

Tennessee Home Visiting Programs Annual Report

July 1, 2009 – June 30, 2010



Tennessee Department of Health
Maternal and Child Health
425 Fifth Ave., North
4th Floor, Cordell Hull Building
Nashville, TN 37243

ANNUAL HOME VISITING REPORT
FOR FISCAL YEAR 2010

Table of Contents

Memorandum from Commissioner Susan Cooper 3

Memorandum from TN Commission on Children and Youth..... 4

Overview 7

Services Offered 8

Description of Families Served 9

Summary Tables..... 13

 1. Home Visiting Chart Comparing Programs 14

 2. Goals, Objectives and Annual Status for Each Program

 Child Health and Development (CHAD) 15

 Healthy Start 16

 Help Up Grow Successfully (HUGS)..... 17

 Nurse Family Partnership..... 20

Challenges/Opportunities..... 23

 Variation in Funding and Data Collection

 Staff Qualification

 Community Referral Sources

 The Home Visiting Review

 The Resource Mapping 2010 Report

 Federal Legislation

Table: Number of Children Served by County 30

Appendices..... 33

 A. State Map with Program Locations

 B. Contract Agencies Providing Services

 C. State statutes/TCA codes and Affordable Care Act (ACA)



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
CORDELL HULL BUILDING
425 5TH AVENUE NORTH
NASHVILLE, TENNESSEE 37243

MEMORANDUM

To: The Honorable Phil Bredesen, Governor
Chair, Senate General Welfare, Health, and Human Resources Committee
Chair, House Children and Family Affairs Committee
Chair, Joint Select Committee on Children and Youth

From: Susan R. Cooper, MSN, RN, Commissioner

Date: January 2011

RE: Annual Report for Home Visiting Programs

As required by Tennessee Code Annotated 68-1-125, the *Tennessee Department of Health Annual Report – Home Visiting Programs* for June 30, 2009 – June 30, 2010 is hereby submitted. The report reflects the status of efforts to identify and expand the number of evidence-based home visiting programs throughout Tennessee.

The report includes the process and outcome measures used to evaluate the quality of home visiting services offered to participating families and compares them, where applicable, to state averages and national objectives as reflected in *Healthy People 2010*, the federal document which sets national health goals and objectives every ten years. Measures from individual programs including the number of people served, the types of services provided, and the estimated rate of success in meeting specific goals and objectives are also included.

The Department has worked over the last two years with the Tennessee Commission on Children and Youth, the Governor's Office of Children Care Coordination and other interested parties concerned about home visiting services. Recommendations from the *Home Visiting Review* written by the Governor's Office of Children's Care Coordination as requested by the Children's Cabinet are included in the report. *The Review* was developed by an interdepartmental committee which included the Department of Health and Tennessee Commission on Children and Youth.

This report will also be made available via the Internet at <http://health.state.tn.us>.



STATE OF TENNESSEE
TENNESSEE COMMISSION ON CHILDREN AND YOUTH

Andrew Johnson Tower, Ninth Floor
710 James Robertson Parkway
Nashville, Tennessee 37243-0800
(615) 741-2633 (FAX) 741-5956
1-800-264-0904

MEMORANDUM

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

From: Linda O'Neal, Executive Director

Date: January 14, 2011

RE: Annual Report for Home Visitation Programs

In accordance with 2008 Public Chapter 1029, codified as TCA 68-1-124, 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 and country for home visitation programs. Passage of the *Patient Protection and Affordable Care Act* in March 2010 makes Tennessee eligible to receive \$3 million in federal funding for home visitation programs. Although there is no match requirement, in order to receive the federal funds, states must maintain the level of state funding for home visiting programs at or above the level of funding in March 2010.

The \$3 million Tennessee is eligible to receive from the *Patient Protection and Affordable Care Act* includes \$1.35 million in federal funds previously awarded directly from the federal funding source to evidence based home visitation programs in Knox and Shelby Counties. Child and Family Tennessee in Knox County and the Shelby County Early Success Coalition are already implementing home visiting services and rely on these federal funds to continue their vital services.

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. We look forward to working with the Governor, Department of Health, members of the General Assembly and all stakeholders to improve the quality of life for Tennessee children and families through implementation of quality home visitation programs.

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

Tennessee Department of Health

John P. Brown
Mary Jane Dewey
Veronica L. Gunn
Lynette Hicks
John Hutcheson
Dennis Llewellyn
Olga Masrejian
Bridget McCabe
Dru Potash
Gary Self
Cathy R. Taylor
Michael D. Warren

Tennessee Commission on Children and Youth

Linda O'Neal
Sumita Banerjee

Tennessee Department of Children's Services

Lance Griffin

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 annually review and identify the research models upon which the home visiting services are based, to report on the 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 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 General Welfare, Health and Human Resources Committee, the House Health and Human Resources Committee, the House Children and Family Affairs Committee and the Joint 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 one that has been shown to improve client outcomes by research in two or more sample populations. "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,

(utilizing several similar models) since the 1970s. Refer to the 2008-2009 annual report for a detailed description of the four home visiting programs administered by the Department of Health (http://health.state.tn.us/Downloads/Home_Visiting_Report_FY_2009.FINAL.pdf). A state map with programs designated by county is contained in the Appendix A.

Services Offered

All home visiting models offered by TDH provide an initial assessment and periodic assessments during the time participants are enrolled to evaluate 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. Review of timeliness of medical services according to standards for health visits and well child checkups including immunizations for children.

Depending on the age of the child, additional assessments are conducted periodically to revise the family service plan and refer for newly identified needs.

All of the home visiting models, except the Nurse Family Partnership (NFP), 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. Information about substance use/abuse; tobacco exposure and maternal depression are included in the curriculum content.

Description of Families Served

CHAD: The Child Health and Development (CHAD) program is a theory-based model and 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 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). The following is based on the fourth quarter cumulative report to DCS for FY 2009-10.

A total of 1,133 children in 741 families were served. All children enrolled in the program were referred by public health clinics or DCS. Family participation is voluntary both to enroll and continue in the program. When a child/family is referred to TDH, staff assess need based on a variety of risk factors 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 risk factors 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 2009-2010

- Total of 741 families with 1,133 children were served by the program; 262 of these were newly enrolled families
- Eighty-four children were in state custody under the guardianship of a relative when enrolled
- Twenty-three children (2 %) who received a home visit were substantiated by DCS as abused and neglected during the year

The most frequent reasons for case closure were children aged out of the program (188), families moved (100) or clients failed to keep appointments (79).

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 among enrolled families. DCS contracts with TDH to implement this program. Based on program data from FY 2009-10, a total of 1,240 families with 1,404 children were served by the program.

Status of Prenatal and Postpartum Mothers Served in FY 2009-10: Based on 129 prenatal and 206 postpartum newly-enrolled families. (Total women = 335)

- 38.5% (129/335) women entered the program during pregnancy
- 28.4% (95/335) mothers enrolled were under age 18
- 59.5% (199/335) were between ages 18 and 25
- Most (293) were single women (87.4%)
- More than half had not completed High School (53.5%)
- 95.2% (319/335) had annual income of \$10,000 or less
- 97.6% (327/335) of the mothers enrolled scored “high” or “very high” on the Stress Checklist

Status of Fathers: Based on 235 men who were identified as the father and willing to disclose enrollment information

- Demographics were very similar to those cited for the mothers
- 48.5% (114/235) lived with mother
- 82.9% (195/235) earned \$10,000 or less per year

Summary of Program Services: Based on a one month snapshot of 368 families served and the total number of visits completed during the year.

- 58.5% (215/368) received weekly visits
- 11.4 % (42/368) received bi-monthly visits
- 93.2% (16,792/18,009) of all visits were conducted in the home
- 3.6% (646/18,009) of visits were group sessions

HUGS: The Help Us Grow Successfully (HUGS) home visiting model was developed by TDH beginning in the 1990s as a means of organizing clinic and home services emphasizing child health and well being. It is a theory-based model and is the only home visiting program that is offered in all counties of the state. The goals of the program are to improve pregnancy outcomes, improve maternal and child health and wellness, improve child development and maintain or improve family strengths.

Status of those receiving HUGS services in FY 2009-10 Based on birth certificate data collected from all families enrolled in HUGS during FY 2009-10 and program data from TDH and DCS

- A total of 5,996 children were served by HUGS in FY 2010
- 5,100 HUGS enrolled children were matched with DCS records
- 20% (1,034/5,100) were reported to DCS during FY 2010
- 15.1% (157/1,034) of those reported were investigated and abuse/neglect indicated
- 3 % (157/5,100) of all children served by HUGS were indicated cases by DCS

Status of Mothers Served in FY 2010: (Based on 2,202 births)

- 64.9 % (1,430/2,202) had adequate prenatal care
- 4.8 % (106/2,202) had no prenatal care
- 28.1 % (619/2,202) reported they smoked during pregnancy
- 53.9 % (1,186/2,202) were first time mothers

Status of the Infants and Children

- 76% (1,673/2,202) were a healthy weight (2,500 grams or more) at birth
- The average gestational age was 37.5 weeks
- 80.5% (4,831/5,996) of the children were enrolled in WIC
- 74% (650/878) of the two year olds were up to date on immunizations

Nurse Family Partnership: Revision of TCA 68-1-2501 designated TDH as the responsible agency for establishing, monitoring and reporting on the Nurse Family Partnership (NFP) pilot project. This state law requires the replication of the national evidence-based program; the project is located at Le Bonheur Hospital in Memphis and targets vulnerable, pregnant mothers to increase the likelihood of achieving healthy outcomes with their first child. Developed by Dr.

David Olds, the Nurse-Family Partnership model has demonstrated results through three major randomized, controlled trials, including one in Memphis in the late 1980's. A longitudinal study of that trial is still being conducted and reports indicate overwhelmingly positive outcomes. Le Bonheur Community Health and Well-Being (formerly Le Bonheur Community Outreach) was approved by the NFP National Service Office (NSO) in November 2009 as an implementation site.

Staff hiring was completed in late November 2009 and the required national training was completed in January 2010. The program currently has 88 families enrolled. Guidelines provided by NFP National Service Office and the Partners in Parenting Education (PIPE) Curriculum are used for home visiting and parenting education.

Visit Guideline /Assessment Schedule for Nurse Family Partnership:

- Enrolled client receive weekly visit for the first four weeks,
- Then biweekly visit until the infant the infant is born,
- Then weekly visit for the first six weeks postpartum,
- Then biweekly visit until child becomes 21 months,
- Then monthly visit until child turns 24 months (2 years).

Status of those receiving Nurse Family Partnership (NFP) services in FY 2010 Based on data submitted by Le Bonheur Community Health

- A total of 172 clients were referred.
- 66.9% (115/172) of referred clients were eligible.
- 90.4% (104/115) of the eligible clients were enrolled.
- 9.6% (11/115) of the eligible clients declined enrollment.
- 91.4% of the expected visits, based on the visit schedule required for the length of time enrolled, were completed.
- 100% of enrolled client received weekly visits for the first four weeks.

Status of Mothers Served in FY 2010

- Out of the 104 enrolled clients, 88 remained compliant with visit schedule.
- 16 cases were closed for the following reasons: 6 miscarriages before 8 weeks gestation; 2 moved out of state and 8 could not be located.
- 100% of enrolled and active clients had prenatal care

- 98% (102/ 104) enrolled before 28 weeks pregnant
- 2% (2/104) enrolled between 28 and 29 weeks (Due to change in due date by medical provider)

Status of Infants in FY 2010

- A total of 39 infants were born
- 57.9% (22/ 39) initiated breastfeeding
- 100% were up-to-date with immunizations
- 98% kept all visits for well baby appointments
- One pregnancy resulted in delivery of very low birth weight twins at 24 weeks gestation (Mother enrolled in program at 22 weeks)

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 11-18) list the goals, objectives, 2010 status based on program data, reference to the Healthy People 2010 national objectives and the statewide indicators 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 2010

Home Visiting Project	Location	Program Model	Target Group(s)	Number served FY2010	Types of Service provided	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	741 families with 1,133 children served	1. Family Assessment 2. Developmental screening 3. Nutrition Assessment 4. Referral for other services as needed 5. Monthly home visits	1. 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	1,240 families with 1,404 children served	1. Family Assessment and Stress Inventory 2. Developmental screening 3. Referral for needed services 4. Home visits as scheduled	1. 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	5,996 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. 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	88 clients enrolled between January 2010 and September 2010	Intensive home visiting services with caseload of 25 or less per worker	Current status: Hired staff of 4 nurses/1 nurse supervisor Completed training with national trainers in January 2010. Began enrolling clients in January

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

Home Visiting Program	GOAL(s)	OBJECTIVES	STATUS FY 2010	Comparison to Targets		
				CHAD	TN Population At Large	Healthy People 2010
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% (1,110/1,133) of enrolled children free of child abuse and neglect as measured by DCS reported involvement in prior 12 months. 2% (23/1,133) children entered DCS custody in this time period.	20.3/1000	7/1000 (2008)	10.3/1,000 ¹
	2) To promote family health	2) 90% of 2 year olds fully immunized (establishes that the child has and uses a medical home)	2) 78% (154/198 of children who turned 2 during the year) were up to date on immunizations	78%	82.3% (2008)	90% ²

¹ Healthy People 2010-15-33a

² Healthy People 2010 -14-22

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

Home Visiting Program	GOAL(s)	OBJECTIVES	STATUS FY 2010	Comparison to Targets		
				HEALTHY START	TN Population At Large	Healthy People 2010
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.	1) 98.8% (1,387/1,404) of those served did not exhibit signs of abuse or neglect during the fiscal year. 17 (1.2%) families were reported by HS workers as suspected for abuse or neglect.	12.1/1000	7/1000 (2008)	10.3/1000 ³
	2) To promote and improve health status of family members	2a) At least 90% of program children are up to date with immunizations by their 2 nd birthday. (Establishes patient has medical home and uses medical home.)	2a) 95% (418/440) children were up to date on immunizations by their 2 nd birthday	95%	82.3%	90% ⁴
		2b) 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.	2b) 93% (1,028/1,106) were not pregnant one year after the birth of the previous child	93%	Tennessee PRAMS data not yet available.	Comparable national target not available.

³ Healthy People 2010, 15-33a

⁴ Healthy People 2010, 14-22

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

Home Visiting Program	GOAL(s)	OBJECTIVES	STATUS FY 2010	Comparison to Targets		
				HUGS	TN Population At Large	Healthy People 2010
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.	1 a) 64.9% (1,430/2,202) of HUGS prenatals had adequate prenatal care. 4.8% (106/2,202) had no prenatal care	64.9%	Tennessee PRAMS data not yet available.	90% ⁵
		1b) At least 90% of women will not smoke during pregnancy.	1b) In the HUGS population, 71.9 % (1,583/2,202) of women reported that they did not smoke during pregnancy.	71.9%	81% (2006-2008)	99% ⁶
		1c.1) At least 90% of women clients are practicing some form of birth spacing.	1c) 54.1% (1,192/2,202) of the births were to first time mothers	54.1%	Tennessee data not available	Comparable national target not available.
		1c.2) New mothers delay another pregnancy for at least 12 months.	1c.2) Of the 1,010 mothers with at least one previous birth, 924 or 91.5% had a birth interval greater than 12 months.	91.5%	Tennessee PRAMS data not yet available.	Comparable national target not available.
		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) 93.4% (2,057/2,202) of babies born to HUGS participants were of a healthy weight. The average birth weight was 2,983 grams.	93.4%	90.6% (2008)	95% ⁷

		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.	1e) The average gestational age was 37.5 weeks and the average number of prenatal visits was 10.0 per mother.	N/A	90% (2008)	92.4% ⁸
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) 74% (650/878) of the 2 year olds were up to date on immunizations		74%	82.3% (2008)	90% ⁹
	2b) At least 90% of infants and children enrolled will receive age appropriate screening for developmental delays.	2b) 11,889 developmental screenings were completed on enrolled children; of these 1,740 or 14 % indicated developmental delays.		N/A	Tennessee state-level data not available	Comparable national target not available.
	2c) 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) 98% (5,909/5,996) of service referrals were completed for identified problems. (Based on data from July 2009 – January 2010.)		98%	Tennessee state-level data not available.	Comparable national target not available.

		2d) Adequate parenting skills demonstrated by no involvement with the Department of Children's Services system during the fiscal year.	2d) Of the 5,100 children matched with DCS 3% (157/5,100) were indicated cases of abuse or neglect.	30.8/1000	7/1000 (2008)	10.3/1000 ¹⁰
		2e) Enrolled mothers and children participate in WIC	2e) 96% (3,549/3,690) of eligible women were enrolled in WIC. 80.5% (4,831/5,996) of enrolled children were enrolled in WIC	96.5%/80.5%	Tennessee state-level data not available.	Comparable national target not available.

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

Home Visiting Program	GOAL(s)	OBJECTIVES	STATUS FY 2010	Comparison to Targets		
				NURSE FAMILY PARTNERSHIP	TN Population At Large	Healthy People 2010
NURSE FAMILY PARTNERSHIP (Goals and Objectives taken from the contract scope of services based on the national program model)	1) Improved pregnancy outcome	1a) At least 75% of eligible women referred to the program will be enrolled.	1a) 90.4 % (104/115) of the referred women were enrolled in the program..	90.4%	Tennessee state-level data not available.	Comparable national target not available.
		1b) At least 90% of enrolled pregnant women have adequate prenatal care. (ie enrolled in first trimester)	1b) 78% (69/88) received adequate prenatal care defined by entering care during the first trimester. 100% (88/88) of women received some prenatal care.	78%	Tennessee state-level data not available.	Comparable national target not available.
		1c) At least 20% or greater reduction in the percentage of women smoking from intake to 36 weeks of pregnancy	1c) 95.4% (84/88) of women reported that they did not smoke during pregnancy	95.4%	81% (2006-2008)	99% ¹¹

		1d) On average a 3.5 reduction in the number of cigarettes smoked per day between intake and 36 weeks of pregnancy	1d) 2 of the 4 women who smoked reduced smoking from 5 cigarettes to 2 cigarettes	N/A	N/A	N/A
2) Improved child health and development		2a) 90% or greater completion of recommended immunizations by the time the child is two years of age.	2a) No enrolled child has attained 2 years of age to date. 100% of infants are up to date on immunizations.	N/A	82.3% (2008)	90% ¹²
		2b) Adequate parenting skills demonstrated by involvement of mothers and fathers using Partners in Parenting Education (PIPE) curriculum	2b) No incidence of child abuse and/or neglect among families receiving service has been reported or observed by the families receiving services	0/1000	7/1000 (2008)	10.3/1000 ¹³
		2c) Enrolled mothers and children participate in WIC	2c) 51.2% (45/88) clients (mothers and babies) are receiving WIC.	51.2%	Tennessee state-level data not available.	Comparable national target not available.
		2d). At least 90% of infants and children enrolled will receive age appropriate screening for developmental delays.	2d). Ages and Stages questionnaire will be used for developmental screening beginning at 4months of age per NFP Guidelines.	N/A	Tennessee state-level data not available.	Comparable national target not available.

	3) Improve economic self sufficiency.	3a) Fewer than 25% of clients will have a subsequent pregnancy in 24 months.	3a) No subsequent pregnancies during project period.	0%	Tennessee state-level data not available.	Comparable national target not available.
		3b) Mothers without a high school diploma or GED will enroll in school	3b) 20% (18/88) went back to school (high school, college or vocational) after six weeks post- partum check up.	20%	Tennessee state-level data not available.	Comparable national target not available.
		3c) No criminal activity reported on all the mothers receiving service.	3c) No criminal activity reported.	0%	Tennessee state-level data not available	Comparable national target not available.

Challenges and Opportunities

Variation in Program Models and Data Collection

There are variations in the funding sources for each of the four home visiting programs implemented by the Tennessee Department of Health (TDH) that require different measures for data collection and reporting annual impact. This requires four different systems for collecting and analyzing the data which have been hampered by lack of capacity in TDH's patient information management system (Patient Tracking Billing Information System, or PTBMIS) and by shortages in staff with skills in data analysis.

PTBMIS is a 30 year old DOS system that has served TDH 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 more robust new system will 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 data to aid in evaluating the effectiveness of programs offered by TDH. Until such a system can be developed, TDH has limited capacity to obtain and manage critical data for decision-making and program development.

In 2008 TDH decided to utilize PTBMIS to create a HUGS database. Since PTBMIS is the only statewide system that every clinic, both rural and metro, uses to record patient data, we modified the system by adding a HUGS module. The module consists of family and individual screens. Staff enter the data, and once collected, it is analyzed and reported back to each region. The current process is cumbersome and labor-intensive.

Healthy Start program personnel enter participant and program service data into an on-site database specifically designed to meet the reporting requirements of the funding source. Since these sites are community based agencies, they do not have access to PTBMIS. The

individual sites' statistics are compiled, analyzed and reported by Department of Health central office staff. The required annual legislative report reflects the summary each year.

Child Health and Development (CHAD) currently uses a manual data collection system established by the funding source. The Department of Children's Services requires child and family data as well as a client satisfaction survey and outcome data.

In compliance with Nurse Family Partnership (NFP) guidelines, all data collected by Le Bonheur's NFP program is entered into the Clinical Information System (CIS), a data base designed by and for NFP programs to report participating family characteristics, needs, services provided and progress toward meeting program goals. The program employs an administrative assistant to input all NFP data into CIS in an accurate and timely manner. Data from each visit is entered into the national web-based Clinical Information System. These data are monitored to ensure that the program is implemented with fidelity to the model as tested in the original randomized, controlled trials so that comparable results are achieved.

Meeting the challenges of data collection is an issue statewide. While it is important to ensure that the information is collected, it is just as important to have a database that is user friendly. Staff must be trained on how to use the system as well as data input. The *Home Visiting Review* conducted by the Governor's Office of Children's Care Coordination and summarized later in this section, identified the need for consistent, cross program agreement on outcome measures that would affect data collection methods. The benefit would be that impact across programs could be compared for effectiveness and program impact. Ensuring the accuracy, reliability and validity of the data must be considered before the information is collected. Other challenges regarding data collection include:

- Cost
- Administrative Support
- Communication
- Ongoing Training
- Data Retrieval and Uses

Staff Qualifications and Training

Home visiting program effectiveness is heavily influenced by staff qualifications and training. Research has shown that home visitors may be professionals, paraprofessionals, paid workers or volunteers. The Tennessee Department of Health home visiting programs use a variety of professionals and paraprofessionals. Of the 165 individuals surveyed who were working in the TDH home visiting programs, 151 responded and indicated their education status as follows:

- 20 % Bachelor of Science in Nursing (BSN)
- 1% Masters in Social Work (MSW)
- 7 % Diploma Nurse
- 11 % Bachelor in Social Work (BSW)
- 36 % Bachelor of Arts (BA) or Bachelor of Science (BS)
- 12% Some College/ 2 years
- 7 % High School Diploma or General Education Degree (GED)

Nurse Family Partnership (NFP) program is staffed in accordance with national program guidelines, a nurse supervisor and four nurse home visitors who were hired and completed the mandatory NFP core training in January 2010. The nurse supervisor holds a Master of Science in Nursing (MSN) degree and has over 15 years experience working with prenatal and new mothers in both clinical and home settings. The four nurse home visitors all have BSN degrees and experience in labor and delivery. 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.

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 which previously provided ancillary services to the home visiting staff and families.

Community Referral Resources

Home visiting program staff must have adequate referral networks to address family 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 assessments of maternal depression without treatment and therapeutic interventions being available across the state.

Each program has a different but similar system for referring families to needed services. The HUGS referral tracker, implemented in July 2009, is an electronic system to track referrals and document services received from community agencies. This system helps us identify, at the

regional level, the type and frequency of needs experienced by families and strengths and gaps in referral systems.

The Referral Tracker is used by workers to record:

- The individual or family receiving services
- The problem
- The date the problem was identified
- The date the referral was made
- The status of the referral
- The date services begin and end
- Reasons for services ending

These data allow evaluation of program process measures. The following is based on the 7 month pilot evaluation. More detailed information about this system and results will be included in next year's report.

- 6,491 problems or issues were identified in the time period
- 91% (5,909/6,491) service referrals were completed for identified problems
- 94% (5,527/5,909) were referred for identified need within 30 days
- 32% (1,866/5,909) of those referred, had service started by January 2010

The Home Visiting Review 2010

In August 2009 the Governor's Children's Cabinet requested that the Governor's Office of Children's Care Coordination (GOCCC) conduct a review of all home visitation programs in Tennessee. The Department of Health as well as other state and private non-profit entities active in providing home visiting services participated on the advisory committee to develop this report. Home visitation programs were defined by those programs that made at least one home visit per month. The link to the complete report is

<http://www.tn.gov/goccc/reports/docs/homevisitation.pdf>. The following recommendations were contained in the final report.

Recommendation 1: *Develop administrative relationships that assure organized, accountable referral and service delivery systems.*

Organize referral systems to help to assure efficient access to and utilization of service capacity, identify unmet need and service gaps, and increase awareness about services, simplifying a family's effort to find services to meet unique needs.

Recommendation 2: *Establish clear distinctions among programs' purposes and stratify their intensities as mechanisms to develop a continuum of early childhood services.*

Establishing a continuum of service models based on a screening process that will direct families toward an appropriate level of support to meet differing levels of needs.

Recommendation 3: *Develop an evaluation system using common, measureable outcomes among HV programs.*

Policy makers and funders increasingly ask for outcome data that indicate services are effective. Tennessee home visiting services should work toward consensus on common, shared measures supported by outcomes of individual programs to have consistency across programs and supportable outcome measures. As an example, different home visiting programs in Wisconsin agreed upon common outcome measures report their results annually.

Recommendation 4: *Utilize the information developed during the Review to help guide the expansion or initiation of additional HV services under the new federal guidelines and funding opportunity.*

The state Home Visiting Collaboration, a voluntary group of 150 home visiting providers formed four ad hoc committees to address these recommendations. Each committee will review best practices from other states, national research on home visiting practices and the federal legislation guidelines and home visitation experience to guide recommendations to the state.

The Resource Mapping 2010 Report

The *Resource Mapping 2010 Report* was published in accordance with Public Chapter 1197, codified as TCA 37-3-116. The report is a detailed description of federal and state funding for services for Tennessee children from birth to five years and presents expenditures on services for children for FY 2007 and FY 2008. The purpose of the statutory requirement for resource mapping is to develop a clearer understanding of services and programs for children across the state to better inform the Governor and members of the General Assembly in developing policy, setting goals and making decisions regarding allocation of funds. As additional years of data are acquired and analyzed, it will provide an opportunity to better identify trends, duplications and gaps thus allowing for more efficient use of the available resources.

The home visiting programs implemented by the Tennessee Department of Health (TDH) are represented in the *Resource Mapping 2010 Report* as a percentage of children ages 0-5 served in each county. Home visitation programs are important strategies for improving outcomes for children and families including improving school readiness. The information in this report and

the *Home Visiting Review* cited above will assist TDH in policy decisions regarding expansion and improvement in home visiting services across the state. The link to the full report is <http://www.state.tn.us/tccy/MAP-rpt10.pdf>.

Federal Legislation

The Affordable Care Act (ACA) was passed in March 2010. This legislation amended Title V of the Social Security Act which included several provisions for consumer protections and established additional funding for evidence based home visiting programs.

Tennessee has already responded to the first two components of the three part application for additional funding for home visiting programs. The initial brief statement of need and proposed structure for deciding use of the federal funds and the formal needs assessment (part two of the application) have been submitted and accepted by the federal Department of Health and Human Services. The state is awaiting the third and final guidance to submit the complete state plan.

These programs target reducing infant and maternal mortality and their underlying causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency. The purpose of the legislation is to: strengthen and improve the programs and activities carried out under this title; to improve coordination of services for at risk communities; and to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities. This opportunity will allow Tennessee to strategically plan for expanding and strengthening home visiting services to assist families with the early years of parenting and improve school readiness for Tennessee's children.

NUMBER SERVED IN CHAD AND HUGS BY COUNTY - 01/2011

Region	County	Children Served in 08 - 09			Children Served in 09 - 10		
		CHAD	HUGS	Total	CHAD	HUGS	Total
Northeast	010 - Carter	68	32	100	87	37	124
	030 - Greene	103	153	256	99	111	210
	034 - Hancock	71	30	101	29	36	65
	037 - Hawkins	150	66	216	93	70	163
	046 - Johnson	35	79	114	36	60	96
	086 - Unicoi	87	93	180	67	70	137
	090 - Washington	222	215	437	258	189	447
	Total	736	668	1,404	669	573	1,242

East Tennessee	001 - Anderson	23	45	68	18	51	69
	005 - Blount	53	48	101	28	41	69
	007 - Campbell	58	65	123	56	68	124
	013 - Claiborne	22	10	32	18	18	36
	015 - Cocke	65	35	100	13	39	52
	029 - Grainger	65	31	96	14	13	27
	032 - Hambleton	33	19	52	20	35	55
	053 - Loudon	29	17	46	38	9	47
	062 - Monroe	51	43	94	36	44	80
	065 - Morgan	18	11	29	15	23	38
	073 - Roane	28	58	86	17	24	41
	076 - Scott	71	15	86	60	22	82
	078 - Sevier	75	67	142	49	60	109
	087 - Union	7	22	29	7	17	24
	Total	621	497	1,118	404	464	868

Southeast	004 - Bledsoe		1	1		4	4
	006 - Bradley		82	82		127	127
	026 - Franklin		2	2		7	7
	031 - Grundy		3	3		9	9
	054 - McMinn		17	17		36	36
	058 - Marion		13	13		48	48
	061 - Meigs		2	2		9	9
	070 - Polk		7	7		16	16
	072 - Rhea		2	2		9	9
	077 - Sequatchie		6	6		17	17
	Total	0	135	135	0	282	282

Region	County	Children Served in 08 - 09			Children Served in 09 - 10		
		CHAD	HUGS	Total	CHAD	HUGS	Total
Upper Cumberland	008 - Cannon		8	8		7	7
	014 - Clay		15	15		13	13
	018 - Cumberland		41	41		48	48
	021 - DeKalb		31	31		22	22
	025 - Fentress		36	36		25	25
	044 - Jackson		21	21		12	12
	056 - Macon		50	50		54	54
	067 - Overton		23	23		17	17
	069 - Pickett		11	11		14	14
	071 - Putnam		88	89		93	93
	080 - Smith		41	41		34	34
	088 - Van Buren		1	1		4	4
	089 - Warren		43	43		34	34
	093 - White		33	33		31	31
Total		0	442	443	0	408	408

Mid Cumberland	011 - Cheatham		22	22		12	12
	022 - Dickson		28	28		13	13
	063 - Montgomery		37	37		54	54
	074 - Robertson		19	19		14	14
	075 - Rutherford		143	143		190	190
	081 - Stewart		13	13		3	3
	083 - Sumner		163	163		153	153
	085 - Trousdale					1	1
	094 - Williamson		32	32		139	139
	095 - Wilson		148	148		38	38
Total		0	605	605	0	617	617

South Central	002 - Bedford		142	142		148	148
	016 - Coffee		28	28		45	45
	028 - Giles		33	33		21	21
	041 - Hickman		14	14		16	16
	050 - Lawrence		24	24		27	27
	051 - Lewis		16	16		14	14
	052 - Lincoln		35	35		40	40
	059 - Marshall		23	23		28	28
	060 - Maury		39	39		88	88
	064 - Moore		1	1		1	1
	068 - Perry		2	2		7	7
	091 - Wayne		8	8		7	7
	Total		0	365	365	0	442

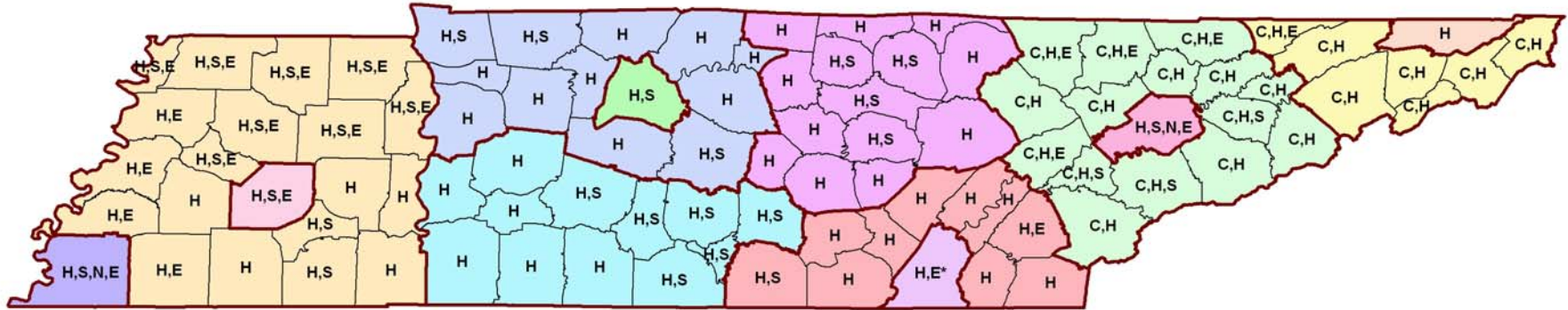
Region	County	Children Served in 08 - 09			Children Served in 09 - 10		
		CHAD	HUGS	Total	CHAD	HUGS	Total
West Tennessee	003 - Benton		9	9		12	12
	009 - Carroll		50	50		44	44
	012 - Chester		11	11		21	21
	017 - Crockett		7	7		41	41
	020 - Decatur		17	17		7	7
	023 - Dyer		70	70		79	79
	024 - Fayette		67	67		49	49
	027 - Gibson		71	71		92	92
	035 - Hardeman		47	47		37	37
	036 - Hardin		68	68		71	71
	038 - Haywood		53	53		41	41
	039 - Henderson		45	45		55	55
	040 - Henry		4	4		22	22
	048 - Lake		48	48		34	34
	049 - Lauderdale		60	60		51	51
	055 - McNairy		5	5		20	20
	066 - Obion		18	18		36	36
	084 - Tipton		90	90		123	123
	092 - Weakley		18	18		37	37
Total		0	765	765	0	872	872
Memphis Shelby		0	1,038	1,038	0	796	796
Nashville Davidson		0	593	593	0	596	596
Chattanooga Hamilton		0	307	307	0	286	286
Jackson Madison		0	57	57	0	53	53
Knoxville Knox		0	99	99	0	336	336
Blountville Sullivan		0	276	276	0	271	271
Grand Total		1,357	5,847	7,205	1,073	5,996	7,069

Appendices

- A. State Map with Program Locations
- B. Contract Agencies Providing Services
- C. State statutes/TCA codes and Affordable Care Act (ACA)

Appendix A

TN Home Visiting Programs by County



Tennessee Department of Health Regions

 Davidson	 Shelby
 East	 South Central
 Hamilton	 Southeast
 Knox	 Sullivan
 Madison	 Upper Cumberland
 Mid-Cumberland	 West
 Northeast	

C - CHAD Program (22 Counties)

H - HUGS Program (95 Counties)

S - State Healthy Start Program (30 counties through contracts with CBOs)

N - Nurse Family Partnership (2 Counties)

E - Early Head Start (21 Counties)*

Updated September, 2010

* Within Hamilton County, Early Head Start is limited to the city of Chattanooga

Appendix B

Agencies Providing Healthy Start Services Contracts through the TN Department of Health December 2010

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 2010**

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.

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).

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.

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.

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.

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

Entities receiving grants shall report to the health 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.

**H. R. 3590—216 Federal Legislation-Affordable Health Care
Subtitle L—Maternal and Child Health Services**

SEC. 2951. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following new section:

SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

(a) PURPOSES.—The purposes of this section are—

- (1) to strengthen and improve the programs and activities carried out under this title;
- (2) to improve coordination of services for at risk communities; and
- (3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities.

(b) REQUIREMENT FOR ALL STATES TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies—

(A) communities with concentrations of—

- (i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;
- (ii) poverty;
- (iii) crime;
- (iv) domestic violence;
- (v) high rates of high-school drop-outs;
- (vi) substance abuse;
- (vii) unemployment; or
- (viii) child maltreatment;

(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

- (i) the number and types of individuals and families who are receiving services under such programs or initiatives;
- (ii) the gaps in early childhood home visitation in the State; and
- (iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k)(2); and

(C) the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into

account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment required under section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State required under section 205(3) of the Child Abuse Prevention and Treatment Act.

(3) SUBMISSION TO THE SECRETARY.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

(A) the results of the statewide needs assessment required under paragraph (1); and

(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include applying for a grant to conduct an early childhood home visitation program in accordance with the requirements of this section.

(C) GRANTS FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS.—

(1) AUTHORITY TO MAKE GRANTS.—In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to enable the entities to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) to eligible families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, school readiness, and the socioeconomic status of such families, and reductions in child abuse, neglect, and injuries.

(2) AUTHORITY TO USE INITIAL GRANT FUNDS FOR PLANNING OR IMPLEMENTATION.—An eligible entity that receives a grant under paragraph (1) may use a portion of the funds made available to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

(3) GRANT DURATION.—The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

(4) TECHNICAL ASSISTANCE.—The Secretary shall provide an eligible entity that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds.

(d) REQUIREMENTS.—The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

(1) QUANTIFIABLE, MEASURABLE IMPROVEMENT IN BENCHMARK AREAS.—

(A) IN GENERAL.—The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program in each of the following areas:

(i) Improved maternal and newborn health.

- (ii) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.
- (iii) Improvement in school readiness and achievement.
- (iv) Reduction in crime or domestic violence.
- (v) Improvements in family economic self-sufficiency.
- (vi) Improvements in the coordination and referrals for other community resources and supports.

(B) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the 3rd year in which the eligible entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

(ii) CORRECTIVE ACTION PLAN.—If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

(iii) TECHNICAL ASSISTANCE.—

(I) IN GENERAL.—The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

(II) ADVISORY PANEL.—The Secretary shall establish an advisory panel for purposes of obtaining recommendations regarding the technical assistance provided to entities in accordance with subclause (I).

(iv) NO IMPROVEMENT OR FAILURE TO SUBMIT REPORT.—If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required under clause (i), the Secretary shall terminate the entity's grant and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

(C) FINAL REPORT.—Not later than December 31, 2015, the eligible entity shall submit a report to the Secretary demonstrating improvements (if any) in each of the areas specified in subparagraph (A).

(2) IMPROVEMENTS IN OUTCOMES FOR INDIVIDUAL FAMILIES.—

(A) IN GENERAL.—The program is designed, with respect to an eligible family participating in the program, to result in the participant outcomes described in subparagraph (B) that the eligible entity identifies on the basis of an individualized assessment of the family, are relevant for that family.

(B) PARTICIPANT OUTCOMES.—The participant outcomes described in this subparagraph are the following:

(i) Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes

(ii) 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.

(iii) Improvements in parenting skills.

(iv) Improvements in school readiness and child academic achievement.

(v) Reductions in crime or domestic violence.

(vi) Improvements in family economic self-sufficiency.

(vii) 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.

(3) CORE COMPONENTS.—The program includes the following core components:

(A) SERVICE DELIVERY MODEL OR MODELS.—

(i) IN GENERAL.—Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

(I) The model conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant, (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous—

(aa) randomized controlled research designs, and the evaluation results have been published in a peer-reviewed journal; or

(bb) quasi-experimental research designs.

(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and

the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

(ii) MAJORITY OF GRANT FUNDS USED FOR EVIDENCE-BASED MODELS.— An eligible entity shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II).

(iii) CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF MODELS.— The Secretary shall establish criteria for evidence of effectiveness of the service delivery models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

(B) ADDITIONAL REQUIREMENTS.—

(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

(iii) The program maintains high quality supervision to establish home visitor competencies.

(iv) The program demonstrates strong organizational capacity to implement the activities involved.

(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

(4) PRIORITY FOR SERVING HIGH-RISK POPULATIONS.—The eligible entity gives priority to providing services under the program to the following:

(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).

(B) Low-income eligible families.

(C) Eligible families who are pregnant women who have not attained age 21.

(D) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services.

(E) Eligible families that have a history of substance abuse or need substance abuse treatment.

(F) Eligible families that have users of tobacco products in the home.

(G) Eligible families that are or have children with low student achievement.

(H) Eligible families with children with developmental delays or disabilities.

(I) Eligible families who, or that include individuals who, are serving or 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.

(e) APPLICATION REQUIREMENTS.—An eligible entity desiring a grant under this section shall submit an application to the Secretary for approval, in such manner as the Secretary may require, that includes the following:

(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve high risk populations described in subsection (d)(4).

(2) An assurance that the entity will give priority to serving low-income eligible families and eligible families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).

(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

(4) A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations is consistent with the results of the statewide needs assessment conducted under subsection (b).

(5) The quantifiable, measurable benchmarks established by the State to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A).

(6) An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

(7) Assurances that the entity will establish procedures to ensure that—

(A) the participation of each eligible family in the program is voluntary; and

(B) services are provided to an eligible family in accordance with the individual assessment for that family.

(8) Assurances that the entity will—

(A) submit annual reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require; and

(B) participate in, and cooperate with, data and information collection necessary for the evaluation required under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

(9) A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this title with

funds made available from allotments under section 502(c), programs funded under title IV, title II of the Child Abuse Prevention and Treatment Act (relating to community-based grants for the prevention of child abuse and neglect), and section 645A of the Head Start Act (relating to Early Head Start programs).

(10) Other information as required by the Secretary.

(f) MAINTENANCE OF EFFORT.—Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

(g) EVALUATION.—

(1) INDEPENDENT, EXPERT ADVISORY PANEL.—The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood development—

(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after the date of enactment of this section;

(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

(2) AUTHORITY TO CONDUCT EVALUATION.—On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (b) and the grants made under subsections (c) and (h)(3)(B). The evaluation shall include—

(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

(B) an assessment of—

(i) the effect of early childhood home visitation programs on child and parent outcomes, including with respect to each of the benchmark areas specified in subsection (d)(1)(A) and the participant outcomes described in subsection (d)(2)(B);

(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and

(iii) the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

(3) REPORT.—Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

(h) OTHER PROVISIONS.—

(1) INTRA-AGENCY COLLABORATION.—The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to—

(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii)(II) and (g)(1), and the evaluation and report required under subsection (g); and

(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development of the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE NOT STATES.—

(A) INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS.—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

(ii) establish quantifiable, measurable 3- and 5- year benchmarks consistent with subsection (d)(1)(A).

(B) NONPROFIT ORGANIZATIONS.—If, as of the beginning of fiscal year 2012, a State has not applied or been approved for a grant under this section, the Secretary may use amounts appropriated under paragraph (1) of subsection (j) that are available for expenditure under paragraph (3) of that subsection to make a grant to an eligible entity that is a nonprofit organization described in subsection (k)(1)(B) to conduct an early childhood home visitation program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require the organization to—

(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

(ii) establish quantifiable, measurable 3- and 5- year benchmarks consistent with subsection (d)(1)(A).

(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

(A) IN GENERAL.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

(B) REQUIREMENTS.—The Secretary shall ensure that—

(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A);

(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

(i) APPLICATION OF OTHER PROVISIONS OF TITLE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

(C) Section 504(d) (relating to a limitation on administrative expenditures).

(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section. H. R. 3590—225

(E) Section 507 (relating to penalties for false statements).

(F) Section 508 (relating to nondiscrimination).

(G) Section 509(a) (relating to the administration of the grant program).

(j) APPROPRIATIONS.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

- (A) \$100,000,000 for fiscal year 2010;
- (B) \$250,000,000 for fiscal year 2011;
- (C) \$350,000,000 for fiscal year 2012;
- (D) \$400,000,000 for fiscal year 2013; and
- (E) \$400,000,000 for fiscal year 2014.

(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

- (A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and
- (B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

(3) AVAILABILITY.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be used for grants to nonprofit organizations under subsection (h)(2)(B).

(k) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—

(A) IN GENERAL.—The term ‘eligible entity’ means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

(B) NONPROFIT ORGANIZATIONS.—Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visitation programs or initiatives in a State or several States.

(2) ELIGIBLE FAMILY.—The term ‘eligible family’ means—

- (A) a woman who is pregnant, and the father of the child if the father is available; or
- (B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child’s primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.”

(3) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ‘Indian Tribe’ and ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings given such terms in section 4 of the Indian Health Care Improvement Act.”.