the Governor's Early Childhood Advisory Council. The TNYCWC consists of over 100 statewide partners, agencies and organizations, and serves as a sustainable state-level structure that focuses on pregnancy, infancy and early childhood and the relationship between early experience, brain development and long term health and developmental outcomes. The TNYCWC strives to increase multi-agency collaboration and coordination toward improved services and data sharing among the various infant and early childhood-serving agencies, organizations, providers and other pertinent partnerships.

Members of the TNYCWC strengthen knowledge of one another's work; embrace a shared goal and agenda; and work to implement collectively identified strategies. This year, the TNYCWC designed a toolkit to assist Evidence-based Home Visiting and other early childhood service providers in forming community-based coalitions to improve referral processes. The toolkit is being piloted in Maury and Hamilton counties, with the goal of being utilized in at least half the counties that provide Evidence-based Home Visiting services within a year. The TNYCWC will provide ongoing technical assistance to those using the toolkit.

TDH continues to partner with the Tennessee Commission on Children and Youth (TCCY) to convene the Home Visiting Leadership Alliance (HVLA). The HVLA began meeting in January 2016 and has met eleven times to date. The HVLA includes leadership from all of the home visiting programs in Tennessee, state departments and other stakeholders from across the state. The HVLA is co-chaired by TDH and TCCY and provides an opportunity for networking, information sharing, collaborating, training and professional development. The HVLA has created a forum for discussion on topics like data and outcomes and infant mental health endorsement. The HVLA is scheduled to meet five times in 2018.

In addition to the HVLA, TDH also partnered with TCCY to explore the feasibility of results-based financing for Evidence-based Home Visiting in Tennessee. TCCY, in partnership with TDH, secured a technical assistance coaching grant from the Institute for Child Success (ICS) in May 2016 to explore the feasibility of Pay for Success/Social Impact Bonds for Evidence-based Home Visiting in Tennessee. A Social Impact Bond is a contract with the public sector in which a commitment is made to pay for improved social outcomes that result in public sector savings. The study initially reviewed all three of the evidence-based

models implemented in Tennessee - Healthy Families America, Parents as Teachers and Nurse Family Partnership. Through the course of the study, Nurse Family Partnership emerged as the model currently most suitable for Pay for Success. The study proposes expansion of home visiting in five counties: Davidson, Hamilton, Knox, Rutherford, Shelby and Sumner Counties. The study was completed in the spring of 2017 with the conclusion that Pay for Success is feasible for Evidence-based Home Visiting in Tennessee.

TCCY is also deeply engaged in *Building Strong Brains Tennessee (BSB).* Specifically for home visiting providers, in partnership with TDH, TCCY hosted a one-day summit on August 10, 2017 with a focus on ACEs. The agenda included a three-hour presentation on "The Role of Life Experiences in Shaping Brain Development", an overview of the NEAR Science Toolkit and a FrameWorks presentation. TCCY also conducted Training for Trainers across the state beginning in 2017 and will provide additional training sessions in 2018. The two-day intensive training provided by TCCY staff has already reached over 535 people statewide. Training participants are prepared to speak knowledgably about early childhood development and ACEs. The Training for Trainers is a key component of the public awareness efforts for *BSB.* TCCY is also coordinating a public awareness campaign for *BSB* with a grant from the Office of Criminal Justice Programs and funding from TDH.

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 those outcomes which are similar among those measured in the different programs. 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. TDH maintains a comprehensive data collection and management 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 home visiting programs and thus strengthen services in the upcoming years.

Emphasis on Evidence-Based Services and Programs

TDH is committed to the implementation of evidence-based programs in high-priority communities based on health related risk factors with the ultimate goal of expanding Evidence-based Home Visiting services statewide. TDH has administered funds for home visiting programs successfully and continues to ensure that at least 75 percent of the funds expended are for evidence-based models. Three evidence-based models are currently delivered by TDH administered programs: Healthy Families America, Nurse Family Partnership, and Parents as Teachers.

TDH supports a strong network of EBHV programs and is equipped to expand services in the next most at-risk counties were additional funding to become 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.

All families of newborns receive a Welcome Baby packet that 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 resources are available in Tennessee to provide additional support.

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 that provides a book each month from birth to age 5 at no 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. This resource provides comprehensive information on a variety of health, development, education and support topics, and a wide-ranging resource inventory of state-funded and operated community-based programs and services. This resource is an important tool for families to learn of available supports.

Welcome Baby provides outreach to families with newborns who reside in the 30 counties recognized as most at-risk in Tennessee. Infants identified from the birth statistical file as being at increased for infant mortality were eligible to receive an additional outreach contact. In the first year of Welcome Baby, 8,494 families identified as high- or medium-risk received an initial outreach contact. The Welcome Baby risk algorithm provides an efficient and cost effective method for identifying infants at risk of infant mortality. This will allow targeted provision of interventions aimed at reducing infant mortality. Though not statistically significant, the "light touch" outreach activities provided through the Welcome Baby program to at-risk families may be beneficial to those who desire less intensive services than those provided by the EBHV models being implemented in Tennessee.

Parents in Welcome Baby counties were more likely to be enrolled in home visiting services than parents in comparison counties, which was expected based on known availability of services. An unexpected finding was the wider than expected availability of home visiting programs funded by entities other than the Tennessee Department of Health, especially in non-Welcome Baby counties.

Results from the follow-up survey indicate that parents receiving Welcome Baby contacts may have greater parenting self-efficacy than similar parents in comparison counties.

Conclusions

TDH has made great strides toward the development of a strong, integrated system of home visiting services. A summary of the accomplishments of the TDH Evidence-based Home Visiting system include:

- Expansion of Evidence-based Home Visiting services to the most at-risk counties in the state and to military families living off base of Fort Campbell Army Installation;
- Continued maintenance of a data collection system to track process and outcome measures;
- Implementation of a home-visiting specific continuous quality improvement (CQI) initiative to strengthen local activities to improve outcomes for program participants;
- Continued implementation of the Welcome Baby 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 roles in supporting the optimal development and wellness of infants and young children; and
- The development of an infant and early childhood workforce development infrastructure licensed to oversee Infant Mental Health Endorsement in Tennessee, further strengthening and standardizing the vocation and professionalism of infant and early childhood service providers, specifically Evidence-based Home Visitors.

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 that help assure all Tennessee children have the opportunity for optimal development and wellness during the early formative years. This creates a sturdy foundation for life-long success. TDH looks forward to continued success and collaboration with public and private partners to ultimately offer home visiting in all 95 counties and to more families to improve child health and well-being and support parents in the important work of helping children flourish.

Appendix: Numbers Served by Evidence-Based Home Visiting Programs by County, July 1, 2016 – June 30, 2017**

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 IN COUNTY	ESTIMATED NUMBER OF CHILDREN UNDER 5 LIVING IN POVERTY IN COUNTY	ESTIMATED PERCENTAGE OF CHILDREN UNDER 5 LIVING IN POVERTY SERVED BY HOME VISITING
Anderson	*	1	19	*	20	3,963	1,255	1.6
Bedford	*	*	22	*	22	3,149	1,107	2
Benton	*	*	*	*	0	790	301	-
Bledsoe	*	*	*	*	0	667	245	-
Blount	*	*	*	*	0	6,387	1,778	-
Bradley	*	*	15	*	15	5,647	1,964	0.8
Campbell	44	23	*	*	67	2,117	934	7.2
Cannon	*	*	*	*	0	772	180	-
Carroll	*	*	*	*	0	1,663	469	-
Carter	*	*	*	*	0	2,829	1,316	-
Cheatham	*	*	*	*	0	2,329	498	-
Chester	*	*	*	*	0	987	233	-
Claiborne	*	16	*	*	16	1,485	446	3.6
Clay	*	*	*	*	0	471	205	-
Cocke	*	23	*	*	23	1,799	978	2.4
Coffee	*	50	*	*	50	3,307	1,229	4.1
Crockett	*	*	*	*	0	865	202	-
Cumberland	*	13	*	*	13	2,624	900	1.4
Davidson	86	92	30	*	208	45,191	14,808	1.4
Decatur	*	*	1	*	0	603	248	-
Dekalb	*	9	*	*	9	1,031	228	3.9

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 IN COUNTY	ESTIMATED NUMBER OF CHILDREN UNDER 5 LIVING IN POVERTY IN COUNTY	ESTIMATED PERCENTAGE OF CHILDREN UNDER 5 LIVING IN POVERTY SERVED BY HOME VISITING
Dickson	*	26	*	*	26	3,128	599	4.3
Dyer	*	41	*	*	41	2,290	528	7.8
Fayette	*	*	*	*	0	2,255	605	-
Fentress	*	*	*	*	0	886	313	-
Franklin	*	*	21	*	21	2,013	446	4.7
Gibson	*	*	*	*	0	3,246	971	-
Giles	*	*	17	*	17	1,617	418	4.1
Grainger	*	*	*	*	0	1,189	380	-
Greene	*	*	*	*	0	3,234	1,271	-
Grundy	*	19	*	*	19	698	288	6.6
Hamblen	*	*	1	*	1	3,867	1,792	0.1
Hamilton	81	27	*	*	108	20,177	5,047	2.1
Hancock	*	*	*	*	0	359	181	-
Hardeman	*	13	*	*	13	1,292	507	2.6
Hardin	*	15	*	*	15	1,365	514	2.9
Hawkins	*	*	*	*	0	2,823	791	-
Haywood	*	11	*	*	11	1,051	459	2.4
Henderson	*	14	*	*	14	1,698	575	2.4
Henry	*	*	11	*	11	1,690	553	2
Hickman	*	*	28	*	28	1,214	332	8.4
Houston	*	*	*	*	0	451	175	-
Humphreys	*	*	*	*	0	917	259	-
Jackson	*	*	*	*	0	569	252	-
Jefferson	*	*	8	*	8	2,624	592	1.4

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 IN COUNTY	ESTIMATED NUMBER OF CHILDREN UNDER 5 LIVING IN POVERTY IN COUNTY	ESTIMATED PERCENTAGE OF CHILDREN UNDER 5 LIVING IN POVERTY SERVED BY HOME VISITING
Johnson	*	13	*	*	13	705	216	6
Knox	28	*	39	*	67	25,865	6,132	1.1
Lake	*	9	*	*	9	321	201	4.5
Lauderdale	*	18	*	*	18	1,629	731	2.5
Lawrence	*	41	*	*	41	2,868	985	4.2
Lewis	1	*	20	*	21	676	177	11.9
Lincoln	*	*	20	*	20	1,895	564	3.5
Loudon	*	*	*	*	0	2,516	892	-
Macon	*	*	20	*	20	1,574	573	3.5
Madison	*	65	25	*	90	6,512	2,496	3.6
Marion	*	9	*	*	9	1,403	521	1.7
Marshall	*	*	18	*	18	1,841	551	3.3
Maury	49	13	*	*	62	5,719	1,472	4.2
McMinn	*	10	*	*	10	3,058	1,001	1
McNairy	*	*	*	*	0	1,473	573	-
Meigs	*	*	*	*	0	485	130	-
Monroe	*	15	*	*	15	2,580	835	1.8
Montgomery	71	7	30	*	108	15,801	4,123	2.6
Moore	*	*	*	*	0	238	47	-
Morgan	*	*	*	*	0	964	332	-
Obion	*	*	19	*	19	1,718	511	3.7
Overton	*	*	*	*	0	1,315	410	-
Perry	*	*	*	*	0	467	213	-
Pickett	*	*	*	*	0	210	33	-

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 IN COUNTY	ESTIMATED NUMBER OF CHILDREN UNDER 5 LIVING IN POVERTY IN COUNTY	ESTIMATED PERCENTAGE OF CHILDREN UNDER 5 LIVING IN POVERTY SERVED BY HOME VISITING
Polk	*	2	*	*	2	779	161	1.2
Putnam	*	*	27	*	27	4,190	1,585	1.7
Rhea	*	13	*	*	13	1,677	546	2.4
Roane	*	*	*	*	0	2,510	754	-
Robertson	*	*	*	*	0	4,467	1,069	-
Rutherford	*	*	*	*	0	18,645	3,604	-
Scott	*	20	*	*	20	1,320	436	4.6
Sequatchie	*	12	*	*	12	839	170	7.1
Sevier	*	46	*	*	46	5,155	1,213	3.8
Shelby	159	270	54	95	578	66,703	25,485	2.3
Smith	*	*	*	*	0	1,053	111	-
Stewart	*	*	*	*	0	731	228	-
Sullivan	*	*	*	*	0	7,685	2,565	-
Sumner	*	*	*	*	0	10,150	1,873	-
Tipton	1	*	10	*	11	3,843	764	1.4
Trousdale	*	*	*	*	0	415	99	-
Unicoi	*	*	*	*	0	745	201	-
Union	*	*	7	*	7	1,201	344	2
Van Buren	*	*	*	*	0	266	154	-
Warren	*	*	*	*	0	2,447	1,159	-
Washington	*	*	*	*	0	6,560	1,369	-
Wayne	*	*	*	*	0	765	286	-
Weakley	*	*	*	*	0	1,849	603	-
White	*	*	17	*	17	1,444	510	3.3

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 IN COUNTY	ESTIMATED NUMBER OF CHILDREN UNDER 5 LIVING IN POVERTY IN COUNTY	ESTIMATED PERCENTAGE OF CHILDREN UNDER 5 LIVING IN POVERTY SERVED BY HOME VISITING
Williamson	*	*	*	*	0	11,795	956	-
Wilson	*	*	*	*	0	7,124	1,345	-
County Missing	0	0	0	0	0	N/A	N/A	N/A
Funding Stream Unidentified	0	0	0	0	0	N/A	N/A	-
TOTAL SERVED	**520**	**956**	**479**	**95**	**2,049**	**395,520**	**118,580**	**1.7%**

* Program not available in county

** This table reports the number of families served by evidence-based models and does not include the 650 families served by the research-based model CHAD (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.