Tennessee Home Visiting Annual Report

July 1, 2018 – June 30, 2019

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

HOME VISITING
ANNUAL REPORT
FOR STATE FISCAL YEAR 2019

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STATE OF TENNESSEE
DEPARTMENT OF HEALTH
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NASHVILLE, TENNESSEE 37243

MEMORANDUM

To: The Honorable Bill Lee, Governor
The Honorable Randy McNally, Lieutenant Governor
The Honorable Cameron Sexton, Speaker of the House
Honorable Members of the Tennessee General Assembly

From: Lisa Piercey, MD, MBA, FAAP
Commissioner, Tennessee Department of Health

Date: December 30, 2019

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, 2018 – June 30, 2019 is hereby submitted. The report provides an overview of the status of efforts to identify, implement and expand the number of Evidence-based Home Visiting (EBHV) programs and research based programs throughout Tennessee. The report also includes process and outcome measures used to evaluate the quality of home visiting services offered to participating families such as the number of families served, the types of services provided, and the estimated rate of success in meeting specific goals and objectives.

A total of 2,569 children and their families received home visiting services from July 1, 2018 – June 30, 2019 through evidence-based or research-based home visiting programs (this figure includes EBHV and CHAD)**.** Each program has different service delivery models and enrollment criteria that are designed to result in different outcomes for participants. Each family is enrolled in the program best suited to their needs. Community Health Access and Navigation in Tennessee (CHANT) provides in-home care coordination and referral to community services to benefit the family. Child Health and Development Program (CHAD) families are those referred to CHANT from DCS. EBHV provides in-home visitation for a substantial length of time (one to five years) to families identified as highest risk. **Impacts include improvements in maternal and newborn health, school readiness, decreased domestic violence and decreased child abuse and neglect.**

The Department of Health is grateful to the Governor and General Assembly for restoring Evidence Based Home Visiting state funding in state fiscal year 2019 to the previous funding level of $3.4 million and designating this funding as recurring. Positive results from home-visiting are especially beneficial to families facing challenges of substance dependence, maternal depression or limited social or financial support. With this increase, TDH has been able to strengthen the scope and quality of home visiting services available to Tennessee children and families, supporting increased work to mitigate and prevent Adverse Childhood Experiences (ACES).

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 Lee, Governor
The Honorable Randy McNally, Lieutenant Governor
The Honorable Cameron Sexton, Speaker of the House
Honorable Members of the Tennessee General Assembly

FROM: Richard Kennedy, Executive Director

DATE: December 30, 2019

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, 2018 – June 30, 2019.

TCCY is a strong supporter of quality home visiting programs as critical infrastructure for improving outcomes for 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 should be an integral part of strategic efforts to improve outcomes for Tennessee's youngest children. Evidence-based home visiting aligns with the strategic goals of *Building Strong Brains Tennessee* and is 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. Quality home visiting services and outcomes also align with several of the Governor's priorities including Early Childhood Literacy, Improving Public Safety, Tackling the Opioid Epidemic and Transformation of Rural Tennessee.

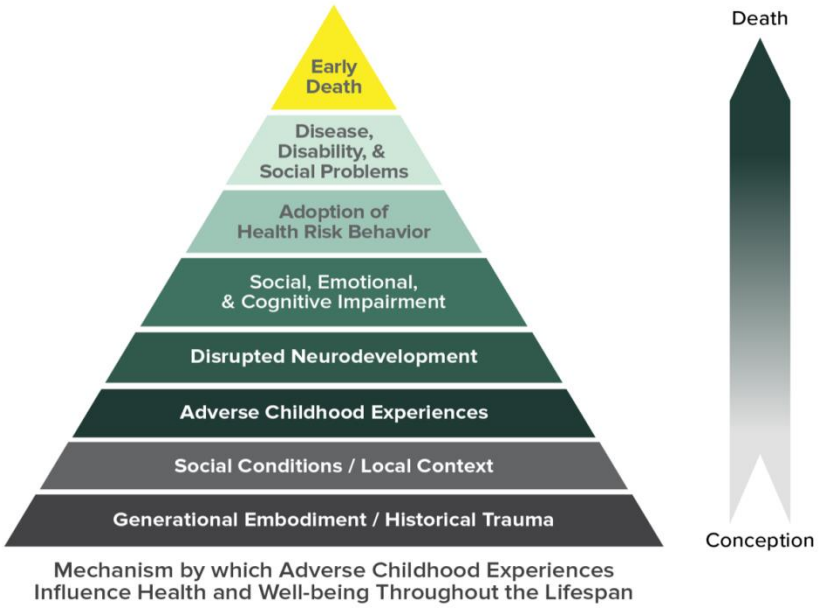
Brain development research makes clear the value of investing in young children. For every $1 invested in evidence-based home visiting, there is a return on investment of $1.80 - $5.70 (according to the 2017 National Home Visiting Yearbook from the National Home Visiting Resource Center). TCCY supports and applauds the Governor and the General Assembly for increasing state funding $1 million in nonrecurring funds for fiscal year 2020 for evidence-based home visiting. Moving these funds to recurring and expanding these vital programs is essential to avoid eroding the foundation of services and opportunities for some of Tennessee's most vulnerable children and families. The TCCY budget recommendations for FY 2020 encourage moving the $1 million to recurring and the continued support and expansion of quality home visiting services in Tennessee.

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 continues to make significant strides in quality home visiting that should be applauded, supported and expanded.

Executive Summary

To conserve health and vitality for the future of Tennessee, investments must be made in infancy and early childhood. Early experiences affect the development of brain architecture, which provides the foundation for all future learning, behavior, and health. Just as a weak foundation compromises the quality and strength of a house, adverse experiences early in life can impair brain architecture, with negative effects lasting into adulthood. (Figure 1) The CDC-Kaiser Permanente Adverse Childhood Experiences (ACEs) study found the greater the exposure to severe stressors such as domestic violence, addiction, and depression in early childhood, the greater the risk for problems later in life 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/tccy/ace/tccy-ace-building-strong-brains.html).

Figure 1: Lifetime Impact of Adverse Childhood Experiences



(https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html)

According to Tennessee's annual Behavioral Risk Factor Surveillance System, over half of adult Tennesseans consistently report at least one ACE, and about 25% had experienced three or more. This is similar to national data. The National Conference of State Legislatures in an August 2018 report indicate "from 2011 to 2014 over half of all U.S. adults (62%) from 23 states (including Tennessee) reported having at least one adverse childhood experience and 25% of adults reported three or more." A February 2019 data analysis by the Sycamore Institute found ACEs cost the state about 5.2 billion in 2017 from direct medical cost and productivity losses.
http://www.ncsl.org/Portals/1/HTML_LargeReports/ACEs_Access_HTML_2.htm
https://www.sycamoreinstitutetn.org/economic-cost-adverse-childhood-experiences/

Evidence Based Home Visiting (EBHV) is a key service known to prevent and mitigate the impact of ACEs. It is an upstream intervention to minimize and diminish the long term impacts of ACEs. Quality EBHV leads to fewer children in social welfare, mental health, and juvenile

corrections systems, with considerable cost savings for states. Research shows home visiting can be an effective method of delivering family support and child development services (https://www.zerotothree.org/resources/144-the-research-case-for-home-visiting).

EBHV both provides immediate support and improves long-term outcomes for children and families. It is a relationship-based system that promotes positive parent-child relationships in a manner that is culturally competent, strengths-based, and family-centered. Elements included in services are routine screening for child development, education to caregivers to prevent child maltreatment and abuse, maternal depression screening, tobacco cessation resources and support, school readiness, and Adverse Childhood Experiences (ACES) mitigation. (https://homvee.acf.hhs.gov/implementation/Healthy%20Families%20America%20(HFA)®/Model%20Overview)

EBHV is inherently a two-generation program, as both the parent/caregiver and infant/child benefit from the positive outcomes resulting from EBHV. Research demonstrates that young children of families enrolled in EBHV show improvements in health and development outcomes and increased school readiness.

Additional outcomes of EBHV programs include:

- Improved family functioning and parenting skills
- Linking families with appropriate social service agencies
- Promotion of early learning
- Help for new parents in providing safe, nurturing environments for their children and become more self-sufficient

A summary of SFY2019 home visiting accomplishments include:

- Ongoing implementation of EBHV services to counties identified as the most at-risk
- Oversight of the infant and early childhood workforce development infrastructure licensed to administer Infant Mental Health Endorsement® in Tennessee, to further strengthen and standardize the vocation and professionalism of infant and early childhood service providers
- Pilot implementation of the CHANT model of care coordination. CHANT has combined CHAD, Help Us Grow Successfully (HUGS), Children's Special Services (CSS) and TennCare Kids Community Outreach into one service framework to streamline TDH service delivery to families
- Implementation of Continuous Quality Improvement (CQI) plans by each EBHV implementing agency to further ensure the success and quality of services delivered
- Collaboration with the Association of Infant Mental Health in Tennessee (AIMHiTN) to provide a standardized level of Reflective Supervision (a required tenant of each EBHV model) to program managers and supervisors of EBHV services at implementing agencies to decrease secondary trauma and staff turnover among home visiting staff
- In FY2019 the Welcome Baby booklet was mailed to 75,930 parents/caregivers. Welcome Baby is a universal outreach in Tennessee to first-time parents and caregivers of newborns. The booklet includes information on infant and early childhood health and development, milestones, immunizations, safe sleep and the home environment to educate parents and caregivers on how to provide the best start for their baby
- An EBHV and CHANT workforce development plan was implemented to increase the skills and knowledge of direct service providers. This included Regional trainings on Implicit Bias, Preconception and Beyond, and Perinatal Mood Disorders or Postpartum

Depression that were provided to the EBHV and CHANT workforce. An EBHV and CHANT training evaluation was revised to collect more outcome specific data

- TDH hosted a 3 (three)-day EBHV Summit in June. Training on topics such as Neonatal Abstinence Syndrome (NAS), value, and customer service were provided. A variety of breakout sessions were also provided on topics that were requested by the workforce
- Continued collaboration with state-level partners, including Education, Mental Health and Substance Abuse, Children's Services, and Human Services to promote information sharing and partnership around common goals impacting infants, children, and families

The single most common factor for children and teens that develop the capacity to overcome serious hardship is having at least one stable and committed relationship with a supportive parent, caregiver, or other adult. These relationships provide the personalized responsiveness and protection that buffer children from developmental disruption and model the capabilities—such as the ability to plan, monitor, adjust, and regulate behavior—that enable individuals to respond adaptively to adversity and thrive. This combination of supportive relationships, adaptive skill-building and positive experiences interacts with genetic predispositions to form the foundation of resilience.

While responsive relationships in childhood help build a lifelong foundation for resilience, they continue to be important throughout our lives. They help adults deal with stress, support self-regulation, and promote a positive outlook for the future. By contrast, the social isolation experienced by many parents living in poverty or dealing with mental health or substance abuse problems can trigger a range of negative side effects.
(https://developingchild.harvard.edu/resources/three-early-childhood-development-principles-improve-child-family-outcomes/)

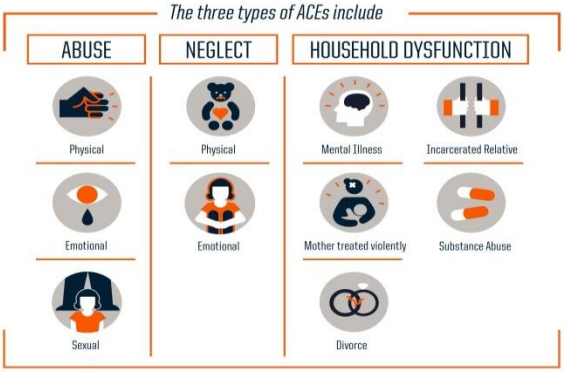
-The Harvard University Center for the Developing Child

THE TRUTH ABOUT ACEs

WHAT ARE THEY?

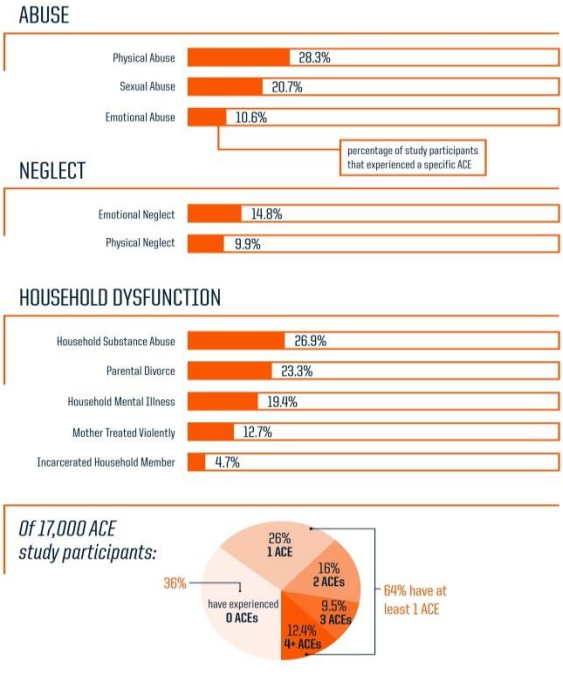
ACEs are ADVERSE CHILDHOOD EXPERIENCES

The three types of ACEs include



HOW PREVALENT ARE ACEs?

The ACE study revealed the following estimates:*

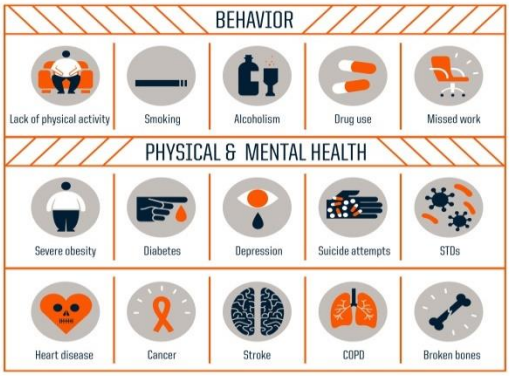


Of 17,000 ACE study participants:

WHAT IMPACT DO ACEs HAVE?

As the number of ACEs increases, so does the risk for negative health outcomes

Possible Risk Outcomes:



rwjf.org/aces

Robert Wood Johnson Foundation

*Source: http://www.cdc.gov/ace/prevalence.htm

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 CHAD program as requested by the General Assembly 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 on December 31 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.

Introduction to Home Visiting Programs in Tennessee

EBHV is a voluntary, in-home service for at-risk pregnant women and caregivers of infants and children up to age five (5). EBHV services help prevent child abuse and neglect, support positive parenting, improve maternal and child health, and promote child development and school readiness. EBHV can be cost-effective in the long term, with the largest benefits from reduced spending on government programs and increased individual earnings. (https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf). A total of 2,569 families received services from one of the evidence-based or research-based home visiting programs administered by TDH during the period of July 1, 2018 through June 30, 2019; including 26,105 visits completed by trained home visitors with families in the home.

Home visits may include:

- supporting preventive health and prenatal practices
- assisting mothers on how best to breastfeed and care for their babies
- helping parents understand child development milestones and behaviors
- promoting parents' use of praise and other positive parenting techniques, and
- working with mothers to set goals for the future, continue their education, and find employment and child care solutions.

(https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview)

Both EBHV and Child Health and Development (CHAD) programs were essential to the development of a new statewide model of care coordination, Community Health Access and Navigation in Tennessee or CHANT. CHANT represents the integration and streamlining of three public health programs, Help Us Grow Successfully (HUGS), Children's Special Services (CSS) and TennCare Kids Community Outreach with the goal of enhancing family-centered engagement, navigation of medical and social services referrals, and impacting pregnancy, child and maternal health outcomes. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes.

TDH implemented the CHANT model in all Tennessee counties by July 2019. The TDH Call Center conducts outreach and screening for medical and social needs within two weeks of birth. All eligible families are referred to available EBHV programs. Families who are not eligible or who decline EBHV services but who have additional needs are placed on care coordination pathways with their permission and are sent as referrals from the Call Center to local CHANT teams for navigation of services. CHAD referrals originating from the Department of Children's Services (DCS) are sent directly to local CHANT teams for screening, assessment and care coordination.

Each state county health department now incorporates the CHANT process for engaging the following target populations:

- Pregnant and Postpartum adolescents and women
- All children 0-21 years
- Children and Youth with Special Healthcare Needs (CYSHCN) (Birth – 21 years)

The priority population for EBHV services includes families with:

- Low incomes as defined by 250 percent or less of the Federal Poverty Level
- Pregnant women younger than age 21
- A history of child abuse or neglect, or have had interactions with child welfare services
- A history of substance abuse or need for substance abuse treatment
- Users of tobacco products in the home
- Children with developmental delays or disabilities and/or families that include individuals who are serving or have formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

While both EBHV and CHANT provide home based visits, the programs differ in both intent and intensity. Each program has different service delivery models and enrollment criteria that are designed to result in different outcomes for participants. The model provided by CHAD/CHANT is evidence informed care coordination, while EBHV programs are evidence based and longer term. EBHV programs are most effective when families participate in the program for the model-recommended period, with services beginning prenatally or at birth.

TDH maintains strong 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.

Home Visiting Funding in Tennessee

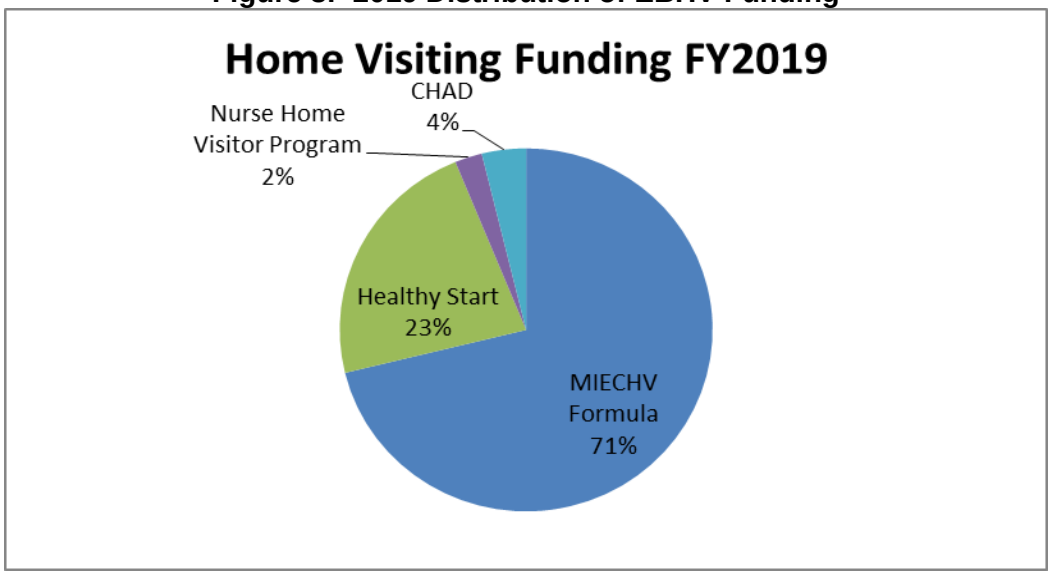
Figure 2: 2019 Home Visiting State Fiscal Year Funding SFY2019

	Funding Source	Recurring/Non-Recurring State Funding	Funding Amount
MIECHV	Federal	NA	**$10,366,741.00***
Healthy Start	State	$3,292,500 Recurring	**$3,292,500.00**
Nurse Family Partnership	State	$345,000 Recurring	**$345,000.00**
CHAD	State	$557,500 Recurring	**$557,500**
Total	**NA**	**Total State Recurring: $4,195,000.00**	**$14,561,741.00**

*$10,366,741.00 federal MIECHV funding during FY2019 includes a one-time amount of $200,000.00 earmarked for needs assessment and CQI purposes.

In Tennessee, home visiting programs are funded through both state and federal funds. (Figure 2) Funding for State Fiscal Year 2019 includes state (Healthy Start, Nurse Home Visitor, and CHAD) and federal (MIECHV). MIECHV-funded direct service contracts total $7,467,200 for the federal fiscal year period of October 1, 2018 - September 30, 2019. MIECHV-funded contracts are on federal fiscal year schedule, whereas Healthy Start funded contracts are on the state fiscal year schedule. The total funding amount (both recurring state and federal funds) is **$14,561,741.00.**

Figure 3: 2019 Distribution of EBHV Funding



Federal MIECHV funding sources provided **71%** of all EBHV funding in SFY2019. (Figure 3) Federal MIECHV funds were re-authorized during FY2019 for an additional five years until 2023. TDH is pleased that state dollars have been restored to original funding amounts and are now recurring as of SFY2019. The funding increases during SFY2019 ensured that beneficial home visiting services were sustained and not disrupted for many high risk families in Tennessee.

Home Visiting Services Administered by the Department of Health

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

The home visiting programs administered by TDH are categorized as evidence-based, promising approach, or a 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.

Promising Approach: As defined by the federal Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) a program is a promising approach if it has little to no evidence of

effectiveness or has evidence that does not meet the criteria for an evidence-based model. A "promising approach" must be grounded in relevant empirical work and have an articulated theory of change. A "promising approach" must have been developed by or identified with a national organization or institution of higher education and must have developed an evaluation plan with a well-designed and rigorous plan to measure impacts.

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 experienced trauma, intimate partner violence, poor mental health, or substance abuse diagnoses. HFA services begin prenatally or right after the birth of a baby and are offered voluntarily, intensively and 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 (recommended program length is prenatal – 2 years). 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. The recommended program length is at least 2 years between pregnancy and kindergarten.
Maternal Infant Health Outreach Worker (MIHOW)	**Promising Approach**	MIHOW trains peer mentors that reflect the culture of the families served. They support women during pregnancy to become physically, mentally, and emotionally healthy for their baby's arrival. Once the baby is born, these MIHOW outreach workers focus on promoting positive parent-child interactions and establishing a safe, stable, nurturing environment. The recommended program length is prenatal to 3 years.
Child Health and Development (CHAD	**Research-based**	CHAD specifically refers to families that have been referred to the CHANT pathway by the Department of Children's Services (DCS). CHANT is the merging of CHAD, Help Us Grow Successfully (HUGS), Children's Special Services

		(CSS) and TennCare Kids Community Outreach into one service framework to streamline services to provide enhanced patient-centered engagement and navigation of medical and social services referrals.

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 SFY2019 was used for evidence-based models. The following section provides a description of each funding source 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 SFY2019 (July 1, 2018 - June 30, 2019).

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. MIECHV funding is now combined into one competitive grant. The MIECHV program provides services in **33** counties through nine community-based agencies and staff employed by those agencies. Funding allocations are used to implement evidence-based home visiting programs in the most at-risk communities, further strengthening the early childhood system. In 2010, Tennessee completed statewide needs assessment related to home visiting services and used the information to develop an initial State Plan for expansion of home visitation services.

Three evidence based home visiting models are implemented in Tennessee: Healthy Families America, Parents as Teachers, and Nurse Family Partnership models. Military families represent one priority population in the legislation, thus one additionally funded project specifically targets military families that live off base in Montgomery County, Tennessee, where the Fort Campbell Army Installation is located.

The annual average cost per child for programs funded by MIECHV funding is **$5,698**.

MIECHV Federal Grant, during State Fiscal Year July 1, 2018 - June 30, 2019

Local Implementing Agency	Evidence-Based or Promising Approach Model	At-Risk County	Number of Families Served July 1, 2018- June 30, 2019	Number of Home Visits	Annual Cost Per Child*
Helen Ross McNabb	Healthy Families America	Campbell	65	1,637	**$4,604**
		Cocke	31		
		Jefferson	3		
		Knox	41		
		Sevier	43		
		H.R. McNabb total	**183**		
Prevent Child Abuse Tennessee	Healthy Families America	Claiborne	16	1,774	**$7,722**
		Davidson	154		
		Grundy	16		
		Hamilton	21		
		Johnson	13		
		Marion	10		
		McMinn	21		
		Monroe	10		
		Polk	4		
		Rhea	10		
		Scott	19		
		Sequatchie	10		
		PCAT total	**304**		

Chattanooga-Hamilton County Health Department	Parents as Teachers	Hamilton	66	786	**$6,626**
		Chattanooga Hamilton total	**66**		
Centerstone	Healthy Families America	Coffee	58	1,892	**$5,369**
		Dickson	16		
		Franklin	0		
		Giles	3		
		Hickman	2		
		Lawrence	58		
		Lewis	1		
		Maury	44		
		Centerstone total	**177**		
Lebonheur Children's Hospital, Community Health and Well-Being	Healthy Families America, Nurse Family Partnership, & Parents as Teachers	Shelby	168 (HFA) 21 (NFP) 201 (PAT)	2,982 (HFA) 294 (NFP) 1,925 (PAT)	**$4,611** (HFA) **$1,829** (NFP) **$2,920** (PAT)
		Tipton (PAT only)	3		
		Lebonheur total	**393**		
Center for Family Development	Healthy Families America	Fort Campbell/ Montgomery	104	1,246	**$2,749**
		Center for Family Dev'p total	**104**		
The Exchange Club/ Holland J Stephens Center for the Prevention of Child Abuse	Healthy Families America	Cumberland	17	240	**$10,773**
		Dekalb	5		
		Exchange Club total	**22**		
Jackson Madison County General Hospital	Healthy Families America	Hardeman	18	1,835	**$4,950**
		Hardin	14		
		Haywood	13		
		Henderson	23		
		Madison	63		
		Jackson-Madison total	**131**		
University of Tennessee (UT)-Martin	Healthy Families America	Dyer	36	786	**$6,430**
		Lake	12		
		Lauderdale	18		
		UT Martin total	**66**		
		TOTALS	**1,446 families served**	**15,397 home visits**	**$5,326 average cost per family**

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 average cost per child is **$5,788**. Funds to support this program come from **State funds**. Healthy Start was funded in FY2019 with mostly non-recurring dollars.

Funding Source: Healthy Start, State					
Local Implementing Agency	Evidence-Based Model	At-Risk County	Number of Families Served July 1, 2018-June 30, 2019	Number of Home Visits	Annual Cost per Child*
Helen Ross McNabb	Healthy Families America	Cocke	1	903	**$4,797**
		Jefferson	14		
		Knox	61		
		Hamblen	1		
		Helen Ross McNabb Center total	**77**		
The Exchange Club/ Holland J Stephens Center for the Prevention of Child Abuse	Healthy Families America	Putnam	19	861	**$6,283**
		White	16		
		Macon	18		
		Exchange Club total	**53**		
Jackson Madison County General Hospital	Healthy Families America	Madison	47	737	**$5,440**
		Jackson Madison total	**47**		
Lebonheur Children's Hospital, Community Health and Well-Being	Healthy Families America	Shelby	53	923	**$6,404**
		Lebonheur total	**53**		
Metro Government of Nashville & Davidson County	Healthy Families America	Davidson	57	607	**$5,693**
		Metro Davidson total	**57**		
Center for Family Development	Healthy Families America	Bedford	19	1,178	**$5,111**
		Franklin	13		
		Lincoln	18		
		Marshall	15		
		Montgomery	45		
		Center for Family Development total	**110**		
		Henry	10		
		Obion	22		
		Tipton	13		
		UT Martin total	**45**		
Centerstone	Healthy Families America	Giles	29	603	**$6,287**
		Hickman	18		
		Lawrence	1		
		Lewis	19		
		Centerstone total	**67**		
Prevent Child Abuse Tennessee	Healthy Families America	Anderson	35	481	**$5,338**
		Bradley	18		

Funding Source: Healthy Start, State					
Local Implementing Agency	Evidence-Based Model	At-Risk County	Number of Families Served July 1, 2018-June 30, 2019	Number of Home Visits	Annual Cost per Child*
		Hamilton	10		
		Union	5		
		Prevent Child Abuse Tennessee total	**68**		
		Totals	**577 families served**	**7,000 home visits**	**$5,788 average cost per family**

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 FY2019, 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 average cost per child is **$3,053^.** Funds to support this program come from State funds. **^Revised 2-12-2020**

Local Implementing Agency	Evidence-Based Model	At-Risk County	Number of Families Served July 1, 2018-June 30, 2019	Number of Home Visits	Annual Cost per Child*
Lebonheur Children's Hospital, Community Health and Well-Being	Nurse Family Partnership	Shelby	113	1,346	**$3,053^**
		Totals	**113 families served**	**1,346 home visits**	**$3,053^ average cost per family**

Funding Source: Child Health and Development (CHAD), State

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 as a part of the CHANT pathway and is staffed by health department CHANT 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 average cost per family is **$1,287.53.** Funds to support this program come from State funds.

Local Implementing Agency	Research-Based Model	At-Risk County	Number of Families Served July 1, 2018- June 30,2019	Number of Home Visits	Annual Cost per Child*
Anderson Co. Health Department	Child Health and Development	Anderson	4	14	Annual cost per child is estimated utilizing the SFY2019 state allocation divided by the total numbers served statewide. As
Blount Co. Health Department	Child Health and Development	Blount	2	2	
Bradley Co. Health Department	Child Health and Development	Bradley	0	0	
Campbell Co. Health Department	Child Health and Development	Campbell	21	100	
Carter Co. Health Department	Child Health and Development	Carter	46	237	
Claiborne Co. Health Department	Child Health and Development	Claiborne	6	42	
Cocke Co. Health Department	Child Health and Development	Cocke	11	46	
Grainger Co. Health Department	Child Health and Development	Grainger	1	1	

Greene Co. Health Department	Child Health and Development	Greene	79	440	such, county specific cost per child is not available.
Hamblen Co. Health Department	Child Health and Development	Hamblen	20	93	
Hancock Co. Health Department	Child Health and Development	Hancock	19	188	
Hawkins Co. Health Department	Child Health and Development	Hawkins	72	379	
Jefferson Co. Health Department	Child Health and Development	Jefferson	1	5	
Johnson Co. Health Department	Child Health and Development	Johnson	12	33	
Loudon Co. Health Department	Child Health and Development	Loudon	5	34	
Monroe Co. Health Department	Child Health and Development	Monroe	10	44	
Morgan Co. Health Department	Child Health and Development	Morgan	5	10	
Rhea Co. Health Department	Child Health and Development	Rhea	0	0	
Roane Co. Health Department	Child Health and Development	Roane	5	30	
Scott Co. Health Department	Child Health and Development	Scott	4	7	
Sevier Co. Health Department	Child Health and Development	Sevier	11	77	
Shelby Co. Health Department	Child Health and Development	Shelby	1	1	
Unicoi Co. Health Department	Child Health and Development	Unicoi	41	345	
Union Co. Health Department	Child Health and Development	Union	5	36	
Washington Co. Health Department	Child Health and Development	Washington	52	198	
		Totals	**433**	**2,362**	**$1,287.53**

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

Total Number of Local Implementing Agencies	Categories and Models	Total Number of Counties With a Home Visiting Program	Number of Families Served July 1, 2018- June 30, 2019	Total Number of Home Visits
34	Evidence-based Programs: -Healthy Families America -Nurse Family Partnership -Parents as Teachers Research-based Programs: -Child Health and Development (CHAD)	**61**	**2,569 families**	**24,759 home visits**

Home Visiting Impact: Outcomes of Promising Approaches

A promising approach does not yet meet the rigorous criteria for evidence-based models but is grounded in relevant empirical work and has an articulated theory of change. The Maternal Infant Health Outreach Worker (MIHOW) program is the Promising Approach delivered in Tennessee. MIHOW is delivered in Tennessee through a partnership between Vanderbilt University and Catholic Charities of Tennessee. The goal of the MIHOW Program is to improve maternal and child health outcomes through a strength-based approach via home visiting. MIHOW trains peer mentors that reflect the culture of the families served. They support women during pregnancy to become physically, mentally, and emotionally healthy for their baby's arrival. Once the baby is born, these MIHOW outreach workers focus on promoting positive parent-child interactions and establishing a safe, stable, nurturing environment.

A recent randomized clinical trial (RCT) to assess the efficacy of MIHOW in a sample of women in Tennessee supported most study hypotheses, providing strong evidence of the effectiveness of MIHOW on improving health outcomes in the areas of depressive symptoms, parenting stress, breastfeeding, safe sleep practices, early literacy, and quality and quantity of stimulation and support available to the child. Study results were published in the *Maternal and Child Health Journal* (https://doi.org/10.1007/s10995-018-2532-z).

A subsequent RCT to replicate and extend our previous evaluation of the efficacy of the MIHOW Program is in process with a broader sample of women in Tennessee began in October 2017. Thus far, the study has recruited 132 women during pregnancy from six counties in middle Tennessee. Researchers selected outcomes that are included in four of the eight domains identified by the HomVEE team and relevant to MIHOW program priorities – child health, maternal health, positive parenting, and linkages and referrals. Data is collected at eight time points – twice during pregnancy and six times postpartum, until the baby reaches 15 months. All prenatal data has been collected. Analysis of baseline and prenatal data is underway. The study will conclude in September 2020.

Home Visiting Impact: Outcomes

The types of outcomes measured vary across the three evidence based home visiting programs delivered in Tennessee based upon specific statutory or fidelity requirements of the models. To align the 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

Measure	MIECHV	Healthy Start	State NFP	Highlights
Breastfeeding Initiation	68.8	74.6	86.4	The percentage of new mothers initiating breastfeeding varied somewhat by funding stream. Initiation is highest among mothers served by Nurse Family Partnership, as women are enrolled much earlier in pregnancy and are able to receive more education and encouragement from a nurse.
Percentage of infants breastfeeding at 6 months, among those who initiated breastfeeding	40.0	28.6	17.6	The percentage of infants receiving any breastmilk at 6 months varies, and is most likely affected by small numbers.
Percentage of parents of infants less than 12 months of age using safe sleep practices (put to sleep on back, alone in crib, with no soft bedding)	62.7	52.4	48.3	Measure reports parents using all safe sleep practices.
Percentage of caregivers with a positive Inimate Partner Violence Screen who received a referral	100	100	*No positive screens*	Home visiting participants are screened for a variety of health and safety concerns. When indicated, they are linked to the appropriate services.
Percentage of caregivers with a positive depression screening who received a referral	98.4	100	100	
Percentage of newly enrolled caregivers with tobacco use at enrollment receiving a tobacco cessation referral or information	97.1	100	100	

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 thru SFY19.

Immunizations

90% of children enrolled in Healthy Start are up to date with immunizations at 2 years old.

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%
2018	99.3%
2019	**99%**

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*	$5,788
Average Estimated Annual Cost per Child *Out of Home Placement: Foster Care, Department of Children's Services*	$8,823.78[1]
Average Estimated Annual Cost per Child *Out-of-Home Placement: Residential Care, Department of Children's Services*	$65,813.06[2]

[1] Tennessee Department of Children's Services, $23.98 per day per child or $8,823.78 per year

[222] Tennessee Department of Children's Services, $166.63 per day per child or $60,819.95 per year

Strengths and Opportunities Related to 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.

TDH currently governs home visiting programs in 50 counties across the state by means of service contracts with local community-based agencies and county and regional health departments. 2,569 families were served by TDH-administered home visiting programs during SFY19. The capacity to serve eligible families varies in the counties where services are available. There also continues to be a need for EBHV services in the remaining 45 counties that do not receive services. Currently there are approximately 47,796 families in need of EBHV services that do not receive services (see Appendix). Many of these families live in counties that do not have EBHV services. The opportunity remains to expand EBHV programs to currently unserved counties and to expand capacity in counties that do have EBHV services.

The 2019 Kids Count Data Book reports that Tennessee ranks 36th in the Nation for overall child well-being. The Data Book includes the following key statistics:

- 21% of children in Tennessee live in poverty
- 28% of children in Tennessee live in homes where their parents lack secure employment
- 7% of Tennessee teens are not in school and not working
- 9.2% of births in Tennessee are low birth-weight
- 37% of children live in single parent families

(https://www.aecf.org/m/databook/2019KC_profile_TN.pdf)

As noted previously, EBHV services have a positive impact on many of the outcomes associated with the above statistics. Parental stress resulting from a lack of resources further compounds any toxic stress that may be experienced by children and families with greatest need. Accessing EBHV services provides opportunities for families to be connected to community services that address health and wellness needs, provide guidance on how best to support their child's health and development, as well as take action toward improving their economic opportunities. EBHV services help prevent child abuse and neglect, support positive parenting, improve maternal and child health, and promote child development and school readiness. EBHV can be cost-effective in the long term, with the largest benefits from reduced spending on government programs and increased individual earnings.
(https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf)

Collaboration between Public and Private Sector Stakeholders

One of the central goals of the federal Maternal, Infant, and Early Childhood Home Visiting funding is to improve coordination among early childhood agencies and increase referrals to other community resources and supports, thus improving access to needed services. Tennessee maintains collaboration with other child and family-serving state agencies and community partners. The Tennessee Young Child Wellness Council (TNYCWC) is a statewide, early childhood entity designated as the Governor's Early Childhood Advisory Council. In September 2018, TDH began partnering with the Tennessee Commission on Children and Youth (TCCY) to convene the TNYCWC. 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.

The TNYCWC provides an opportunity for infant and early childhood state agencies and community stakeholders to collaborate and share expertise around a common agenda and shared goals. Strategies are collaboratively developed and informed by all involved to ensure a comprehensive action plan. Since moving from TDH to TCCY in 2018, TNYCWC completed a strategic planning process to help identify updated strategic goals for the Council across sectors and the state.

TDH continues to partner with TCCY to convene the Home Visiting Leadership Alliance (HVLA). HVLA partners include leadership from evidence based home visiting programs in Tennessee, state departments and other early childhood 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 for Evidence Based Home Visiting leadership and programs. The HVLA also convenes several action teams to focus on areas that require additional processing, including data and outcomes, Infant Mental Health Endorsement (IMHE) ®, and outreach/education.

TCCY continues to provide "Train the Trainer" opportunities across the state for *Building Strong Brains Tennessee (BSB)*. Training participants are prepared to speak knowledgably about early childhood and brain development and ACEs. The Training for Trainers is a key component of the public awareness efforts for *BSB.* To date, 1,055 geographic and sector diverse participants have become trainers. These individuals have subsequently presented to over 50,000 people. TCCY also began a twelve month *BSB TN* social media campaign guided by technical assistance from The FrameWorks Institute. Additionally, TCCY continues to provide technical assistance through the BSB Learning Collaborative. Between November 2018 and October 2019, over 600 individuals have accessed materials and information, including shared resources, research, and meaningful conversation.

Data Collection for Program Evaluation and Continuous Quality Improvement

TDH continues to seek out quality improvement best practices to ensure that the provision of effective and appropriate services to families that are enrolled in our home visiting programming. In FY16, TDH began monitoring program participant duration for families enrolled in evidence based home visiting with the aim of extending family retention, toward better outcomes for those families. From this surveillance process, TDH was able to develop action

plans around increasing family retention. Additionally, TDH has implemented an initiative further around performance management strategies in an effort to strengthen the systems that support home visiting service providers. Family retention has seen an improvement for families enrolled in all of the home visiting models in Tennessee.

Welcome Baby

Federal MIECHV funding continues to support the Welcome Baby program, a universal outreach and education program to assure that families of newborns are aware of available community programs and educated on health, safety, and development. All families of newborns receive a Welcome Baby booklet within ten to fourteen days after birth. The booklet 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 that provide extra support to families.

The Welcome Baby booklet shares information about health and safety messages such as the ABCs of Safe Sleep and protecting a child from toxic stress as well as two resources unique to Tennessee: Imagination Library/Books from Birth and kidcentraltn.com. 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. Kidcentraltn.com 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. Kidcentraltn.com is administered by TCCY.

Challenges

During SFY2019, a concentrated effort was placed on increasing the length of family retention in EBHV programs. When families stay enrolled longer, the overall number of families served is expected to be reduced because there is not as much family turnover. Retaining families in an EBHV program for the recommended length of time as determined by the model results in better outcomes for families. This characteristic of EBHV, referred to as family retention, is a quality metric of the program. To ensure delivery of high-quality services that are individualized to meet the needs of families, EBHV models have recommendations for caseload capacity. This ensures that each family gets the appropriate service dosage based on their needs and initial assessment results. EBHV models also require home visitors to receive comprehensive training, including reflective supervision, which ensures that home visitors maintain objectivity when serving enrolled families.

An ongoing challenge of EBHV programs is staff retention. It takes approximately 6 (six)-months to hire and train a new home visitor due to the intensity of the training provided to ensure home visitors are equipped to work with families that often have a myriad of complex issues. Many of the parents/caregivers served have experienced multiple Adverse Childhood Experiences (ACES) and lack systemic supports. As EBHV is a relationship-based program, the length of family retention is impacted by staff retention. Home visitors frequently experience secondary trauma as a result of working closely with families who have experienced trauma. This ongoing stress, along with minimal opportunities for wage increases contribute to high turnover rates in home visiting positions. Families that have built relationships often do not want to begin the relationship-building process with a new home visitor, so they exit services; thus,

family retention and staff retention are frequently connected. Family and staff retention impact overall cost per family in programs.

In Conclusion

Tennessee is on the forefront in preventing and mitigating ACES partly due to the work of TDH infant and early childhood programs. As noted previously, ACEs are highly prevalent in Tennessee, putting our residents are increased risk of chronic health conditions and diseases in adulthood, alcohol and drug abuse, unintended pregnancy, and other negative health outcomes throughout the lifespan. Safe and nurturing relationships serve as protective factors in a child's life to mitigate the impact of ACEs when they are more likely to be hard wired. Home visiting programs provide education, support and referral to community resources to parents and caregivers to create the opportunity to build healthy and strong families, and thus create a healthy Tennessee both now and in the future. Evidence Based Home Visiting (EBHV) is a key service known to prevent and mitigate the impact of ACEs. It is an upstream intervention to minimize and diminish the long term impacts of ACEs. To conserve health and vitality for the future of Tennessee, investments must be made in infancy and early childhood when children's brains can be most impacted. Home visiting services are essential in this effect. TDH and its partners have improved the quality of EBHV services provided to Tennessee families and appreciates the ongoing commitment of the Governor and General Assembly to provide critical support to families when it is most needed and in a manner that is most effective.

Appendix: Number of Families Served by Evidence-Based Home Visiting Programs by County, July 1, 2018 – June 30, 2019**

COUNTY	MIECHV (Families served)	HEALTHY START (Families served)	NURSE HOME VISITOR PROGRAM (Pregnant women served)	TOTALS SERVED BY COUNTY	NUMBER OF FAMILIES IN NEED OF HOME VISITING SERVICES	PERCENT OF ELIGIBLE FAMILIES SERVED BY EBHV SERVICES
Anderson	*	35	*	35	259	13.5%
Bedford	*	19	*	19	501	3.8%
Benton	*	*	*	*	228	*
Bledsoe	*	*	*	*	52	*
Blount	*	*	*	*	397	*
Bradley	*	18	*	18	1,607	1.1%
Campbell	65	*	*	65	602	10.8%
Cannon	*	*	*	*	146	*
Carroll	*	*	*	*	402	*
Carter	*	*	*	*	645	*
Cheatham	*	*	*	*	299	*
Chester	*	*	*	*	217	*
Claiborne	16	*	*	16	481	3.3%
Clay	*	*	*	*	60	*
Cocke	31	1	*	32	255	12.5%
Coffee	58	*	*	58	66	87.9%
Crockett	*	*	*	*	116	*
Cumberland	17	*	*	17	370	4.6%
Davidson	154	57	*	211	4,270	4.9%
Decatur	*	0	*	0	42	*
Dekalb	5	*	*	5	202	2.5%
Dickson	16	*	*	16	391	4.1%
Dyer	36	0	*	36	303	11.9%
Fayette	*	*	*	*	378	*
Fentress	*	*	*	*	113	*
Franklin	*	13	*	13	50	26%
Gibson	*	*	*	*	398	*
Giles	*	29	*	29	354	8.2%
Grainger	*	*	*	*	167	*
Greene	*	*	*	*	782	*
Grundy	16	*	*	16	47	34%
Hamblen	0	1	*	1	461	0.2%
Hamilton	87	10	*	97	1,404	6.9%

COUNTY	MIECHV (Families served)	HEALTHY START (Families served)	NURSE HOME VISITOR PROGRAM (Pregnant women served)	TOTALS SERVED BY COUNTY	NUMBER OF FAMILIES IN NEED OF HOME VISITING SERVICES	PERCENT OF ELIGIBLE FAMILIES SERVED BY EBHV SERVICES
Hancock	*	*	*	*	99	*
Hardeman	18	*	*	18	91	19.8%
Hardin	14	*	*	14	92	15.2%
Hawkins	*	*	*	*	701	*
Haywood	13	*	*	13	64	20.3%
Henderson	23	*	*	23	100	23%
Henry	*	10	*	10	463	2.2%
Hickman	0	18	*	18	182	9.9%
Houston	*	*	*	*	117	*
Humphreys	*	*	*	*	264	*
Jackson	*	*	*	*	90	*
Jefferson	3	14	*	17	190	8.9%
Johnson	13	*	*	13	203	6.4%
Knox	41	61	*	102	3,087	3.3%
Lake	12	*	*	12	61	19.7%
Lauderdale	18	*	*	18	256	7%
Lawrence	58	1	*	59	520	11.3%
Lewis	1	19	*	20	143	14%
Lincoln	0	18	*	18	41	43.9%
Loudon	*	*	*	*	523	*
Macon	0	18	*	18	244	7.4%
Madison	63	47	*	110	1,212	9.1%
Marion	10	*	*	10	100	10%
Marshall	0	15	*	15	337	4.5%
Maury	44	*	*	44	950	4.6%
McMinn	21	*	*	21	814	2.6%
McNairy	*	*	*	*	93	*
Meigs	*	*	*	*	42	*
Monroe	10	*	*	10	468	2.1%
Montgomery	104	45	*	149	1,045	14.3%
Moore	*	*	*	*	8	*
Morgan	*	0	*	0	326	*
Obion	*	22	*	22	246	8.9%
Overton	*	*	*	*	172	*
Perry	*	*	*	*	96	*
Pickett	*	*	*	*	40	*

COUNTY	MIECHV (Families served)	HEALTHY START (Families served)	NURSE HOME VISITOR PROGRAM (Pregnant women served)	TOTALS SERVED BY COUNTY	NUMBER OF FAMILIES IN NEED OF HOME VISITING SERVICES	PERCENT OF ELIGIBLE FAMILIES SERVED BY EBHV SERVICES
Polk	4	*	*	4	257	1.6%
Putnam	*	19	*	19	593	3.2%
Rhea	10	*	*	10	114	8.8%
Roane	*	*	*	*	539	*
Robertson	*	*	*	*	519	*
Rutherford	*	*	*	*	1,872	*
Scott	19	*	*	19	333	5.7%
Sequatchie	10	*	*	10	52	19.2%
Sevier	43	*	*	43	343	12.5%
Shelby	390	53	113	556	8,642	6.4%
Smith	*	*	*	*	202	*
Stewart	*	*	*	*	70	*
Sullivan	*	*	*	*	729	*
Sumner	*	*	*	*	279	*
Tipton	3	13	*	16	585	2.7%
Trousdale	*	*	*	*	86	*
Unicoi	*	*	*	*	202	*
Union	*	5	*	5	65	7.7%
Van Buren	*	*	*	*	36	*
Warren	*	*	*	*	422	*
Washington	*	*	*	*	474	*
Wayne	*	*	*	*	201	*
Weakley	*	*	*	*	480	*
White	*	16	*	16	168	9.5%
Williamson	*	*	*	*	265	*
Wilson	*	*	*	*	723	*
TOTAL SERVED	**1,446**	**577**	**113**	**2,136**	**47,796 FAMILIES IN NEED OF EBHV SERVICES**	**4.5% OF ELIGIBLE FAMILIES IN TN SERVED BY EBHV SERVICES**

* *Program is not available in county*

***This table reports the number of families served by EBHV and does not include the 433 families served by the research-based model CHAD, that is now included in CHANT.*

****Methodology for the "estimated number of children eligible for evidence based home visiting that do not receive services":*

Number of families likely to be eligible for EBHV services (*Data Source: ACS 2017 1-Yr PUMS Data)*

- *Number of families likely to be eligible for MIECHV services is based on the below criteria:*

- *Number of families with children under the age of 6 living below 100% of the poverty line and the number of families in poverty with a child under the age of 1 (one) and no other children under the age of 6 (six) [a proxy for families with a pregnant woman that would also be eligible for EBHV services].*
  AND
- *Belongs to 1 (one) or more of the following at-risk sub-populations:*
  - *Mothers with low education (high school diploma or less).*
  - *Young mothers under the age of 21.*
  - *Families with an infant [child under the age of 1 (one)].*

(Analysis includes primary families and unrelated sub-families living in the same household).

The method to define need is the number of families who are in poverty and meet one additional risk factor. Our analysis begins by identifying all families (primary families and unrelated sub-families) with children under the age of six, living below 100% of the poverty line. Families were then identified facing other risk factors that relate to the statutory definition or risk and are available in Child Protective Services (CPS) data (mothers with low education – a proxy for poor education outcomes, young mothers under the age of 21, and families with an infant). The populations (e.g., low income, low maternal education, and young mothers) were chosen because they are linked with negative maternal and child health outcomes such as low birth weight, child injury, child maltreatment, school readiness disparities, etc.