Tennessee
Home Visiting Programs
Annual Report

July 1, 2008 – June 30, 2009

Tennessee Department of Health
Maternal and Child Health
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ANNUAL HOME VISITING REPORT
FOR FISCAL YEAR 2009

Table of Contents

STATE OF TENNESSEE
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MEMORANDUM

TO: The Honorable Phil Bredesen, Governor
The Honorable Ron Ramsey, Lieutenant Governor
The Honorable Kent Williams, Speaker of the House
Members of the Tennessee General Assembly

From: Linda O'Neal, Executive Director

Date: January 14, 2010

RE: Annual Report for Home Visitation Programs

As required by Public Chapter 1029, the Tennessee Commission on Children and Youth worked with the Department of Health (DOH) and others to report on the status of quality, evidence-based home visitation programs funded through DOH.

It is a critical time in our state for home visitation programs. Two of the programs offered through the Department of Health, Child Health and Development (CHAD) and Healthy Start, are receiving non-recurring funding for fiscal year 2009-2010. The preservation of these vital programs is essential to avoid eroding the opportunity to provide quality home visitation services in Tennessee. Home visitation programs are one of the most important things the state can do to improve long-term outcomes for vulnerable children.

Quality home visitation programs have demonstrated success in reducing child maltreatment in high-risk families, including single or young mothers, low-income households and families with low-birth-weight infants. Child maltreatment, including abuse and/or neglect, is not only traumatic in itself and can result in state custody, it also increases the risk of adverse consequences among maltreated children, including early pregnancy, substance abuse, school failure and mental illness. Children who have been physically abused are also more likely to exhibit aggressive behavior and violence later in their lives.

Home visitation programs for high-risk families, high-risk infants and young children could be instrumental in reducing premature and low-birth-weight babies, infant mortality and child abuse, improving immunization rates, and increasing parental understanding of the developmental needs of their children. Available data report children served by these programs have better outcomes on some measures than the state as a whole. Quality home visitation programs are a sound long-term investment in the future of Tennessee.

The Commission on Children and Youth is committed to efforts to maintain and improve quality home visitation programs in Tennessee. They are a wise investment in improving outcomes for young children.

Special thanks to those who assisted in the development of this report

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Overview

Tennessee Code Annotated 68-1-125 requires that the Department of Health (TDH) report annually on the department's home visiting programs. The intent of the legislation is to review and identify the research models upon which the home visiting services are based, to report on the annual process and 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 that TDH shall work in conjunction with the Tennessee Commission on Children and Youth (TCCY) and other experts and providers to identify those programs that are evidence-based, research-based and theory-based and report such findings to the Governor, the Senate Welfare Committee, Health and Human Resources Committee, the Children and Family Affairs Committee of the House of Representatives and the Select Committee on Children and Youth of the General Assembly no later than January 1 of each year. The report must contain measurements of individual programs including the number of people served, the types of services provided and the estimated rate of success of the population served.

For the purposes of this report, "evidence-based" means a program or practice that is governed by a program manual or protocol that specifies the nature, quality and amount of service that constitutes the program and scientific research has demonstrated in two or more client samples that the program improves client outcomes. "Research-based" means a program or practice that has some research demonstrating effectiveness but does not yet meet the standard of evidence-based. "Theory-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature and has potential for becoming a research–based program or practice.

TDH provides home visiting services in all counties through county health departments or under contract with community based agencies. TDH has offered home visiting services,

implementing several similar models since the 1970s. The following is a brief description of the home visiting models implemented. A state map with programs designated by county is contained in the Appendix A.

History of Home Visiting Services

Child Health and Development Program (CHAD)

The Child Health and Development (CHAD) program, based on the Demonstration and Research Center for Early Education model developed by Peabody College, began as a research and theory-based model. CHAD, 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. Families can receive services until the child turns 6 years of age. Prenatal services are provided only for pregnant girls who are less than 18 years of age. Because of program changes over the years, CHAD is now primarily a theory based model for home visiting. The program is offered in 22 counties and staffed by state employees. Funds to support this program are from the Social Services Block Grant administered by the Department of Children's Services (DCS).

Healthy Start

Legislatively mandated by The Tennessee Childhood Development Act of 1994 (TCA 37- 3-703), the Healthy Start program is provided in 30 counties by eight community-based agencies and is an evidence-based model. The program aims to reduce or prevent child abuse and neglect in families who are enrolled. DCS contracts with TDH to implement this program. Families at high risk of child abuse and/or neglect as measured by Kempe Family Stress Checklist are eligible for enrollment in the program; participation is voluntary. Funding is through DCS from the Association of Children, Youth and Families (ACYF) to prevent child abuse and neglect. These projects are staffed by employees of the community based agencies. A list of the agencies and the counties they serve is contained in the Appendix B.

Help Us Grow Successfully (HUGS)

The Help Us Grow (HUG) home visiting model was developed by TDH beginning in the 1990s as a means of clarifying public health home visiting services emphasizing child health and well being. In FY 2003**,** the HUG program was renamed HUGS – Help Us Grow Successfully (HUGS) and was modified in FY 2007 to provide these services using a standardized curriculum for parenting skills. In 2008-2009, it was further modified to include an electronic data collection system on all children and families enrolled in the program, including quarterly assessments of family wellness and child growth and development using the standardized Ages and Stages questionnaire. It is a theory-based model and is the only home visiting program that is offered in all counties of the state.

The HUGS program provides home-based prevention and intervention services to pregnant/postpartum women, children from birth up to their 6th birthday and the parent/guardian. The goals of the program are to:

1) improve pregnancy outcomes
2) improve maternal and child health and wellness
3) improve child development and
4) maintain or improve family strengths.

The HUGS program was developed by TDH to improve birth outcomes as measured by gestational age and birth weight and to increase the number of children who receive the health assessment services of Early Periodic Screening Diagnosis and Treatment (EPSDT). Funds to support this program are from the Bureau of TennCare to provide preventive health services to young children. The program is staffed by state or metropolitan employees; one project is a faith based community agency in Memphis.

The data collection system uses some newly formatted screens in the TDH Patient Tracking Billing Management Information System (PTBMIS) to collect uniform information on each member of the family involved in home visiting services. The data entered into the system can

be extracted for ad hoc reporting and data analysis specifically designed for HUGS. The HUGS data management module has five major components: HUGS family screen, HUGS baseline data, HUGS encounter screen, HUGS referral screen and Question and Result Database where questions from the HUGS program forms can be added and removed from user-generated screens by central office staff.

Nurse Family Partnerships

Revision of TCA 68-1-2501 designated TDH as the responsible agency for establishing, monitoring and reporting on the Nurse Family Partnership pilot project. This state law requires the replication of the national evidence-based program with the goal of expanding the program as funds become available. Contract processing was completed in May 2009; the project is located at Le Bonheur Hospital in Memphis. Home visiting nurses will provide services to low income, first time mothers from pregnancy through the child's second birthday. The program is funded through a state appropriation. This project is staffed by nurses hired by Le Bonheur Hospital.

Services Offered

All home visiting models offered by TDH provide initial assessment of child and family needs. When indicated, individuals are referred to community-based agencies for additional services outside the scope of public health. The initial assessment includes the following:

1. Assessment of risk using the Domains of Wellness checklist developed by TDH and/or the Kempe Family Stress Checklist

2. Developmental screening based on the age of the child using the Denver Developmental Screening Tool or the Ages and Stages Questionnaire

3. Nutrition assessment and food scarcity assessment with referral to WIC and/or community food banks

4. Periodic assessments and review of needs during enrollment to revise the family service plan and refer for newly identified needs

5. Review of timeliness of medical services according to standards for health visits and well child checkups including immunizations for children.

All of the home visiting models, except the Nurse Family Partnership, use the Partners for a Healthy Baby curriculum, also called the Florida curriculum, which is a research-based curriculum especially designed for home visiting services provided to pregnant women and parents. In addition to information about what to expect at various stages of pregnancy, the curriculum provides age specific topics on growth and development, parenting skills and anticipatory guidance about what is normal and how to provide play and learning opportunities to enhance child development. Issues about substance use/abuse; tobacco exposure and maternal depression are included in the curriculum content.

Description of Families Served

CHAD: Based on the fourth quarter report to the Department of Children's Services for FY 2008-09. A total of 1,342 children in 948 families were served.

All children enrolled in the program were referred by public health clinics or the Department of Children's Services. Family participation is voluntary both to enroll and continue in the program. When a child/family is referred to TDH, the staff person assesses need based on a variety of issues that impact health and well being. Some of these are:

- Inadequate or no income per patient
- Unstable housing
- Education less than 12 years
- History of substance abuse
- Teen mom and/or first time mom
- No prenatal care, late prenatal care, and/or poor compliance
- History of poor pregnancy outcomes
- Prematurity/low birth weight/failure to thrive
- At risk for or has identified developmental delays
- Inadequate parenting skills
- History of or current depression and/or other mental health issues

- Marital or family problems/Domestic violence
- Limited support system

These issues are then addressed by referral to community-based agencies or as part of the home visiting content.

Status of those receiving CHAD services in FY 2008-09

- A total of 948 families with 1,342 children were served by the program
- 364 of these were newly enrolled families
- Ninety-four children were in state custody under the guardianship of a relative when enrolled
- Twenty-one children (1.56%) who were home visited were substantiated by DCS as child abuse and neglect cases during the year

The most frequent reasons for case closure were that the family moved (192), they completed or aged out of the program (118) or they failed to keep appointments (91).

Healthy Start: Based on program data from FY 2008-09. A total of 1,375 families with 1,553 children were served by the program.

Status of Mothers Served in FY 2008-09: Based on 153 prenatal and 284 postpartum enrolled families. Another 948 families with children under age 6 were served for a total of 1,375 families.

- 35% (153/437) women entered the program during pregnancy
- 36.6% (160/437) mothers enrolled were under age 18
- 52% (227/437) were between ages 18 and 25
- Most (365) were single women (83.5%)
- Half had not completed High School (50.5%)
- 94.2% (412/437) had annual income of $10,000 or less

Status of Fathers: Based on 436 men who were identified as the father and willing to disclose enrollment information

- Demographics were very similar to those cited for the mothers
- 32.3% (141/436) lived with mother
- 79.1% (316/399) earned $10,000 or less per year

Assessment of Risk and Program Services: Based on 437 prenatal or postpartum women

- 94.5% (413/437) of the mothers enrolled scored high or very high on the Stress Checklist

- 67.5% (295/437)received weekly visits
- 14.4% (63/437)received bi-monthly visits
- 93% (19,594) of all visits were conducted in the home and 3.6% were group sessions

HUGS: Based on birth certificate data collected from all families enrolled in HUGS during FY 2008-09 and program data from TDH

Status of those receiving HUGS services in FY 2008-09

- A total of 5,889 children were served by the program
- 16.8% (989/5889) had contact with DCS during the fiscal year
- 2.6% (154/5889) of children receiving services were identified as abused or neglected children after DCS case review

Status of Mothers Served in FY 2009: (Based on 3078 births)

- 78.8% (2,426/ 3078) had adequate prenatal care
- 4.2% (129/ 3078) had no prenatal care
- 23.6% (727/3078) reported that they smoked during pregnancy
- 55% (1,693/ 3078) were first time mothers

Status of the Infants and Children

- 77.6% (2,389) were a healthy weight (2500 grams or more) at birth
- The average gestational age was 37.8 weeks
- 95% of the children were enrolled in WIC
- 87% of the two year olds were up to date on immunizations

Nurse Family Partnership: As of June 30, 2009 there was no descriptive information available on the women/families served. The contract with Le Bonheur to establish the Nurse Family Partnership pilot program was finalized in May 2009. Program implementation began immediately with interviewing and hiring staff. This evidence-based home visiting model is specifically designed to work with first time, low income mothers beginning in the prenatal period or before the infant is 4 months old. Home visits continue until the child is 2 years old. Process and outcome measures based on the national program standards will be reported in the FY 2009-2010 annual report. Information about the women and their pregnancy outcomes will be included.

This program received special approval from the national Nurse Family Partnership office to modify the model by hiring diploma and associate degree nurses rather than the Bachelor of

Science in Nursing (BSN) staff as required for replication of the model. Limits on the availability of BSN nurses and salary requirements of interested BSN nurses necessitated this special request. Staff hiring was completed in late November 2009 and the required national training is scheduled for January 2010. Families cannot be enrolled until the training is completed.

Summary Tables

The following section contains descriptive tables that summarize the similarities and differences between the home visiting programs discussed in this report. Individual tables for each program (pages 14-20) list the goals, objectives, 2009 status based on program data, reference to the Healthy People 2010 national objectives and the statewide status for each objective. The data points reflected on these tables are used to measure our progress with the families we serve against both the state average and the national objective.

SUMMARY OF HOME VISITING PROGRAM MODELS
December 2009

Home Visiting Project	Location	Program Model	Target Group(s)	Number served FY2009	Types of Service provided	Rate of Success Measures
CHAD	22 counties in Northeast and East TN	Theory Based	Teen parents under 18; other parents at risk of abuse and neglect (DCS referred);AFDC,SSI or FPL Families	948 families with 1,342 children served	1.Family Assessment 2. Developmental screening 3. Nutrition Assessment 4. Referral for other services as needed 5. Monthly home visits	1. No DCS involvement 2. Indicators of family health 3. Satisfaction Survey collected at closure or one year of service
HEALTHY START TCA 37-3-703 Appendix C	30 counties in Middle and West TN	Research and Evidence Based	Prenatal or with infants less than 4 months; families with children under 5years old; low income	1,375 families with 1,553 children served	1.Family Assessment and Stress Inventory 2. Developmental screening 3. Referral for needed services 4. Home visits as scheduled	1. No DCS involvement 2. No subsequent pregnancy within 12 months 3. Healthy birth weight and gestation for those in the program 4. Immunization rates for children
HUGS	All counties	Theory based	Prenatal; families with children under 6 years old; women up to 2 yrs postpartum; loss of a child before age 2; no income requirements	5,889 children served	1. Family assessment 2. Developmental assessment 3. Referral for needed services 4. Home visits as scheduled	1.Healthy birth for those entering as prenatals 2. Check ups and screens according to schedule 3. Referred for needed services 4. No DCS involvement
NURSE FAMILY PARTNER-SHIP TCA 68-1-2503 Appendix C	1 pilot project in Memphis	Research and Evidence Based	First time mothers only; can continue service until child is 2 yrs. old	Project started May 2009 with hiring and training staff; no service data available for FY 2009	In process Intensive home visiting services with caseload of 25 or less per worker	NA Current status: Hired staff of 4 nurses/1 nurse supv. Training with national trainers scheduled for Jan 2010.

CHAD
Goals, Objectives and Annual Status
Compared to Healthy People 2010 Goals and State Data
Fiscal Year 2009

Home Visiting Program	GOAL(s)	OBJECTIVES	STATUS FY 2009	HP 2010 Goal/ State Status
CHAD	1) To prevent child abuse and neglect	1) 100% of children free of child abuse and neglect as measured by DCS reported involvement in prior 12 months	1) 98.4% of enrolled children free of child abuse and neglect as measured by DCS reported involvement in prior 12 months 1.56% (21) children entered DCS in this time period.	**Healthy People 2010 -15-33a**. Reduce maltreatment and maltreatment fatalities of children to 10.3/1,000 children under age 18. Nat'l Target = 10.3/1,000 TN status (2008) = 7/1,000
	2) To promote family health	2) 90% of 2 year olds fully immunized (establishes that the child has and uses a medical home)	2) 97.7% (258 of the 264 two year olds) enrolled in CHAD were up to date on immunizations	**Healthy People 2010 -14-22** Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children at 90%. Nat'l Target = 90% TN status (2008) = 88%

HEALTHY START
Goals, Objectives and Annual Status
Compared to Healthy People 2010 Goals and State Data
Fiscal Year 2009

Home Visiting Program	GOALS	OBJECTIVES	FY 2009 STATUS	Healthy People 2010/ State status
HEALTHY START	1) To prevent child abuse and neglect	1) At least 95% of program children will be free from abuse and neglect and remain in the home.	31 (1.96%) families were reported by HS workers as suspected for abuse or neglect . 98.1% of those served did not exhibit signs of abuse or neglect during the fiscal year.	**Healthy People 2010, 15-33a** Reduce maltreatment and maltreatment fatalities of children to 10.3/1,000 children under age 18. Nat'l Target = 10.3/1,000 TN status (2008) = 7/1,000
	2) To promote and improve health status of family members	2) At least 90% of program children are up to date with immunizations by their 2nd birthday. (Establishes patient has medical home and uses medical home.)	2) 97.3% (479) children were up to date on immunizations by their 2nd birthday	**Healthy People 2010, 14-22** Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children at 90%. Nat'l Target = 90% TN status (2008) = 88%
		3) At least 94% of Healthy Start program mothers will delay a subsequent pregnancy for one year (12 months) after the birth of the previous child.	3) 76% (659) were not pregnant one year after the birth of the previous child	**Healthy People2010- 9-2** Increase the proportion of births occurring more than 24 months after a previous birth to 94% or more. Nat'l Target = 94% TN status **=** Tennessee PRAMS data, special study of pregnant and post partum Tennesseans, will be available for FY 2010 report.
	3) To promote healthy birth measured by birth weight 2,500 grams or more and gestational age of at least 37 weeks.	3a) At least 90% of mothers receive adequate prenatal care starting in the first trimester.	Data will be available for the FY 2010 report	**Healthy People 2010, 16-6** Increase the proportion of pregnant women who receive early and adequate prenatal care in the first trimester to 90%. Nat'l Target = 90% TN (2008) = 86%

		3b) At least 85% of mothers enrolled during the prenatal period will have a healthy birth measured by birth weight 2,500 grams or more.	3b) 87.2% (334) births weights were 2500 grams or more	**Healthy People 2010, 16-10** Increase normal birth weight (2500 grams or greater) births to 95% or more. Nat'l Target = 95% TN (2008) = 90.6%
		3c) At least 85% of mothers enrolled during the prenatal period will have a healthy birth measured by gestational age of at least 37 weeks to 42 weeks.	3c) 85% (332) were at least 37 weeks gestational age	**Healthy People 2010, 16-11** Increase term births (between 37 and 42 week) to 92.4% or more Nat'l Target = 92.4% TN (2008) = 90%

HUGS
Goals, Objectives and Annual Status
Compared to Healthy People 2010 Goals and State Data
Fiscal Year 2009

Home Visiting Program	GOALS	OBJECTIVES	FY 2009 STATUS	Healthy People 2010/ State Status
HUGS	1) Pregnant women in the program will have a healthy pregnancy and birth.	1a) At least 90% of enrolled pregnant women have adequate prenatal care.	1a) 78.8% (2,426) of HUGS prenatals had adequate prenatal care 4.2% (129) had no prenatal care	**Healthy People 2010, 16-6, 16-10, 16-11** Increase the proportion of pregnant women who receive early and adequate prenatal care in the first trimester to 90%. Nat'l Target = 90% TN = Tennessee PRAMS data, a special study of post partum Tennesseans, will be available for FY 2010 report.
		1b) At least 90% of women will not smoke during pregnancy.	1b) In the HUGS population, 76.4% (3078) of women reported that they did not smoke during pregnancy	**Healthy People 2010 – 16-17** Increase abstinence from cigarette smoking among pregnant women to 99% Nat'l Target = 99% TN = (2006-2008) 81% of women reported they did not smoke during their pregnancy
		1c.1) At least 90% of women clients are practicing some form of birth spacing. 1c.2) New mothers delay another pregnancy for at least 12 months.	1c.1 and 1c.2) 55% (1,693) of the births were to first time mothers Birth spacing is measured in the new data collection system. Data will be available for FY 2010.	**Healthy People2010- 9-2** **Increase the proportion of** births occurring more than 24 months of a previous birth to 94% or more. Nat'l Target = 94% TN (2007) = Tennessee PRAMS data, a special study of post partum Tennesseans, will be available for FY 2010 report.

		1d) At least 85% of mothers enrolled during the prenatal period will have a healthy birth measured by birth weight 2,500 grams or more	1d. 77.6% (2,389) of babies born to HUGS participants were of a healthy weight. The average birth weight was 2,997 grams.	**Healthy People 2010, 16-10** Increase normal birth weight (2500 grams or greater) births to 95% or more. Nat'l Target = 95% TN (2008) = 90.6% (Birth Certificate Data)
		1e) At least 85% of mothers enrolled during the prenatal period will have a healthy birth measured by gestational age of at least 37 weeks to 42 weeks.	The average gestational age was 37.8 weeks and the average number of prenatal visits was 12.6 per mother.	**Healthy People 2010, 16-11** Increase term births (between 37 and 42 week) to 92.4% or more Nat'l Target = 92.4% TN (2008) = 90%
	2) Parents/caregivers nurture their child's growth and development before school entry.	2a) At least 90% of the infants and children enrolled will receive and maintain effective vaccination coverage for universally recommended vaccines among young children.	2a) 87% (707/812) of the 2 year olds were up to date on immunizations	**Healthy People 2010 14-22** Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children at 90%. Nat'l Target =90% TN (2008) = 88%
		2b) At least 90% of infants and children enrolled will receive age appropriate screening for developmental delays.	2b) Evidence based developmental screening tool implemented. Data available for the FY 2010 report	Based on Policy Guidelines by the American Academy of Pediatrics which state that early identification of developmental disorders is critical to the well-being of children and their families."
		c) At least 90 percent of the program participants (caregivers and children) identified as needing other community services are referred within one month and receipt of the service is documented.	2c) Data on completed referrals will be available for the FY 2010 report. Data collection began in July 2009.	No comparative national objective or state data available

		2d) Adequate parenting skills demonstrated by no involvement with the Department of Children's Services system during the fiscal year. 2e) Enrolled mothers and children participate in WIC	2d) Of the 5889 children served, 2.6% (154) were substantiated cases of abuse or neglect during the fiscal year. 2e) 94% of the eligible women were enrolled in WIC 95% of the children were enrolled in WIC	**Healthy People 15-33** Reduce maltreatment and maltreatment fatalities of children to 10.3/1,000 children under age 18. Nat'l Target = 10.3/1,000 TN (2008) = 7/1,000

Nurse Family Partnership
Goals, Objectives and Annual Status
Compared to Healthy People 2010 Goals and State Data
Fiscal Year 2009

Home Visiting Program	GOALS	OBJECTIVES	FY 2009 STATUS	Healthy People 2010/ State Status
NURSE FAMILY PARTNERSHIP (Goals and Objectives taken from the contract scope of services based on the national program model)	1) Improved pregnancy outcome	1) Reduce the occurrence of behavioral impairment due to use of alcohol and other drugs	Contract finalized in May 2009 and staff hired. Full program implementation scheduled to begin in FY 2010. Detailed data will be available in the annual report to be submitted Jan 2010.	Behavioral Risk Factor Surveillance data (2008) indicates that of the women in Shelby County: 34.3% reported drinking within the last 30 days 8.3% report binge drinking and 4.1% report heavy drinking.
	2) Improved child health and development	2a) Reduce the number of subsequent pregnancies		
		2b) Reduce reported incidence of child abuse and neglect among families receiving service		
		2c) Reduced criminal activity engaged in by the mothers receiving service		
		2d) Reduced receipt of public assistance by mothers receiving program services		

Challenges/Obstacles

Explanation for the Variation in Program Models and Funding Streams

As discussed briefly in the opening section of this document, the development of home visiting services in Tennessee began over 30 years ago when the state implemented the Child Health and Development Program (CHAD). This research and theory based program evolved from a research and demonstration project at Peabody College of Vanderbilt University. Each county had a team consisting of a nurse, a social worker, a lay home visitor and a nutritionist available for consultation and education when indicated. Cases were assigned based on the family's needs and periodic assessments were completed to evaluate the child's development. Parenting education was provided through discussion, educational materials and demonstration.

As time passed, funding streams to support such services changed and state reductions in force resulted in changes in the staffing pattern and program requirements. In the 1990's, DCS contracted with TDH to provide CHAD home visiting services to families with young children at risk of abuse and neglect. Today, only 22 counties have CHAD services, concentrated in East and Northeast Tennessee. The teams no longer exist. A home visitor in a county has consultation available for nutrition or nursing/medical needs and social work referral. All workers have supervision and periodic in-service training.

The Tennessee Child Development Act of 1994 (TCA 37-3- 703) mandated that the state implement Healthy Start home visiting programs based on the Healthy Start – Hawaii model. Since these programs are child abuse/maltreatment prevention focused, state funding was appropriated to DCS which in turn, contracted with TDH, the department with the most experience implementing home visiting programs. Healthy Start programs are implemented by eight community based agencies that focus on child abuse prevention through contracts with TDH. These agencies have implemented the program in 30 counties across the state. Each site uses a Healthy Start designated data collection system that is sent electronically to TDH each

month. The data elements collected were determined by DCS to meet the requirements of the law and the internal reporting that they needed. The Healthy Start model requires staff training by a nationally recognized trainer in Healthy Start; scheduling training and preparing new employees has sometimes been a problem for these agencies dependent on the availability of the trainer.

Data Collection System

Data collection and reporting on home visiting activities have been hampered by TDH's patient information management system called PTBMIS and staff with skills in data analysis. PTBMIS is a 30 year old DOS system that has served the Department well but has limitations given the need for accurate and timely data on program outcomes. The Department has developed a proposal to upgrade this important public health tool that affects all programs but the current fiscal climate has postponed contracting for new system development to meet our needs. A new system must not only maintain client demographic information, but also include encounter, pharmacy and payment information systems. Individual programs could also add and collect process and outcome indicators to aid program managers in evaluating the effectiveness of programs offered by TDH. Until such a system can be developed, TDH is limited in data that can be extracted from PTBMIS.

Staff Qualifications and Training

Home visiting program effectiveness is heavily influenced by staff qualifications and training. Much of the current rhetoric on the importance of evidence based programs emphasizes the need for staffing by nurses who are assigned limited caseloads and can work intensively over at least two years with the families enrolled. In principle, these are desired program standards; in reality, they are difficult to implement and maintain. The Nurse Family Partnership model established in Memphis could not find nurses with Bachelor's degrees who agreed to work for the salary offered. This problem resulted in the program asking the national office for an approved exception to allow them to hire nurses with other degrees.

Training- both orientation and in-service training - impacts the quality of a home visiting program. New workers need orientation to public health and the state administrative procedures in addition to the specifics of the home visiting model. They need frequent individual and group supervision; they need periodic in-service training on topics of relevance to their role with families and they need qualified staff in other disciplines to consult and advise about issues they have identified that impact child and family well being. Like teachers, they need salary grades that are commensurate with their job duties. They also need office support staff to assist with many of the administrative tasks involved with enrolling and documenting services provided. The recent TDH reduction in force has resulted in the loss of office support who previously provided ancillary services to the home visiting staff and families.

Community Referral Resources

Home visiting program staff need constant upgrading of skills to address family needs and regional/local networks that address those identified needs. Some services are not available in certain areas of the state; others are not accessible because of long waiting lists or distance. Tennessee's patchwork of referral agencies make it difficult to get families to the services they need; occasionally, when services are available, only a small portion can be enrolled. As an example, home visiting services are available in all counties but only a few families receive this service due to staff and funding limitations.

Another example of the need for community resources relates to maternal depression. It has been identified as a problem for some mothers following the birth of the baby and we now know that maternal depression left untreated, affects appropriate child development. Reliable methods for assessing maternal depression exist that can be used by others besides the medical profession. If a mother is identified with probable maternal depression, she can be referred for further evaluation and treatment. Screening and identification provides a gateway to treatment that should impact the outcome of mother and child. Unfortunately, the lack of mental health services, especially in the rural areas of Tennessee, and the limited availability of health care coverage for mental health services limits our ability to include maternal depression

as a component of home visiting services. Guided by the public health principle that we do not screen for medical problems unless we can address those identified, we cannot implement broad based assessment of maternal depression without treatment and therapeutic intervention being available across the state.

In July 2009, TDH implemented an electronic system to track referrals and document serviced received from community agencies. This system should help us identify the type and frequency of needs experienced by families and strengths and gaps in referral systems at the regional level. Since much of the home visiting work centers on quarterly assessments of the child and family to identify potential problems, it's important to evaluate our ability to link families with those needed services. Information about this system will be included in next year's report.

Program Accomplishments

The overall goal of these home visiting programs is similar and contributes to the efficacy of providing these services to children and families at risk. The following accomplishments are noted for the year:

- At least 98% of the children enrolled were free of abuse and neglect
- Immunization rates at age 2, which is an indicator that the child has a medical home, were at 85% or higher. Tennessee has the third highest immunization rate in the nation.
- At least 75% of the mothers were not pregnant 12 months after the birth of a baby
- 87.2% of the births were babies weighing 2500 grams or more which is considered a healthy birth weight.
- 85% of the babies were born at 37 weeks gestation or more.
- 76.4% of the mothers reported they were non-smokers (HUGS)
- 94% of the women participated in WIC (HUGS)
- 95% of the children were enrolled in WIC (HUGS)

NUMBER SERVED IN CHAD AND HUGS BY COUNTY 12/2009

		Children Served in 07 - 08			Children Served in 08 - 09		
Region	**County Name**	**CHAD**	**HUGS**	**Total**	**CHAD**	**HUGS**	**Total**
Northeast	Carter	133	26	159	67	37	104
Northeast	Greene	126	155	281	102	152	254
Northeast	Hancock	76	18	94	71	30	101
Northeast	Hawkins	137	125	262	148	66	214
Northeast	Johnson	37	76	113	32	78	110
Northeast	Unicoi	96	55	151	84	93	177
Northeast	Washington	146	217	363	219	212	431
Total		**751**	**672**	**1423**	**723**	**668**	**1391**
East	Anderson	31	20	51	44	22	66
East	Blount	60	26	86	53	48	101
East	Campbell	49	74	123	58	65	123
East	Claiborne	20	2	22	21	10	31
East	Cocke	89	19	108	62	34	96
East	Grainger	46	9	55	52	31	83
East	Hamblen	30	21	51	33	18	51
East	Jefferson	43	17	60	23	10	33
East	Loudon	40	14	54	28	17	45
East	Monroe	52	58	110	65	43	108
East	Morgan		7	7		11	11
East	Roane	31	12	43	27	56	83
East	Scott	47	7	54	71	15	86
East	Sevier	85	48	133	75	66	141
East	Union	4	8	12	7	20	27
Total		**627**	**342**	**969**	**619**	**466**	**1085**
Southeast	Bledsoe		1	1		1	1
Southeast	Bradley		117	117		82	82
Southeast	Franklin		0	0		2	2
Southeast	Grundy		0	0		3	3
Southeast	Marion		2	2		13	13
Southeast	McMinn		17	17		17	17
Southeast	Meigs		4	4		2	2
Southeast	Polk		17	17		7	7
Southeast	Rhea		4	4		2	2
Total		**0**	**162**	**162**	**0**	**129**	**129**

		Children Served in 07 - 08			Children Served in 08 - 09		
Region	**County Name**	**CHAD**	**HUGS**	**Total**	**CHAD**	**HUGS**	**Total**
Upper Cumberland	Cannon		12	12		8	8
Upper Cumberland	Clay		13	13		15	15
Upper Cumberland	Cumberland		31	31		37	37
Upper Cumberland	Dekalb		27	27		31	31
Upper Cumberland	Fentress		35	35		35	35
Upper Cumberland	Jackson		20	20		21	21
Upper Cumberland	Macon		35	35		50	50
Upper Cumberland	Overton		18	18		23	23
Upper Cumberland	Pickett		6	6		11	11
Upper Cumberland	Putnam		116	116		88	88
Upper Cumberland	Smith		45	45		39	39
Upper Cumberland	Van Buren		0	0		1	1
Upper Cumberland	Warren		49	49		43	43
Upper Cumberland	White		33	33		33	33
Total		**0**	**440**	**440**	**0**	**435**	**435**
Mid Cumberland	Cheatham		7	7		19	19
Mid Cumberland	Dickson		13	13		27	27
Mid Cumberland	Houston		0	0		0	0
Mid Cumberland	Humphreys		2	2		0	0
Mid Cumberland	Montgomery		10	10		36	36
Mid Cumberland	Robertson		12	12		17	17
Mid Cumberland	Rutherford		62	62		143	143
Mid Cumberland	Stewart		21	21		13	13
Mid Cumberland	Sumner		138	138		163	163
Mid Cumberland	Trousdale		0	0		0	0
Mid Cumberland	Williamson		17	17		31	31
Mid Cumberland	Wilson		93	93		147	147
Total		**0**	**375**	**375**	**0**	**596**	**596**
South Central	Bedford		137	137		141	141
South Central	Coffee		37	37		28	28
South Central	Giles		43	43		33	33
South Central	Hickman		15	15		14	14
South Central	Lawrence		343	343		23	23
South Central	Lewis		13	13		16	16
South Central	Lincoln		26	26		35	35
South Central	Marshall		36	36		23	23
South Central	Maury		31	31		39	39
South Central	Moore		1	1		1	1
South Central	Perry		5	5		2	2
South Central	Wayne		2	2		7	7
Total		**0**	**689**	**689**	**0**	**362**	**362**

		Children Served in 07 - 08			Children Served in 08 - 09		
Region	**County**	**CHAD**	**HUGS**	**Total**	**CHAD**	**HUGS**	**Total**
West	Benton		0	0		9	9
West	Carroll		46	46		50	50
West	Chester		0	0		10	10
West	Crockett		0	0		7	7
West	Decatur		13	13		17	17
West	Dyer		67	67		70	70
West	Fayette		73	73		67	67
West	Gibson		45	45		68	68
West	Hardeman		44	44		47	47
West	Hardin		64	64		67	67
West	Haywood		48	48		52	52
West	Henderson		51	51		45	45
West	Henry		0	0		4	4
West	Lake		72	72		47	47
West	Lauderdale		57	57		57	57
West	McNairy		0	0		5	5
West	Obion		27	27		18	18
West	Tipton		82	82		90	90
West	Weakley		0	0		18	18
Total		**0**	**689**	**689**	**0**	**748**	**748**
Shelby	Shelby		614	614		1156	1156
Davidson	Davidson		381	381		591	591
Hamilton	Hamilton		260	260		307	307
Knox	Knox		54	54		99	99
Madison	Madison		40	40		57	57
Sullivan	Sullivan		245	245		275	275
Total		**0**	**1594**	**1594**	**0**	**2485**	**2485**
State Total		**1378**	**4963**	**6341**	**1342**	**5889**	**7231**

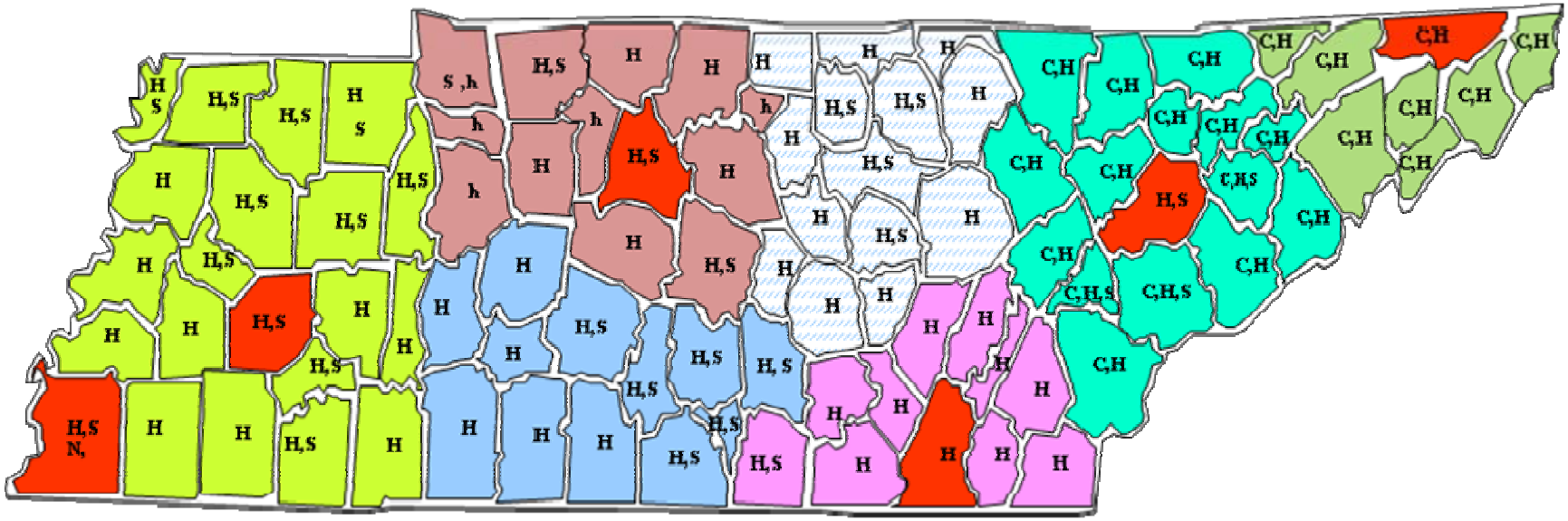
Appendices

A. State Map with Program Locations

B. Contract Agencies Providing Services

C. State statutes/TCA codes

Tennessee Department of Health
Home Visiting Programs



Metropolitan Regions

West Region

South Central Region

Mid-Cumberland Region

Upper Cumberland Region

Southeast Region

East Region

Northeast Region

C – CHAD Program (22 Counties)

H – HUGS Program (95 Counties)

h - Limited HUGS Services (4 Counties P/T Nurse)

S – State Healthy Start Program (30 Counties through contracts with CBOs)

N – Nurse Family Partnership (1 County through contract)

Revised 12/09

Appendix B

Agencies Providing Healthy Start Services

Contracts through the TN Department of Health
December 2009

Healthy Families
The Center for Family Development
Shelbyville, TN 37160

Bedford, Coffee, Lincoln, Marshall, Moore, Maury, Rutherford & Franklin

Healthy Start Madison, Chester & Crockett Counties
Jackson-Madison County General Hospital
Jackson, TN 38301-3956

Madison, Chester & Crockett

Healthy Families East Tennessee
Helen Ross McNabb Center
Knoxville, TN 37921

Blount, Jefferson, Knox & Loudon

Healthy Start Northwest
University of Tennessee – Martin
Martin, TN 38238-5045

Benton, Carroll, Gibson, Henry, Lake, Obion & Weakley

Healthy Start of Clarksville
Clarksville Health System
Clarksville, TN 37043

Montgomery & Stewart

Le Bonheur Healthy Families Program
LeBonheur Community Outreach
Memphis, TN 38112

Shelby County

Healthy Start
Exchange Club/Holland Stephens Center
Livingston, TN 38570

Jackson, Overton, Putnam & White

Nashville Healthy Start
Metro. Nashville/Davidson Co. Health Dept.
Nashville, TN 37203

Davidson County

Help Us Grow Successfully (HUGS) Contract Sites

December 2009

Name: Metropolitan Nashville Davidson County Health Department
Location: 311 23rd Avenue North, Nashville, TN 37203
County: Davidson

Name: Knox County Health Department
Location: 140 Dameron Avenue, Knoxville, TN 37917
County: Knox

Name: Chattanooga-Hamilton County Health Department
Location: 921 East Third Street, Chattanooga, TN 37403
County: Hamilton

Name: Jackson - Madison County Health Department
Location: 804 North Parkway, Jackson, TN 38305
County: Madison

Name: Memphis-Shelby County Health Department
Location: 814 Jefferson Avenue, Memphis, TN 38105
County: Shelby

Name: Sullivan County Health Department
Location: 154 Blountville Bypass, Blountville, TN 37617
County: Sullivan

Name: The Healing Word Counseling Center
Location: 3910 Tullahoma Road, Memphis, TN 38118
County: Shelby

NURSE FAMILY PARTNERSHIP SITE

Name: LeBonheur Community Outreach-Nurse Family Partnership
Location: 2400 Poplar, Suite 550, Memphis, TN 38112
County: Shelby

Appendix C

68-1-125. Funds for in-home visitation programs – Emphasis on evidence-based programs — Report on findings. —

(a) As used in this section, unless the context otherwise requires:

(1) "Evidence-based" means a program or practice that meets the following requirements:

(A) 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

(B) Scientific research using methods that meet high scientific standards for evaluating the effects of such programs must have demonstrated with two (2) or more separate client samples that the program improves client outcomes central to the purpose of the program;

(2) "In-home visitation" means a service delivery strategy that is carried out in the homes of families of children from conception to school age that provides culturally sensitive face-to-face visits by nurses, other professionals, or trained and supervised lay workers to promote positive parenting practices, enhance the socio-emotional and cognitive development of children, improve the health of the family, and empower families to be self-sufficient;

(3) "Pilot program" means a temporary research-based or theory-based program or project that is eligible for funding from any source to determine whether or not evidence supports its continuation beyond the fixed evaluation period. A pilot program must provide for and include:

(A) Development of a program manual or protocol that specifies the nature, quality, and amount of service that constitutes the program; and

(B) Scientific research using methods that meet high scientific standards for evaluating the effects of such programs must demonstrate on at least an annual basis whether or not the program improves client outcomes central to the purpose of the program;

(4) "Research-based" means a program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based; and

(5) "Theory-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, may have anecdotal or case-study support, and has potential for becoming a research-based program or practice.

(b) (1) With the long-term emphasis on procuring services whose methods have been measured, tested and demonstrated to improve client outcomes, the department of health, and any other state agency that administers funds related to in-home visitation programs, shall strive to expend state funds on any such program or programs related to in-home visitation, including any service model or delivery system in any form or by any name, that are evidence-based.

(2) With the goal of identifying and expanding the number and type of available evidence-based programs, the department shall continue the ongoing research and evaluation of sound, theory-based and research-based programs and to that end the department may engage in and fund pilot programs as defined in this section.

(c) The department shall include in any contract with a provider of services related to in-home visitation programs a provision requiring that the provider shall set forth a means to measure the outcome of the services. The measures must include, but not be limited to, the number of people served, the type of services provided, and the estimated rate of success of the population served.

(d) The department of health, in conjunction with a representative of the Tennessee commission on children and youth, and with ongoing consultation of appropriate experts and representatives of relevant providers who are appointed by the commissioner of health to provide such consultation, shall determine which of its current programs are evidence-based, research-based and theory-based, and shall provide a report of those findings, including an explanation of the support of those findings, to the governor, the general welfare, health and human resources committee of the senate, the children and family affairs committee of the house of representatives, and the select committee on children and youth of the general assembly by no later than January 1 of each year. The department of health shall also provide

in its report the measurements of the individual programs, as set forth in § 68-1-124(c).

[Acts 2008, ch. 1029, §§ 1, 2.]

37-3-703. Healthy start pilot project established — Objectives — Evaluation — Required disclosures. —

(a) The state of Tennessee shall develop, coordinate, and implement a healthy start pilot project within ten (10) or more counties of the state. The healthy start pilot project shall be based upon the nationally recognized model, shall focus on home visitation and counseling services, and shall improve family functioning and eliminate abuse and neglect of infants and young children within families identified as high risk. Healthy start services for participating families shall extend at least through a child's first three (3) years of life. However, family participation shall be voluntary; and, if a family refuses healthy start services, then such refusal shall not be admissible in evidence for any subsequent cause of action.

(b) Healthy start pilot projects shall ensure that:

(1) Families are educated about child health and child development;

(2) Families receive services to meet child health and development needs;

(3) Families receive services as identified and prioritized by the family and the project; and

(4) Services focus on empowering the family and strengthening life-coping and parenting skills.

(c) Specific objectives for healthy start pilot projects shall include that:

(1) Family stress is reduced and family functioning is improved;

(2) All of the children receive immunizations by two (2) years of age;

(3) All of the children receive developmental screening and follow-up services;

(4) All of the children are free from abuse and neglect; and

(5) Mothers are enrolled in prenatal care by the end of the first trimester of any subsequent pregnancy.

(d) The state of Tennessee shall conduct ongoing evaluations of the healthy start pilot project and shall file a joint report, on or before December 31 of each year, with the governor, the chair of the general welfare, health and human resources committee of the senate, the chair of the health and human resources committee of the house of representatives, and the chair of the select committee on children and youth. All state agencies that provide services to children shall make available nonidentifying information about healthy start participants for the purpose of conducting the evaluation. The report shall include the following information for the preceding fiscal year:

(1) The number of families receiving services through the pilot project;

(2) The number of children at risk of abuse and neglect prior to initiative of service to families participating in the pilot project;

(3) Among those children identified in subdivision (2), the number of children who have been the subjects of abuse and neglect reports;

(4) The average cost of services provided under the pilot project;

(5) The estimated cost of out-of-home placement, through foster care, group homes or other facilities, that reasonably would have otherwise been expended on behalf of children who successfully remain united with their families as a direct result of the project, based on average lengths of stay and average costs of such out-of-home placements;

(6) The number of children who remain unified with their families and free from abuse and neglect for one (1), two (2), three (3), and four (4) years, respectively, while receiving project services; and

(7) An overall statement of the achievements and progress of the pilot project during the preceding fiscal year, along with recommendations for improvement or expansion.

(e) (1) When offering healthy start services to a family, the state or its contractor shall provide that family with a written statement and oral explanation. Both the statement and explanation shall describe the following information:

(A) The purpose of the healthy start project;

(B) Project services that may be offered;

(C) The voluntary nature of participation and the family's right to decline services at any time;

(D) The project records to be maintained with respect to participating families; and

(E) The family's right to review project records pertaining to that family.

(2) After providing the oral explanation, the state or its contractor shall, on the written statement, obtain signed consent from the parents or caretakers of a child. The parents or caretakers shall receive a copy of the signed statement and a copy will be maintained in the family's record.

(3) Each participating family shall have the right to review project records pertaining to that family. The state or its contractor shall make such record available for review during regular office hours.

[Acts 1994, ch. 974, § 3; 1995, ch. 538, § 1.]

NURSE FAMILY PARTNERSHIP PILOT PROJECT

68-1-2503. Part definitions. —

As used in this part, unless the context otherwise requires:

(1) "Department" means the department of health;

(2) "Entity" means any nonprofit, not-for-profit, or for-profit corporation, religious or charitable organization, institution of higher education, visiting nurse association, existing visiting nurse program, local health department, county department of social services, political subdivision of the state, or other governmental agency or any combination thereof;

(3) "Health care and services facility" means a health care entity or facility identified pursuant to § 68-1-2505 to assist the department in administering the program;

(4) "Low-income" means an annual income that does not exceed two hundred percent (200%) of the federal poverty level;

(5) “Nurse” means a person licensed as a professional nurse pursuant to title 63, chapter 7; and

(6) “Program” means the nurse home visitor program established in this part.

[Acts 2007, ch. 530, § 1.]

68-1-2504. Establishment of program — Participation — Rules and regulations. —

(a) There is established the nurse home visitor program to provide regular, in-home, visiting nurse services to low-income, first-time mothers, with their consent, during their pregnancies and through their children's second birthday. The program training requirements, program protocols, program management information systems, and program evaluation requirements shall be based on research-based model programs that have been replicated in multiple, rigorous, randomized clinical trials and in multiple sites that have shown significant reductions in:

(1) The occurrence among families receiving services through the model program of infant behavioral impairments due to use of alcohol and other drugs, including nicotine;

(2) The number of reported incidents of child abuse and neglect among families receiving services through the model program;

(3) The number of subsequent pregnancies by mothers receiving services through the model program;

(4) The receipt of public assistance by mothers receiving services through the model program; and

(5) Criminal activity engaged in by mothers receiving services through the model program and their children. The program shall provide trained visiting nurses to help educate mothers on the importance of nutrition and avoiding alcohol and drugs, including nicotine, and to assist and educate mothers in providing general care for their children and in improving health outcomes for their children. In addition, visiting nurses may help mothers in locating assistance with educational achievement and employment. Any assistance provided through the program shall be provided only with the consent of the low-income, first-time mother, and she may refuse further services at any time. The program should be significantly modeled on the national Nurse-Family Partnership program.

(b) The program shall be administered in a community or communities by an entity or entities selected under this part. For the purpose of this pilot program, if the commissioner determines that it is necessary in order to implement a pilot project for the program, then the commissioner is authorized to make a grant or grants without competitive bidding. If selection is made on a competitive basis, any entity that seeks to administer the program shall submit an application to the department as provided in § 68-1-2506. The entity or entities selected pursuant to § 68-1-2507 for implementing the project shall be expected to provide services for up to one hundred (100) low-income, first-time mothers in the community in which the entity administers the program. A mother shall be eligible to receive services through the program if she is pregnant with her first child, and her gross annual income does not exceed two hundred percent (200%) of the federal poverty level.

(c) The department may promulgate rules pursuant to Uniform Administrative Procedures Act, compiled in title 4, chapter 5, for the implementation of the program.

(d) Notwithstanding subsection (c), the department may adopt rules pursuant to which a nurse home visitation program that is in operation in the state as of July 1, 2007, may qualify for participation in the program if it can demonstrate that it has been in operation in the state for a minimum of five (5) years and that it has achieved a reduction in the occurrences specified in subsection (c). Any program so approved shall be exempt from the rules adopted regarding program training requirements, program protocols, program management information systems, and program evaluation requirements, so long as the program continues to demonstrate a reduction in the occurrences specified in subsection (a).

[Acts 2007, ch. 530, § 1; 2008, ch. 1126, § 1.]

68-1-2505. Health care and services facility to assist with program. —

(a) The commissioner of health shall select the national service organization of the Nurse-Family Partnership program as the health care and services facility with the knowledge and experience necessary to assist the department in selecting entities from among the applications, if any, submitted pursuant to § 68-1-2506 and in monitoring and evaluating the implementation of the program in communities throughout the state.

(b) The health care and services facility shall monitor the administration of the program by the selected entities to ensure that the program is implemented according to the program training requirements, program protocols, program management information systems, and program evaluation requirements established by the department. The health care and services facility shall evaluate the overall implementation of the program and include the evaluation, along with any recommendations concerning the selected entities or changes in the program training requirements, program protocols, program management information systems, or program evaluation requirements, in the annual report submitted to the department pursuant to § 68-1-2508.

(c) The department shall compensate the health care and services facility for the costs incurred in performing its duties under this part. The compensation shall be included in the actual costs incurred by the department in administering the program and paid out of the amount allocated to the department for administrative costs.

[Acts 2007, ch. 530, § 1; 2008, ch. 1126, § 2.]

68-1-2506. Application to administer program. —

(a) Any entity that seeks to administer the program in a community pursuant to any competitive bidding process shall submit an application to the department. At a minimum, the application shall specify the basic elements and procedures that the entity shall use in administering the program. Basic program elements shall include, but are not limited to, the following:

(1) The specific training to be received by each nurse employed by the entity to provide home nursing services through the program;

(2) The protocols to be followed by the entity in administering the program;

(3) The management information system to be used by the entity in administering the program;

(4) The reporting and evaluation system to be used by the entity in measuring the effectiveness of the program in assisting low-income, first-time mothers; and

(5) An annual report to both the health care and services facility and the community in which the entity administers the program that reports on the effectiveness within the community and is written in a manner that is understandable for both the health care and services facility and members of the community.

(b) Any program application submitted pursuant to this section shall demonstrate strong, bipartisan public support for and a long-term commitment to operation of the program in the community.

(c) The department shall initially review any applications received pursuant to this section and submit to the health care and services facility for review those applications that include the basic program elements. Following its review, the health care and services facility shall submit to the department the name of the entity or entities that the health care and services facility recommends to administer the program.

[Acts 2007, ch. 530, § 1; 2008, ch. 1126, § 3.]

68-1-2507. Selection of entities recommended by the health care and services facility — Grants — Creation of fund. —

(a) The department shall select the entities that will administer the program.

(b) (1) The entity or entities selected to operate the program shall receive grants in amounts specified by the department. The grants may include operating costs, including, but not limited to, development of the information management system, necessary to administer the program. The number of entities selected and the number of communities in which the program shall be implemented shall be determined by moneys available in the nurse home visitor program fund created in subdivision (b)(2).

(2) Grants awarded pursuant to subdivision (b)(1) shall be payable from the nurse home visitor program fund, which fund is hereby created in the state treasury. The nurse home visitor program fund, referred to in this section as the fund, shall consist of moneys appropriated to the fund by the general assembly from general revenue and moneys received from the federal government. Any revenues or moneys deposited in the fund shall remain in the fund until expended for purposes consistent with this part and shall not revert to the general fund on any June 30. In addition, the state treasurer may credit to the fund any public or private gifts, grants, or donations received by the department for implementation of the program. The fund shall be subject to annual appropriation by the general assembly to the department for grants to entities for operation of the program. Notwithstanding any other law, all interest derived from the deposit and investment of moneys in the fund shall be credited to the fund.

[Acts 2007, ch. 530, § 1; 2008, ch. 1126, § 4.]

68-1-2508. Program oversight — Reporting. —

Entities receiving grants shall report to the heath sciences facility as often as the department determines to be beneficial to program oversight. The health care and services facility shall report to the department as often as the department determines to be beneficial to program oversight, but at least annually. The department shall report in writing on an annual basis to the general assembly.

[Acts 2007, ch. 530, § 1.]

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